



# **Support at Home Program submission to Senate Community Affairs References Committee**

Prepared by  
**COTA Australia**

**July 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.

## About COTA National Alliance

COTA Australia is part of the national COTA Alliance along with the 8 State and Territory COTA organisations. The National Alliance partners have contributed their knowledge and experiences in their local areas to this submission.

The COTA National Alliance is deeply committed to safeguarding the rights, dignity, and well-being of older Australians and ensuring their voices are central to all policies and programs that impact their lives.

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## Introduction

The Support at Home program is a central part of the aged care reforms recommended by the Royal Commission into Aged Care Quality and Safety. COTA Australia supports the objective of a rights-based, integrated home and community care system that enables older people to live safely, independently and with dignity at home.

The program contains positive design features, including eight ongoing funding classifications, dedicated restorative and end-of-life pathways, separate funding for assistive technology and home modifications, fully funded clinical care, and greater transparency about care management costs. These features provide a sound platform, but the design and implementation must work in practice for older people.

Since the program commenced on 1 November 2025, older people have reported serious problems with access, waiting times, interim funding, pricing, service reductions, assessment outcomes, provider choice, self-management, hardship assistance and access to assistive technology and home modifications. Some problems carried over from the previous Home Care Packages Program. Others developed under the new arrangements.

The common thread is a gap between the program's rights-based objectives and the experience of people trying to obtain and manage essential support. Older people have described a system that is difficult to navigate, slow to respond and too dependent on provider practices that are not always transparent or consistent.

*"I have written detailed letters to my Member of Parliament. The situation is utterly appalling. My relative has received contradictory, incorrect information in letters, and I have spent dozens of hours on the phone. The distress and frustration is indescribable. The system is broken".55-59 years, Female, New South Wales*

This submission is informed by COTA Australia's ongoing engagement with older people, input from the COTA alliance, and a national survey undertaken with OPAN that included direct quotations and case studies. The experience of older people is integrated throughout the submission because it is evidence of how policy settings operate in practice.

A Catalyst Australia study supported by COTA Australia found that two in three respondents had a negative experience of home care or home support following the introduction of Support at Home. Cost, access, administrative complexity, communication and assessment were the most common concerns. New participants were generally more positive, but also raised concerns about cost, inflexibility and inadequate communication.<sup>1 2</sup>

Any further reform of care delivered at home must result in older people receiving more timely, appropriate and effective support, not simply a different set of program rules.

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<sup>1</sup> The Catalyst Report 2026 – Home Care Study

<sup>2</sup> *ibid*

## Executive summary

COTA Australia supports the purpose of Support at Home and the shift to a rights-based aged care system. However, the program is not yet reliably delivering the timely, affordable and person-centred support older people were promised. The key test is not whether administrative milestones are met. It is whether an older person can obtain the services, equipment and support they have been assessed as needing, when they need them, at a price they can afford.

The evidence presented to COTA Australia shows that long waits, partial funding, higher prices, confusing contracts, restricted provider choice and inconsistent assessment outcomes are reducing services and undermining trust. These problems are most serious for people with declining health, low or fixed incomes, limited family support, complex needs, or few providers in their area. They also place additional pressure on carers, hospitals and residential aged care.

*“The situation is utterly appalling. My relative has received contradictory, incorrect information in letters, and I have spent dozens of hours on the phone. The distress and frustration is indescribable. The system is broken.”*  
55-59 years, Female, New South Wales

COTA Australia’s primary purpose in this submission is to highlight the experiences of older people against the Committee’s terms of reference and recommend improvements to the design and implementation of Support at Home. The recommendations have been developed around four operational priorities: timely access, affordability and consumer protection, genuine autonomy, and effective stewardship of the broader home support system.

## Priority reform agenda

- Waiting lists and waiting times: publish a funded strategy by 30 June 2027 to reduce the waiting list and establish an official benchmark that no older person waits more than 30 days from application to receiving support. Reporting must cover each stage from application and assessment through to funding, agreement and activation of individual services.
- Interim packages: require interim packages to convert to the full assessed package value within 30 days. The maximum period must be enforceable through the Rules, and participants must receive clear information about the amount, expected duration and next steps.
- Assessment and reassessment: restore capacity for assessors and relevant health professionals to override the Integrated Assessment Tool where professional judgement indicates that the automated outcome does not reflect the person’s needs. Rapid review, transparent guidance and analysis of appeals and complaints are required.

- Pricing and consumer protection: implement enforceable pricing protections that preserve the purchasing power of packages and protect against unreasonable unit prices, unaffordable total contributions, hidden charges and unfair contract terms. Government should publish its pricing methodology, and regulators should actively enforce compliance.
- Choice, self-management and multiple providers: endorse the right of older people to self-manage and implement a multiple-provider system no later than 1 July 2027. Older people should be able to engage suitable registered providers and specialist suppliers directly, with proportionate administrative requirements and clear accountability.
- Assistive technology and home modifications (AT-HM): amend the application pathway and program guidelines to improve access to AT-HM support including for people where equipment or home modifications is their primary need. Existing clinical evidence should be used, funding tier decisions should be transparent, and provider conflicts of interest must be addressed.
- Financial hardship: redesign hardship provisions so they are simpler, faster and fairer. The settings must reflect actual living costs, debt and housing circumstances, provide automatic or streamlined assessment for people at greatest risk, and require determinations within 28 days.
- Entry-level home support: set a clear reform agenda and timetable for quality entry-level home care and support services. Reform of the Commonwealth Home Support Program must be co-designed with older people, protect continuity of current services, measure unmet demand and connect entry-level support with more intensive care.

Supporting reforms are also needed. These include independent navigation support, standardised plain English service agreements, stronger regional stewardship, protection of specialist and culturally safe services, improved respite and hospital discharge arrangements, and linked data across aged care, health and community services.

Support at Home can deliver better outcomes. Doing so requires access, affordability, professional judgement and participant autonomy to be core safeguards, not optional features. The program should be judged by the support that reaches older people and the outcomes it enables in their homes and communities.

## Terms of Reference (a): The ability for older Australians to access services to live safely and with dignity at home

### Waiting times are unsafe and undermine trust

As at 31 March 2026, official government data shows that around 198,797 older Australians were waiting for an assessment or for Support at Home services to be assigned<sup>3</sup>. The average time from application to commencement of ongoing services was 364 days.<sup>4</sup> Given this is the average timeframes, many older people are also waiting far longer.

Older people and carers generally seek assistance because support is already needed. Delay can cause deterioration, falls, carer breakdown, avoidable hospital stays and premature entry to residential care. In the worst cases, people die while waiting<sup>5</sup>. The burden also falls heavily on family and friend carers, particularly women who may reduce or leave paid work.<sup>6</sup>

Government's commitment to reduce waits to 90 days by 30 June 2027 is an improvement, but it remains too long for a person with assessed support needs. COTA Australia's benchmark is no more than 30 days from application to the delivery of support, backed by a waiting-list reduction strategy.

The longer-term objective should be an integrated and sufficiently funded home support system in which basic assistance starts early and prevents avoidable deterioration.

In COTA Australia and OPAN's national survey, more than seven in ten aged care participants found the wait for approved services difficult or very difficult. This was the most challenging stage of access reported by participants.<sup>7</sup>

Once services commenced, more than half of respondents reported a positive experience, while 37 per cent reported a negative experience. This reinforces that delay, rather than the value of support itself, is the main issue people experience.<sup>8</sup>

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<sup>3</sup> This includes 98,606 referrals for aged care needs assessments 'on hand' (which includes people awaiting a triage decision), as well as 100,191 people waiting for their approved SAH classification or Transitioned HCP level (at either an interim or full package value). There may be some duplication of individuals in both figures reported given the revised methodology of removing people from the reassessment and support plan review from the wait times report announced in August 2026.

This figure does not include the 53,718 people (as at 31 March 2026) who had been allocated interim funding and were waiting for their full funding, as outlined to [Senate Estimates on 2 June](#) (pg 54). The total number of people waiting for their full funding at their assessed level of need would therefore be 252,515.

<sup>4</sup> Australian Government Department of Health, Ageing and Disability (2026) Aged Care Act 2024 Wait Times Report: Residential care and Support at Home, First report, 1 November 2025 – 31 March 2026.

<sup>5</sup> *ibid*

<sup>6</sup> In 2024-25 4,812 older people died while waiting for a Home Care Package. Additional Estimates, Community Affairs Committee, February 2026. Available from: <https://cathnews.com/2026/02/13/aged-care-crisis-revealed-as-almost-5000-people-died-waiting-for-help/>

<sup>7</sup> The Plug In (2026) Support at Home National Survey Insights Report: Report for COTA Australia and OPAN (Adelaide, June 2026) Unpublished.

Patricia's experience illustrates the consequences of delay and poor communication.

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***Patricia's story (Female, 80-84 years, South Australia)***

Patricia lives alone in South Australia with a terminal illness. She sought aged care support after hospital discharge following shoulder surgery. Despite being assessed as needing urgent help, she waited almost three months for meal delivery and faced repeated delays obtaining essential equipment.

*"it took far too long to access a meal delivery service, almost 3 months".*

After several falls, Patricia sought a walker through My Aged Care. Weeks passed without resolution. With another hospital appointment approaching, she said:

*"I can't wait... I could die waiting"*

She ultimately paid \$475 herself because she feared another fall and needed to attend hospital safely. The delays and lack of communication eroded her trust in the system:

*"I am now very wary... do I trust them to send me the right thing?"*

She described the experience as one in which she:

*"had to virtually fight for [her] life."*

The absence of regular communication compounded the harm:

*"Nobody was in touch for a very long time".*

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**Recommendation 1**

**1.1 By 30 June 2027, establish as an official benchmark that no older person waits for more than 30 days from application to receiving support.**

**Waiting-time reporting must show the full pathway to services**

Waiting-list information is spread across separate government reports covering triage, assessment and funding allocation. The reports use different terminology and measures and do not provide a complete account of the time from first contact to the delivery of each approved service.

- COTA Australia's *Accessing Aged Care Framework*, detailed in Appendix 1, identifies five stages that should be measured consistently: application, assessment (incl triage decisions), funding allocation, service agreement and service activation. Reporting

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<sup>8</sup> ibid

should show volumes and actual wait times by priority, program, service type and region, including interim packages and assistive technology and home modifications.

- Comprehensive reporting is required for public accountability, workforce and service planning, and regular communication with older people about their progress. It should also identify people who have funding but cannot secure a provider or activate all assessed services.
- Confidence in the full wait time process, including a clear understanding of what is and is not being reported from the moment a person submits a referral/application on My Aged Care, until the moment their individual services commence, is needed to ensure full transparency and eliminate any confusion.

### CHSP waiting times must also be visible

The Commonwealth Home Support Program is often the first source of assistance and is also used as a stopgap while people wait for Support at Home. Yet CHSP providers manage availability and waiting lists inconsistently, and information on My Aged Care is frequently incomplete or out of date.

Waiting-time reporting should be extended to CHSP immediately. It should identify people who hold a referral but have not commenced services, the time to service commencement, and regional variation. This information is essential to understand unmet demand and plan the transition of entry-level support.

#### **Recommendation 2**

**2.1 By 30 June 2027, publish a clear strategy to reduce the waiting list and waiting times.**

**2.2 Address data gaps and inconsistent methodology for reporting aged care waiting lists and waiting times. See Appendix 1 for a suggested framework. It should include people who have applied but not yet had their application assigned to an assessment organisation, as well as reporting on how many days for individual service types to commence.**

**2.3 The Australian Government should publish more detailed AT-HM waiting time and allocation data, including the number of people waiting, the number allocated funding, pathway stage, priority, region, funding level, and the number of people allocated funding who have not yet found a provider or activated services.**

**2.4 Implement a broad population measure of the number of Support at Home places per 1,000 eligible population to inform how the program is responding to the ageing population over time.**

## Interim packages must convert to full funding within 10 weeks

As at 31 March 2026 there were 53,718 people who had been allocated interim funding and were waiting for their full funding.<sup>9</sup> Our understanding was that Interim packages, also described as Minimum Service Offers (MSO), were intended as a temporary response when demand exceeded available funding. It seems that most participants in the system are now offered an interim package providing only 60 per cent of the package they have been assessed as needing. Older people are told an average number of weeks they can expect to receive the interim package for but there are no firm guarantees about the length of time. People are confused about why, when they have been waiting for a long time, they receive less than what they were assessed as needing.

While interim support is preferable to no support, it must be genuinely temporary and accompanied by a firm conversion date.

*“Only receiving 60% of my Level 3 package. Why?”  
– 70-74 years, Female, Queensland*

The impact is not abstract. Participants report that partial funding does not cover existing services or respond to needs that have increased while they waited.

*“The 60% that lasted for six months was a nightmare as I was underfunded to meet my needs and provider support was very poor”  
– 75-79 years, Female, Victoria*

*“I was having home care services and then applied for a package and from then on, I had no idea really what was going on, when the care package came through it was level one and then finally only 60% of it came through which did not cover the services I already had., and I had since developed other health issues. The whole process was very confusing, and I am a well-educated person.” – 75-79 years, Female, South Australia*

If interim packages are to remain an ongoing feature of the system, there should be clear information for older people who receive them including a set timeline for the maximum length of time they will receive it. The Department’s stated expected average period of 10

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<sup>9</sup> Senate Community Affairs Legislation Committee, *Estimates*, 2 June 2026, Parliament of Australia, [https://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/29626/toc\\_pdf/Community%20Affairs%20Legislation%20Committee\\_2026\\_06\\_02.pdf;fileType=application%2Fpdf](https://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/29626/toc_pdf/Community%20Affairs%20Legislation%20Committee_2026_06_02.pdf;fileType=application%2Fpdf)

weeks should be stated in the Rules as the maximum time rather than expressed as an average expectation.<sup>10</sup>

Current report times do not publish figures or timeframes between allocation of interim packages and full packages. Once a person is allocated either interim or full funding they are no longer included in the wait time report. If seeking to determine the number of people waiting for the full funding, they were assessed as needing,, the 53,718 people on interim packages as at 31 March should be added to the wait times list.

### Recommendation 3

**3.1 At a minimum, legislate the Department's stated expected average period of 10 weeks as the maximum period that an interim package may be allocated before converting to the full package value.**

**3.2 Provide participants with consistent and clear information on the interim packages.**

**3.3 Include number of packages and wait times in days for interim and full package allocation in all quarterly reports for Support at Home program.**

### Reassessment must respond promptly to changed needs

Older people report long and complex reassessment processes. Some seek reassessment because their health has changed. Others seek it because higher prices have reduced the services their existing funding can purchase, even though their underlying needs have not changed.

*"I now need reassessment for extra services; the process is taking months" – Grandfathered participant, 75+<sup>11</sup>*

Industry data also indicates declining confidence in the Single Assessment System, with positive feedback falling from 46 per cent in 2025 to 32 per cent in 2026.<sup>12</sup>

The process is particularly difficult for people already struggling with inadequate support or declining capacity.

*The idea of negotiating a morass of forms & assessments is horrifying. So, we limp along without – Grandfathered participant, 75+<sup>13</sup>*

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<sup>10</sup> Mr Greg Pugh, First Assistant Secretary, Department of Health, Disability and Ageing, Senate Estimates appearance on 11 February 2026, Community Affairs Committee. Available at: [https://www.aph.gov.au/Parliamentary\\_Business/Hansard/Hansard\\_Display?bid=committees%2Festimate%2F29370%2F&sid=0000](https://www.aph.gov.au/Parliamentary_Business/Hansard/Hansard_Display?bid=committees%2Festimate%2F29370%2F&sid=0000)

<sup>11</sup> The Catalyst Report – SAH Insights 2026

<sup>12</sup> *ibid*

<sup>13</sup> *ibid*

*Need a formal assessment every time. Surely a lifetime need doesn't require repeat assessments? – Grandfathered participant<sup>14</sup>*

The maximum timeframes that published rules indicate a non-urgent reassessment can take is between 57 to 71 days from initial request to formal in-person reassessment. A participant may then wait several more months for the higher funding to be allocated and further time for this additional funding to be operationalised in services. Clear timeframes for completing reassessments and support plan reviews, along with the timeframe to allocate the approved additional funding is required.<sup>15</sup>

*"I am relieved and have confidence now that Dad is checked in on every day and he is taking his medication properly... The process to get to this point was difficult, confusing and time consuming with multiple different assessments from My Aged Care and the hospital and GP visits needed and letters from the government sent to him and then lost. Now I know he is mostly safe at home"*

*50-54 years, Female, South Australia*

While there are processes in place for urgent priority cases to be handled more quickly, the standard pathway remains too slow. A clear benchmark is required from first contact to completed in-person reassessment.

#### **Recommendation 4**

**4.1 Establish a new standard (non-urgent) Support at Home reassessment benchmark of 28 days from initial contact to formal in-person assessment to ensure existing participants, whose health circumstances significantly change, receive the higher levels of service they need in a timelier way.**

**4.2 Introduce reporting of wait timeframes and the number of people for:**

- **Support Plan Reviews and Reassessment to be completed, and**
- **the timeframe for additional funding from reassessments to be allocated.**

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<sup>14</sup> The Catalyst Report – SAH Insights 2026

<sup>15</sup> The *Aged Care Act 2024 Wait Times Report – Residential care and Support at Home Second report Quarter 4* released on 11 August advised that a Departmental review has resulted in a revised methodology where "applications from people seeking Support Plan Review or reassessment" fall outside the scope of reporting under section 342A. Until the June data for the Single Assessment System and Support at Home Program is released, it is unclear whether reassessments will be reported in any quarterly reports.

Funding from reassessments, once allocated, may not be able to be separately reported on as it will form part of an existing service agreement that would be considered already operational on the day the funding was allocated.

## Professional judgement must be able to correct assessment outcomes

A sound assessment depends on trained people observing the older person, applying clinical and professional judgement to determine the support required. The Integrated Assessment Tool should inform that process, not displace it.

COTA Australia understood that assessors and relevant health professionals would retain the capacity to override outcomes that did not accurately reflect a person's needs.

Older people have instead reported anxiety about automated decisions and a loss of trust in the assessment process.

*"My biggest concern was about the decision about my mother's level of need being determined by an algorithm - it felt a lot like RoboDebt for old people"*

*70-74 years, Female, South Australia*

Clear human oversight, transparent information and a rapid review pathway are essential. The quality and experience of the assessor also materially affect whether a person's needs are identified.

*"The algorithm used for assessing Support at Home clearly has flaws (I have assisted 3 relatives with assessments) and also how experienced the assessor is in guiding the person through the assessment makes a difference".*

*60-64 years, Female, Queensland*

COTA Care Finder services have encountered people with very high needs who were classified at Support at Home Level 1, without a clear explanation of the outcome or why it was maintained on review.

Government's rapid review and escalation work is welcome. It must result in a practical override mechanism based on appropriate clinical involvement and transparent analysis of appeals and complaints.

### **Recommendation 5**

**5.1 Ensure human clinical judgement remains central to the assessment process by establishing clear assessor and health professional override mechanisms for the Integrated Assessment Tool (IAT) supported by:**

- **publicly available guidance and decision-making criteria;**
- **an efficient review processes that allow timely amendment of inappropriate assessment outcomes and care plans; and**
- **a targeted review of assessment outcomes where concerns have been raised about the appropriateness of package levels, including cases subject to appeal, review or complaint.**

## Independent navigation support is needed for people who do not meet Care Finder eligibility

Older people consistently emphasise the value of speaking with a trusted person who can explain how the system applies to their circumstances. Existing Care Finders provide effective local support for people with complex vulnerabilities, while My Aged Care and Aged Care Specialist Officers provide important assistance. However, a gap remains for people who need short-term, low intensity help to understand options, compare providers, manage administrative processes and connect with related services.<sup>1617</sup>

A broadly available navigation service should be independent of providers, delivered by non-government organisations, and available in person as well as by phone or video. It should complement, not duplicate, Care Finders and Services Australia support.

### Services Australia

*Why changes to bank account balances require checking by Services Australia although the ACSO says they should be automatically accepted by their system. Their IT department don't seem to know either. – 60-64 years, Female, South Australia*

### My Aged Care

*MAC is EXTREMELY cumbersome to navigate even when you know data is there. E.g. doing price comparisons between providers. – 60-64 years, Female, South Australia*

## Recommendation 6

**6.1 Implement a new, independent, non-government navigation service with broad-based eligibility, providing short term, low intensity support to older people, their families and carers.**

## Remove barriers to assistive technology and home modifications

Assistive technology and home modifications can prevent falls, maintain mobility and enable older people to remain safely at home. Access therefore needs to be timely, proportionate and connected to relevant clinical and technical expertise.

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<sup>16</sup> **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>.

<sup>17</sup> In a survey with older people regarding My Aged Care and navigational support, informing a 2024 submission to the Inspector General of Aged Care, we found that for those using Aged Care Specialist Officers (ACSO) provided by Services Australia, their experience was overwhelmingly positive. ACSOs were seen as providing valuable advice, different from other Services Australia staff. Survey respondents were recommending ACSOs to other older people and thought they should be better promoted.

Participants report that the new pathway is confusing and that delays, repeated assessments, limited provider choice and inconsistent evidence requirements are preventing or slowing access.

*I've had difficulty finding a provider to assess, supply, or install assistive technology or home modifications, I have experienced long wait times or delays, there was under-assessment of needs initially, which has added to the wait.*  
– 60-64 years, Female, Queensland

The same five access stages apply to assistive technology and home modifications. The current barriers can be grouped as follows:

- **Application and assessment**
  - Older people should be able to apply specifically for equipment or a home modification without being channelled through an unnecessary ongoing package process.
- **Existing clinical evidence should be used in assessment**
  - Evidence from GPs, specialists, occupational therapists and other allied health professionals should be accepted where it establishes functional need. Older people should not have to repeat their history or undergo further assessment without a clear reason.
  - Funding-tier guidance must also be transparent. A low-tier allocation should not be consumed by the assessment required to demonstrate that a higher tier is necessary.
- **Allocation and reporting**
  - Published data indicates shorter median waits for assistive technology and home modifications than for ongoing Support at Home, but it does not show the number waiting, regional gaps, funding tiers or whether people can secure a provider after funding is allocated.
  - Quarterly reporting should show demand, allocation, provider access and service activation by pathway, priority, region and funding tier.
- **Provider choice and conflicts of interest at the agreement stage**
  - Older people should be able to choose AT suppliers and allied health professionals directly. Requiring all access to be brokered through the main Support at Home provider can add cost, delay and administrative distance.
  - Providers must disclose any commissions, rebates, preferred supplier arrangements and other financial interests. Undisclosed payments for recommending specific equipment and requiring older people to use a particular supplier under state and territory law create significant conflicts of interest, undermine informed choice, and are inconsistent with aged care obligations to respect older people's rights and decision-making.

- The Aged Care Quality and Safety Commission should actively monitor and enforce conflict of interest requirements through complaints handling, targeted compliance activity, and appropriate regulatory action where necessary.
- **Activation and market capacity**
  - Evidence and prescription requirements should be proportionate to the risk and cost of the item. Government guidance must be applied consistently by providers and assessors.
  - Payment arrangements should not drive specialist suppliers out of aged care. The system should keep older people connected to suppliers who understand selection, installation, training, maintenance and follow-up.
  - CHSP funded AT-HM and SAH funded AT-HM operate under different lifetime versus annual cap rules. COTA Australia supports the Committee's recommendation to abolish the \$15,000 lifetime cap on home modifications that may result in some older people prematurely entering residential care because of increased financial stress, hospitalisations from preventable falls including not being able to shower safely at home.<sup>18</sup>

### Interface with disability supports for people aged over 65

The Foundational Supports Agreement, recently signed by the Australian Government and state/territory governments, limits access to disability supports to people aged under 65. People with a disability over the age of 65 years who were supported by state disability programs outside of the NDIS will now be dependent on aged care to receive their supports. While the Australian Government disability approach is being redesigned, we are concerned that this will include (over time) the erosion of AT-HM equipment support or to older people with disability, increasing demand on aged care services with limited expertise and capacity.

Older people who acquire or live with disability after 65 should not be forced to undergo a holistic application and assessment process if their singular purpose of coming to aged care is their need for equipment, maintenance or disability-related supports.

There is a potential gap between disability-related equipment systems and the AT-HM scheme under the Support at Home program. People who have existing equipment provided through state-based equipment schemes or disability systems before they turn 65 may not be able to use their AT-HM funds to maintain them. The rules should support continuity of equipment and support. The Foundational Supports rule changes mean State Equipment provided to a 60yo may need to be services by a 65yo from the AT stream, but the rules don't allow that today.

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<sup>18</sup> Senate Community Affairs References Committee. (2026). The transition of the Commonwealth Home Support Program to the Support at Home Program. Parliament of Australia

## Recommendation 7

**The Australian Government should:**

**7.1 Amend the application pathway so older people can clearly apply for AT-HM support, including where their primary need is equipment or home modification support rather than an ongoing Support at Home package.**

**7.2 Publish clear guidance on funding tiers and on how evidence from GPs, specialists and allied health professionals can be used to streamline assessment and avoid unnecessary reassessment.**

**7.3 Enable multiple providers for assistive technology, home modifications and allied health so older people can directly choose and engage suitable specialist suppliers and professionals.**

**7.4 The Aged Care Quality and Safety Commission should monitor and enforce provider obligations relating to conflicts of interest, preferred supplier arrangements, disclosure and informed choice in AT-HM purchasing and service coordination.**

**7.5 The Australian Competition and Consumer Commission (ACCC) should be asked to examine preferred supplier, brokerage, rebate, commission and tied-service arrangements in the assistive technology and home modification market under Support at Home, including whether provider practices are restricting choice, limiting competition or raising exclusive dealing concerns.**

**7.6 Implement the Senate Community Affairs References Committee recommendation to abolish the \$15,000 lifetime cap on home modifications and establish a new funding framework for home modifications.**

### Standardised contracts are needed to protect informed consent

Older people report service agreements of 60 to 70 pages, little capacity to negotiate and pressure to accept provider terms. Some agreements include inappropriate guarantor provisions or do not clearly explain prices and charges.

A mandatory national plain English contract, supported by active regulatory enforcement against unfair terms, would improve comparability, informed consent and accountability. It will also be important that the Commission runs a targeted compliance/ enforcement program on contracts.

Appendix 2 outlines the proposed content and structure of a standardised aged care contract.

We would expect that the Aged Care Quality and Safety Commission would ensure compliance with aged care service agreements and contracts as part of its ongoing work.

## Recommendation 8

**8.1 The Australian Government should mandate and enforce standardised aged care contracts and provide a template for use which would:**

- a) be written in plain English and meet readability standards;**
- b) include a top sheet of key information, standard terms (such as a cooling off period), 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.**

### Self-management requires genuine autonomy and practical support

Self-management provides autonomy and control for the individual participant and increase the purchasing power of a package. Participants report, however, that providers are applying conservative approval processes and inconsistent administrative charges.

The single-provider model limits the ability of self-managing participants to engage preferred workers or suppliers directly. Associated-provider requirements and additional loadings can remove the financial benefit of self-management and weaken control over who enters the person's home.

*I self-manage. As well as the 10% Management fee they add a 10% loading fee on my invoices. This has made me worse off than when I was on HCP – 70-74 years, Female, Tasmania*

Charges beyond the permitted administration fee should be transparent, consistently applied and enforceable. A multiple-provider model is required so self-management is a genuine form of participant direction rather than a limited delegation within one provider's system.

Government information should clearly explain the right to self-manage, provider obligations, permissible fees, invoice processes and avenues for review or complaint.

*“The system needs to change so that my family member can have complete control over her package and dispense entirely with the services of a provider and then engage a service provider directly. As it stands self-management is just a means by which providers can maintain their monopoly position in the market, particularly in regional locations, and not be held to account.” – 70-74 years, Male, Victoria*

*“I self-manage and the information about the finance part of the package is mainly inappropriate. Too much time is taken to let me know what portion I have available. All information takes too long... I’m not able to know when I could have more help. Information gets to me too late to be used”. – 80-84 years, Female, Australian Capital Territory*

#### **Recommendation 9**

**9.1 The Australian Government should endorse and support the right of older people to self-manage their package and amend information, guidance and provider obligations accordingly.**

**9.2 The Australian Government should implement a system of multiple providers no later than 1 July 2027.**

#### **Medication management must remain clinically available and affordable**

Dose Administration Aids organise medicines by day and time and are important for many people with multiple medications or complex dosing schedules.

Support at Home participants can no longer use aged care funding for these aids in the same way as under Home Care Packages. Community Pharmacy Agreement funding is capped, and some pharmacies have chosen not to provide the subsidised DAA services to older people with Home Care Packages because it is more financially viable to recover the full cost through the package. This effectively allows pharmacies to reserve their capped subsidised DAA allocations for older people who are not Support at Home participants. This exacerbates inequity, particularly for financially vulnerable individuals with complex health needs.

Whilst it is understood that the Australian Government wants to avoid double funding, the safety and affordability of medication for older people is critical. The Australian Government should ensure that DAAs are available on demand where clinically required for all older people regardless of whether they are a Support at Home participant and not subject to caps.

Funding boundaries should not prevent clinically necessary medication management. Support at Home settings should align with the rights-based objectives of the Aged Care Act 2024 and provide targeted hardship and transition arrangements where cost is a barrier.

## Recommendation 10

**10.1 Review and amend SaH policy and operational settings to ensure funding arrangements support access to clinically appropriate, needs-based medication management and are consistent with the objectives of the *Aged Care Act 2024* and the SaH program.**

**10.2 Introduce targeted hardship and transition arrangements to ensure older Australians are not prevented from accessing clinically necessary medication management supports provided under the Community Pharmacy Agreement due to financial barriers or the transition from HCPs to SaH.**

## **Terms of Reference (b): The impact of co-payment contributions for independence and everyday living services on the financial security and wellbeing of older Australians**

## **Terms of Reference (c): Trends and the impact of pricing mechanisms on consumers**

COTA Australia addresses terms of reference (b) and (c) together because contribution rates, provider prices and the purchasing power of packages are inseparable in the experience of consumers.

### Pricing and contributions have reduced services and confidence

Support at Home was intended to provide better access to rights-based quality care and support independence at home. During implementation, many older people experienced the process as being dominated by prices, contributions and pressure to sign new service agreements.

The sharpest impact was on people transitioning from Home Care Packages. The “no worse off” principle meant that a transitioning individual wouldn’t pay more co-contributions than they already were assessed as needing to contribute under Home Care Packages.

Several implementation decisions negatively impacted on older people:

- price caps were delayed and providers were permitted to set their own prices;
- prices increased substantially and were applied to existing services, often requiring participants to reduce support to stay within their budget;
- provider price publication was delayed, limiting comparison at the time new agreements were being signed;
- the “no worse off” arrangements were complex and poorly communicated. Some full pensioners feared new contributions that did not apply to them, while people whose former provider had waived fees began paying contributions under Support at Home;

- the transition from Home Care Package administration charges to Support at Home unit prices was poorly explained;
- Services Australia contribution letters were often unavailable when providers sought signatures; and
- the “reasonable price” requirement was weakly defined and did not protect against unaffordable total monthly contributions, hidden charges or unfair contract terms.

*Provider staff did not have time to read the volumes of information published at the last minute in spite of the delay in implementation of SAH. The proforma Service Agreements developed by providers are poorly written and, in some cases, don't even follow very basic standards for referring to legislation etc. They appear to be deficient both from legal standpoint and by ease of understanding by those signing. Providers are still using coercion to get signed. – 60-64 years, Female, South Australia*

As a result, many people had to reduce services or pay more to maintain their previous support, despite no change in their assessed needs.

Reassessment and changing provider were theoretically available responses, but long waits and delayed price publication made both options ineffective for many people during transition.

Transitioned participants therefore commonly reported being worse off, while new participants expressed concern about whether they would be able to afford the services they need.

While some of these were transition problems, which will reduce over time, the underlying question of whether prices and contributions are affordable, transparent and fair remains.

### The full impact of standard Support at Home contributions is still emerging

At the end of March 2026, 98 per cent of Support at Home participants held transitioned Home Care Package classifications and are assumed to be protected under the “no worse off” principle. This means most people are shielded from full co-contribution rates including transitioned full pensioners who pay 0% rather than 5% or 17.5%.<sup>19</sup> For more data on

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<sup>19</sup> All people in the system on 1 November 2025 (including those with an assessment outcome, waiting for a package allocation, including waiting for their assigned level, and those who had been allocated a home care package) were transitioned into support at Home with a Transition HCP 1-4 allocation under Support at Home. The number of people currently allocated Transition HCP 1-4 packages are reported in the Support at Homes program quarterly report. However, of all those people only those participants who were in the System at 12 September 2025 had the No Worse Off principle apply to them. It is unpublished how many of these people entered the system after 12 September 2024 and would therefore pay the lower No Worse Off fee.

transitioning Support at Home participants, pricing transition and explanatory factors, see Appendix 3.

This means current system-wide data does not yet show the effect of standard Support at Home contribution rates, including contributions of up to 50 per cent for independence services and 80 per cent for everyday living services.

Any assessment of the current available data and its impact on participant purchasing decisions must be segmented between those paying:

- the lower No Worse Off co-contribution rates of between 0% and 25%, (most SaH participants) and
- those contributing under the new standard SAH contribution rates of 5 - 50% for independence services and 17.5% - 80% for everyday living services.

Government analysis should distinguish transitioned participants from people paying standard Support at Home rates and examine the combined effect of unit prices, contribution percentages and service use.

Older people transitioning from HCP to SaH, initially reported a significant amount of confusion around how a percentage-based co-contribution worked in practice. Some participants tried to work out how much they would pay per service, while many available calculators at the point of transition only discussed a quarterly or monthly overall contribution.

Higher unit prices reduced the purchasing power of transitioned packages. Some participants sought reassessment simply to maintain services they previously received, and uncertainty remained about contribution treatment when moving to a higher Support at Home classification.

### Affordability and equity must be assessed at the household level

Aged care must be affordable and equitable. A person should receive the support they need regardless of income, assets, housing tenure or the intensity of services required in a particular month.

Older people are meeting aged care costs alongside higher housing, utilities, insurance, transport and other essential expenses.

StewartBrown analysis shows that median prices for five common services increased by 39 per cent between June 2025 and February 2026. The scale and variation of increases have reduced service hours and made it difficult for older people to understand whether prices are justified.<sup>20</sup>

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<sup>20</sup> StewartBrown Home Care/Support at Home Financial Performance Survey Report (May 2026) Unpublished

This has placed pressure on people with low and/or fixed retirement incomes. COTA Australia's State of the Older Nation research found that while 28% are considered wealthy many older Australians experience financial hardship with 1 in 4 living in poverty.<sup>21</sup> We are concerned that people in poverty may decline services due to co-payments, with not all likely to be eligible for current hardship. While those in the middle living on fixed incomes will also be sensitive to price increases and cost pressures, particularly when requiring high level of services in a month and may decline services as a result.

A recent industry survey found that seven in ten respondents reported a negative Support at Home experience because costs had increased, compared with three in ten who identified inadequate provider communication.

Older people described the consequences in practical terms:

*"A transition HCP Level 3 delivers 4 hours of care per week; the rest of the budget goes to: 30min per week of physio; incontinence & nursing supplies; nutrient supplements; transport (wheelchair access taxi) to medical appointments; the occasional prepared meal, pureed L4... No \$ for OT, speech pathologist nor dietician. No room for additional hours of care should the unpaid family carer need to go out."*

*– 60-64 years, Female, Western Australia*

*"My Mum has had her needs met very well for 6 years now but since 1 November, with price increases, she has not received the same amount of services. Mum has been approved to go up one level but has been waiting 9 months for the funding".*

*– 60-64 years, Female, South Australia*

It is not acceptable for people to forgo assessed services because of price or contribution settings. "Reasonable" unit prices and a hardship process have not, by themselves, provided sufficient protection.

*"I'm concerned that when I need home care it will cost me a lot of money for simple things"*

*- 65 – 74 years, Female*

COTA Australia supports fully funded clinical care and the use of the Commonwealth Seniors Health Card to moderate contributions for people just above pension eligibility.

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<sup>21</sup> COTA Australia (2025) *State of the Older Nation Report* (SEC Newgate Research)

However, we have also consistently stated that:

- fees must be fair, equitable and affordable;
- people must not miss out on assessed services because they cannot pay;
- hardship provisions and contribution caps must be effective and accessible; and
- all participants must be protected by transparent and enforceable pricing rules.

#### Prices have increased substantially and vary widely

*“It’s not about living at home it is about greedy providers taking more money now than before the new rules came out in November 2025. Things were better back then. Example showering \$72 now \$100, physiotherapy \$150 half hour, cleaning \$400 for 2 hours, massage \$200 1 hour.” – 85-89 years, Female, New South Wales*

*“The new provider increase in prices is making the services previously available now too expensive which is causing serious health issues” – 75-79 years, Female, Queensland*

*“Only having 1 gardener and 1 cleaner a month, due to the massive price increases. Going without food.” – 85-89 years, Female, South Australia*

*“I’m not able to contribute more and so have had to cut back on what I need. Transport to medical appointments is especially expensive as I need someone with me when I leave home and the cost is so much added to regular services”- 80-84 years, Female, regional NSW*

Transport should be affordable for Support at Home participants and not swallowed up by package funds. It enables access to medical care, pharmacies, shopping and community participation. The limited provision of transport in some rural and regional areas can make it less affordable.

COTA Australia can identify sector-wide factors that explain a 29 percent price increase from the old Home Care Package program to Support at Home, including the incorporation of former package and care management costs and the October 2025 wage increase. Increases beyond that level vary by provider and are not supported by consistent national cost data.

Appendix 4 shows the wide national range in published common prices for selected services. Appendix 3 compares government and industry pricing summaries.

*“I have no clue of costs, it is like shopping with no price showing” – 70-74 years, Female, South Australia*

We believe Government holds the data needed to examine actual prices, participant contributions, services delivered and differences in outcomes for people with similar needs but different financial circumstances. An analysis of these factors would be useful and could be published on a regular basis by service type and geography and include the total monthly cost faced by participants, not only individual unit prices.

This would assist in understanding whether co-contributions are affordable and the impact they have on package purchasing power. It would also enable assessment of service gaps between and within planning regions and local areas.

The results should inform price protections, contribution settings, hardship assistance and what is required in terms of regional stewardship.

### **The service list and contribution categories require review**

The service list plays an important role in defining and shaping the services available under Support at Home. Only services included on the Support at Home service list may be purchased. The allocation of services across clinical, independence and everyday living categories determines whether and how much a participant contributes. Co-payment contributions are the % amount of the variable price providers are charging which is applied to each service under that category of care. Each person contributes a % based on their income and assets with a full pensioner paying the least and a self-funded retiree not eligible for the CSHC paying the most.

In some instances, there is no clear rationale for why some services are classified in one category of care over another.

However, the lack of clarity regarding service classifications and concerns about whether services are affordable and meeting need are rationale for a review of the service list. The legislated review should examine the service list, category allocation, contribution percentages and total monthly impact on people with high needs and modest incomes.

Earlier action should be taken where evidence of harm is already available just as Government has already addressed the placement and co-contribution required for personal care.

### **Recommendation 11**

**11.1 Comprehensively review the service list, including the categorisation of services within the three types of care, co-contribution percentages and the total monthly impact on people with high needs and modest incomes, as part of the legislated 3-year review (or earlier), to ensure the current approach is affordable and delivering the outcomes older people need.**

### **Enforceable consumer pricing protections are required**

Current safeguards have not prevented substantial price variation, confusion about charges or erosion of package purchasing power. The delayed introduction of price caps left the

“reasonable price” requirement to carry too much weight without a sufficiently clear methodology or, initially, visible enforcement.

Government has acknowledged the need for stronger protections and has introduced some welcome measures, including refunds where prices are found to be unreasonable. The work must now proceed quickly and with participant input.

Quarterly publication of a National Summary of Support at Home Prices is useful, but it is not a substitute for enforceable limits, accurate real-time price disclosure and fair contracts.

The first national summary was published in May 2026 using December 2025 data. Government should disclose the methodology, data quality controls and treatment of regional variation so the information can be relied upon by participants and regulators.<sup>22</sup>

Appendix 3 identifies material differences between the government summary and StewartBrown data for some services, reinforcing the need for transparency and scrutiny.

### **Consumer protection reforms should be settled through immediate consultation**

Consultation should lead to a defined package of protections, including:

- a transparent methodology for reasonable prices and any price caps or approval arrangements;
- accurate, current and comparable price disclosure before a participant gives consent;
- protection against unreasonable total monthly contributions as well as individual unit prices;
- standardised contracts and clear disclosure of all fees, loadings, travel and subcontracting arrangements;
- adopt the NDIS Code of Conduct to ensure aged care prices are not higher for participants, than non-participants;
- multiple-provider choice and direct access to suitable registered providers; and
- active enforcement, public reporting and effective remedies by the Aged Care Quality and Safety Commission and other regulators.

Comparable essential-service and social-program sectors use price caps, approval processes, subsidy limits, codes of conduct and active monitoring. These examples are summarised in Appendix 6 and demonstrate that stronger intervention is practical where there is limited bargaining power.

Government announced further work to occur on pricing and consumer protections earlier this year, including looking closely at price caps, which is welcome and much needed.

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<sup>22</sup> Australian Government Department of Health, Disability and Ageing, National summary of Support at Home prices – November to December 2025 (Fact sheet, 19 May 2026) <https://www.health.gov.au/resources/publications/national-summary-of-support-at-home-prices-november-to-december-2025?language=en>

## Recommendation 12

**12.1 The Australian Government should develop, consult on and implement enforceable pricing protections for Support at Home, including protections against unreasonable unit prices, unaffordable total contributions and undisclosed charges.**

### Terms of Reference (d): the adequacy of the financial hardship assistance for older Australians facing financial difficulty

#### Hardship assistance is difficult to access and does not fully reflect disadvantage

A reasonable unit price does not protect a person from an unaffordable total contribution where they need many services. Financial hardship assistance is therefore a critical safeguard, but current settings and processes may exclude or deter people who genuinely cannot pay.

In the two months prior to the program's rollout on 1 November 2025, Services Australia received 1,429 hardship applications. In the two months following implementation, that figure rose 88% to 2,598, indicating growing awareness and need.<sup>23</sup>

The data shows that most completed claims are granted, but it does not reveal how many eligible people do not apply because the process is too complex, intrusive or poorly explained.

Older people may delay seeking help because of shame, fear of judgement and a strong commitment to self-reliance. Hardship processes must therefore provide clear information, safe assistance and proportionate evidence requirements.<sup>2425</sup>

Participants report that collecting three months of records and explaining complex expenses is stressful, particularly for people with low literacy, cognitive impairment, limited digital access or no informal support.

*"I have found that important information about fees, package changes, co-payments and hardship support is not explained in a simple or transparent way"*

*-55-59 years, Female, Tasmania*

*"Hardship is impossible to navigate. All in all, we are breeding a group of sad beggars"*

*– 75-79 years, Female, Victoria*

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<sup>23</sup> Egan, C, (2026) *Latest on financial hardship applications for Support at Home* (The Weekly Source, February 2026) quoting figures from Senate Estimates for Finance and Public Administration

<sup>24</sup> See ASIC (2024) *Hardship, hard to get help. Lenders fall short in financial hardship support* (Report 783)

<sup>25</sup> *ibid*

The Rules and administrative process should ensure:

- provision of clear information about hardship provisions and the application process. Simple messaging explaining eligibility and how to apply should be on every letter outlining a determination of client contribution rates by Services Australia;<sup>26</sup>
- that the hardship application process is fair, timely and that Government has powers to direct providers to not charge fees to people assessed as in financial hardship;
- flexibility in responding to older people in exceptional circumstances or who require additional support.

Assessment of hardship should consider debt, housing costs, annual or irregular essential expenses, aged care costs and the person's actual disposable income. Automatic or streamlined assessments should be provided for Support at Home participants who are pensioners with little or no assets to respond more effectively to financial hardship.

Services Australia officially aims to process Support at Home financial hardship claims within 28 calendar days. However, a surge in applications has led to some applicants facing delays due to complex paperwork or requests for extra evidence compounding financial disadvantage and stress and delaying access to services.

### Broader hardship protections and caps

Hardship assistance should sit within broader protections, including fair lifetime caps and consideration of a time-based cap for Support at Home. The objective must be to prevent aged care costs from causing deprivation over the period a person requires support.

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<sup>26</sup> Messaging should explain both the eligibility criteria and the process to apply for hardship, such as

If you think after paying your aged care co-payments and other ordinary expenses, you would be left with less than 15% of the age pension (currently \$XXXX), and if the current market value of all your assets other your home (including financial assets such as bank accounts, super, term deposits etc) is less than 1.5 the annual age pension (currently \$xxxx), you may be eligible for a reduction in your aged care fees by apply for financial hardship. Go to [www.myagedcare.gov.au](http://www.myagedcare.gov.au) and enter "Hardship Application" for more information.

### Recommendation 13

#### 13.1 The Australian Government should review financial hardship arrangements and:

- test whether retaining only 15 per cent of the basic Age Pension after essential expenses is adequate in current cost-of-living conditions;
- provide automatic or streamlined assessment for Support at Home participants who receive the Age Pension and have little or no assets;
- automatically assess Support at Home participants who receive Commonwealth Rent Assistance;
- include debt and the full range of essential and aged care expenses in the assessment;
- implement a legislative requirement that Services Australia determine applications within 28 days; and
- require every relevant Services Australia letter to explain eligibility, the application process and available support.

### Terms of Reference (e): Impact on the residential aged care system, and hospitals

Long waits, inadequate package purchasing power and gaps in community support increase the risk of avoidable hospital admission, delayed discharge and premature entry to residential care. National data does not yet show how many people could return home if the right support were available at the right time.

#### Home support, health services and respite must work effectively together

Most older Australians prefer to remain at home. Timely access to Support at Home, including restorative and end-of-life pathways, can reduce avoidable hospital use and delay or prevent residential care.<sup>27</sup>

Support at Home is only one part of the service environment. Primary health care, hospitals, community services, transition care and respite must work together around the older person rather than program or jurisdictional boundaries. However, poor communication and delayed transitions result in older people not receiving the care they need.

#### **Hospital discharge must be planned around the older person's needs**

Public hospitals are under sustained pressure, but rapid discharge targets must not overlook the complexity of recovery for older people or the support required for a safe return home.<sup>28 29</sup>

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<sup>27</sup> Australian Institute of Health and Welfare 2013. The desire to age in place among older Australians Bulletin no. 114. Cat. no. AUS 169. Canberra: AIHW.

<sup>28</sup> See Australian Medical Association (2023). Hospital exit block: A symptom of a sick health system. Retrieved from <https://www.ama.com.au/media/hospital-exit-block-costing-health-system-billions> and Bridges J. Pope C. Braithwaite J. Making health care responsive to the needs of older people. 2019. Published by Oxford University Press on behalf of the British Geriatrics Society. Access at: <https://pubmed.ncbi.nlm.nih.gov/31268496/>

Older people face heightened risks of deconditioning, falls, functional decline and distress in hospital. Discharge planning should begin early and assess the person's home environment, health and support needs, and the willingness and sustainable capacity of any family or friend carer.<sup>30</sup> However hospital staff can be reluctant to initiate Support at Home assessments due to acute care focus, of hospitals, assessment delays, and the availability of faster discharge pathways. Prioritising medical stabilisation and bed turnover, staff often view aged care navigation as outside their core role.<sup>31</sup> Long wait times and administrative backlogs further discourage referrals, leading staff to favour options such as Transition Care or CHSP over waiting for formal package approval.<sup>32</sup>

*The social worker at the rehab hospital on 3 separate occasions did not complete transition plan before discharge. In last event at rehab hospital, we had to push, stalk and follow up to make it happen after finding out for ourselves how things worked. Someone without family support to advocate for them would not have received a transition plan, or care assessment. – 60-64 years, Female, Victoria*

Returning home with appropriate Support at Home, transition care, health and community services should be treated as a standard option. Delayed discharge should not lead by default to permanent residential care, and discharge should not proceed without essential supports in place.

#### Recommendation 14

**14.1 All governments should ensure older people who plan to return home can receive an aged care assessment while in hospital, supported by timely discharge planning, rapid access to essential services and follow up review where required.**

#### More support for respite would improve care and service outcomes

Reliable planned and emergency respite is essential to sustain carers, prevent crises and improve the health and aged care service response. Shortages, particularly in regional areas, can lead to hospital presentation or permanent residential care that might otherwise have been avoided.

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<sup>29</sup> Australian Institute of Health and Welfare (2023). Older people in hospital. Retrieved from <https://www.health.vic.gov.au/older-people-in-hospital/print-all>

<sup>30</sup> Australian Human Rights Commission (2025) The age barrier: older adults experiences of ageism in health care (AHRC, Sydney), NSW Health (2024) Preventing Hospital Acquired Functional Decline. The untapped value of Allied Health (NSW Ministry of Health, Sydney), Edvardsson, D & Nay, R (2010) Acute care and older people: challenges and ways forward, Australian Journal of Advanced Nursing, Volume 27 Number 2

<sup>31</sup> Broomham L (2026) *Home care push as 3,000 older Australians remain stuck in hospital* (The Weekly Source)

<sup>32</sup> Department of Health, Disability and Ageing, Intent of the Support at Home program (<https://www.health.gov.au/our-work/support-at-home/about/intent-of-the-support-at-home-program>)

Access to reliable planned and emergency respite is essential to ensure that carers are supported in their role and that the care relationship is protected to ensure its long-term sustainability. Where respite is unavailable, carers may be unable to continue safely in their role, leading to crisis hospital presentations or premature permanent entry to residential aged care. This risk is especially acute in regional areas with limited residential and in-home respite capacity.

All governments should identify and address gaps in planned and emergency respite, report unmet demand and ensure that short-term medical treatment or respite does not interrupt ongoing Support at Home services.<sup>33</sup>

Processes within aged care and across health and community service programs should be reviewed and updated to ensure that short term medical treatment and access to respite does not disrupt longer term continuity of care for older people and their carers. The needs of carers should be considered given how critical they are in supporting people to remain at home. Consideration should be given to providing specifically targeted grants for services supporting carers to ensure continuity of care is maintained.

The policy objective should be continuity of care and a safe outcome for the older person, with explicit consideration of the carer's capacity and wellbeing.

#### **Recommendation 15**

##### **15.1 The Australian Government should work with states and territories to:**

- **identify and address gaps in planned and emergency respite capacity, including regional shortages, and report publicly on unmet respite demand.**
- **ensure access to planned and urgent respite is available for older people and flexible outcomes can be achieved across aged care and health and community programs that respond to changing circumstances.**

##### **15.2 The Australian Government should provide specifically targeted grants for services supporting carers to ensure continuity of care is maintained.**

#### **Transition Care requires clearer national direction**

The Transition Care Program is intended to help older people regain independence after hospital, avoid premature residential care and establish appropriate ongoing support.

Transition Care and Support at Home should be coordinated so that services complement rather than duplicate one another and the person can resume ongoing support after recovery.<sup>34</sup>

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<sup>33</sup> Sutton N, Parker D, McAllister G (2022) 'Respite care' can give carers a much-needed break, but many find accessing it difficult (The Conversation, 18/07/2022)

<sup>34</sup> See Victorian Department of Health, Transition Care Program, <https://www.health.vic.gov.au/patient-care/transition-care-program>

In practice, fragmentation, limited capacity, rigid eligibility and time limits, and inconsistent state and territory delivery reduce the effectiveness of the program.<sup>3536</sup>

The Australian Government should work with states and territories on a clearer national model, including the appropriate role of community-based access, flexible duration and consistent outcomes and reporting.

#### **Recommendation 16**

**16.1 The Australian Government should work with states and territories to expand and improve the Transition Care Program, including national consistency and review of restrictive access and duration settings.**

#### **Linked data is needed to identify system failures**

There is no unified national dataset on delayed discharge of older people. COTA Australia welcomes the establishment by Federal, state and territory health ministers to establish a national Hospital Discharge Joint Taskforce to address delayed hospital discharges and improve transitions into aged care, which includes working toward nationally consistent data and definitions. This work should result in improvements in data linkages and outcome measures enabling analysis of people movement between hospitals and aged care including Support at Home.

#### **Recommendation 17**

**17.1 The Australian Government should work with states and territories to provide clear information through My Aged Care and relevant government websites on the services that support older people to remain at home and return home safely after hospital.**

### **Terms of Reference (f): The impact on older Australians transitioning from the Home Care Packages Program**

Many transition impacts are addressed under access, pricing, contributions, reassessment, contracts and self-management. This section draws together the distinctive experience of people moved from Home Care Packages to Support at Home, but it will repeat some key messages from our response to the other Terms of Reference.

Older people describe the transition as confusing and poorly communicated. Higher unit prices, additional charges and delayed reassessment have reduced services and increased the effort required to monitor budgets and care arrangements.

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<sup>35</sup> KPMG (2019) Review of the Transition Care Programme (Australian Government Department of Health, Canberra)

<sup>36</sup> KPMG (2019) Review of the Transition Care Programme (Australian Government Department of Health, Canberra)

The recurring message is that many participants feel worse off despite the government commitment. They report fewer hours of support, higher out-of-pocket costs to maintain services, reduced carryover and more complex administration.

*“The old HCP we seemed to get more help and now to be reassessed is taking a long time and our budgets are dropping quickly so will have to give up services and the care will be less. The so-called grandfathering doesn't seem to mean much. Had to get OPAN to help. I feel for the providers their work level has increased, but the participants have to be all over budgets which are not clear and when we will run out of funds, we have to lose services. The new system seems to me to be far more complicated for everyone.” – 70-74 years, Female, Queensland*

*“Despite being 'no worse off' I have less to roll over compared to previous HCP funding.” – 75-79, Male, Queensland*

Provider surcharges, invoice fees and mark-ups are particular concerns because they directly reduce the care hours available within a fixed package.

The transition has not yet delivered the autonomy, independence and choice expected from a rights-based system. The recommendations proposed elsewhere in this submission are necessary to make the no-worse-off commitment meaningful in practice.

## **Terms of Reference (g): Thin markets, including geographic remoteness and population size**

### Service gaps are an equity problem, not only a market problem

COTA Australia prefers the term “low-density populations” as “thin market” frames the problem as insufficient economic activity, while the policy issue is whether older people can obtain equitable access to essential support. It is a better term because it describes a population reality rather than a transactional deficit.

Low density populations refer to both geographic regions and population cohorts where there are significant barriers to older people accessing services.

In many regions of Australia with rapidly ageing populations, there is a dispersed settlement pattern and significant workforce constraints across home care, health and community services. Service gaps are not confined to locations formally classified as remote; they also occur in small rural and regional communities within relatively short distances of major centres. In these areas, an older person may receive an assessment and funding allocation

yet still be unable to obtain a particular service, face only one provider, or lose package purchasing power to travel and workforce costs.

Population cohorts such as First Nations, CALD communities, people experiencing homelessness are also low-density populations where specific issues are at play and need to be considered and addressed.

Ensuring that people in remote rural and regional areas as well as those who require specialist or culturally safe services will require active government stewardship, targeted funding and protection of specialist capability.

### Availability varies by service and region

Older people regularly tell us of their difficulties in finding services that provide in-home support in their local area. Some can pay for services privately, at their own expense, whilst others are on a waiting list expecting services to become available.

*“Despite having breast cancer, chemotherapy, neuropathy causing me to feel like falling, I was only given CHSP and there are less providers in my area. All councils have given up CHSP money, many other providers don't do it either or don't have workers to help me. I pay for private cleaners and allied health; I bought my own walker and have to beg family or friends to transport me to doctors' appointments. What happens in 2027 when CHSP finishes, will I need to wait for months for assessment or a package”. – 70-74 years, Female, South Australia*

Price transparency alone is not sufficient where no alternative provider exists. Regional policy must address workforce, travel, provider entry and exit, and continuity of essential services.

*The feedback we receive comes from metropolitan as well as, regional and rural areas. “Found that we had multiple service providers and no coordinator. So, it's difficult to know who to call. Still waiting after 9mths for the home care package to be approved although we are receiving some services. Services are available on paper but not in practice, so we wait in silence. When WE do find a provider, they can't provide because there is no package yet created” – 90+ years, Female, South Australia*

### Regional reporting must measure actual service delivery

Current reporting does not show whether participants can activate each assessed service, how many approved hours are actually delivered or where services are repeatedly cancelled because of workforce shortages. This is particularly important in areas where funding may be available, but participants may still be unable to secure a provider, worker or service.

As referred to in our Accessing Aged Care Framework (Appendix 1) data should be published by service type and region and should inform local planning, investment, contracting and supplements. Improved data collection under this framework is particularly important for identifying service gaps in geographic low-density populations.

Further data measures specifically addressing issues for rural and remote areas should address:

- scheduled services not delivered because of provider or workforce constraints;
- the effect of travel charges, regional pricing and non-contact time on the amount of direct care participants receive; and
- provider exits, service withdrawals and areas with only one provider or no provider accepting new participants.

Much of this information should already exist, or could be developed progressively, through claims data, service agreements, participant statements, provider reporting and registration information. Where administrative data is not available, it should be supplemented by standardised provider reporting and regular participant experience surveys.

The purpose is not to scrutinise individual care choices or isolated cancellations. It is to identify persistent gaps in service availability, workforce capacity and market coverage by region and service type.

Stewardship must also protect specialist services for cohorts including First Nations people, culturally and linguistically diverse communities, LGBTIQ+ older people, veterans, people experiencing homelessness and care leavers.

Small and medium specialist providers may not be sustained by mainstream market settings, despite delivering trusted and effective support to distinct communities.

Government should therefore plan and fund specialist capacity rather than waiting for service failure.

Performance should be measured through transparent data on actual access, service continuity and outcomes.

## Recommendation 18

### 18.1 The Australian Government to:

- implement local area planning and regional stewardship to anticipate demand and direct investment;
- publish Support at Home data by service type and region, including waiting, activation and actual service delivery data on the time from funding allocation to provider agreement and commencement of services; whether assessed service types are available and delivered; planned services not delivered because of provider or workforce constraints; regional travel-related costs and price impacts; and areas affected by provider withdrawal, limited competition or the absence of an available provider;
- develop and report annually on a plan to sustain and improve specialist services; and
- establish a provider-of-last-resort framework, supported by targeted commissioning, flexible funding and regional stewardship arrangements to ensure essential aged care services remain available in low-density populations and areas experiencing persistent service failure.

## Terms of Reference (h): The impact on First Nations communities and culturally and linguistically diverse communities

COTA Australia works with NATSIAACC, Partners in Culturally Appropriate Care and FECCA and supports these organisations as leading voices on the needs and aspirations of their communities. The text and recommendations below are based on information provided by these peak bodies.

First Nations people experience dementia at three to five times the rate of non-Indigenous Australians, and about one third of people living with dementia are from culturally and linguistically diverse backgrounds. However, these communities are underrepresented in aged care including Support at Home and face cultural, geographic and systemic barriers to accessing care. Support at Home must therefore be designed and implemented for cultural safety, language access and diverse models of family and community support.<sup>37</sup>

### Support at Home must respond to First Nations lived experience and aspirations

First Nations older people continue to experience delayed or reduced access, extended hospital stays, ageing away from Country or Island Home, and disengagement from services that are not trusted, culturally safe or connected to community.<sup>38</sup>

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<sup>37</sup> AIHW (2025) *Dementia in Australia* (Australian Government, Canberra)

<sup>38</sup> NATSIAACC (2026) *Overdue Action Required on First Nations Aged Care Reform*, Joint Statement 29 May 2026

Implementation should align with the National Agreement on Closing the Gap and be developed in partnership with First Nations organisations, communities and the First Nations Aged Care Commissioner.<sup>39</sup>

Clear benchmarks are required for access, culturally appropriate care, workforce capability and outcomes.<sup>40</sup>

### Support at Home must address language, cultural and service barriers for CALD communities

About one in three Support at Home participants are from a culturally and linguistically diverse background. These communities are highly diverse and face different cultural, structural and service barriers.<sup>41</sup>

- Information may be unavailable in the person's language or poorly targeted; family and caring expectations may not be understood; and providers may lack culturally competent staff or fail to use interpreters effectively.
- Government and providers need measurable obligations for translated information, interpreter use, workforce capability, bilingual navigation and outreach through trusted community organisations.

#### **Recommendation 19**

**19.1 Ensure Support at Home implementation aligns with the National Agreement on Closing the Gap.**

**19.2 In partnership with NATSIAACC, establish implementation benchmarks for culturally appropriate care, access and workforce training.**

**19.3 Provide Support at Home information in recognised community languages and accessible formats.**

**19.4 Set and monitor provider benchmarks for knowledge and use of interpreter services.**

**19.5 Strengthen Care Finder engagement with CALD communities through bilingual navigators, multilingual information, assertive outreach and partnerships with trusted community leaders, health workers and seniors' groups.**

### **Terms of Reference (i): Any other related matters**

#### Entry-level home support requires a clear reform agenda and timetable

COTA Australia welcomed the Senate Committee's report on the future of the Commonwealth Home Support Program. Government should now provide a formal response, a reform timetable and clear consultation arrangements.

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<sup>39</sup> ibid

<sup>40</sup> ibid

<sup>41</sup> Centre for Cultural Diversity in Ageing (2022) Data and Demographics Practice Guide

The objective of this reform should be to create an integrated continuum from entry-level assistance to complex support, organised around the outcomes an older person needs rather than program names and administrative boundaries.

Older people must be directly involved in designing entry-level services, including how need is assessed, how quickly basic support starts and how continuity is protected when needs increase.

Current CHSP objectives, eligibility and monitoring should be reviewed so unmet demand, waiting times, service delivery and outcomes can be measured consistently.

A blended funding model approach that includes block funding for key services will deliver the best outcome. 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).

Assessment should operate through a single front door and use relevant information from GPs and other health professionals. People should not have to wait for basic assistance while a more comprehensive assessment is completed.

We will provide more detailed comments on the CHSP integration once Government has outlined its response to the Senate report and future directions.

## **Recommendation 20**

### **20.1 The Australian Government should:**

- **set a clear reform agenda and timetable for designing and implementing quality entry-level home care and support services;**
- **fund dedicated consultation and co-design with older people;**
- **establish clear eligibility, service objectives, measures of unmet demand, waiting time reporting and outcome monitoring; and**
- **ensure existing CHSP participants experience no interruption, reduction or delay in essential services. Current services should continue until assessment, funding, provider arrangements and replacement services are complete.**

## **Conclusion**

The Support at Home program is an essential part of delivering quality aged care services to older Australians and delivering on the rights-based intention of the new Aged Care Act. While there are positive features in the program design, throughout its older people have experienced significant access and affordability issues that must be addressed. COTA Australia looks forward to working to resolve these issues and ensure better outcomes for older people.

## Appendices

### Appendix 1: Access Aged Care

Reporting across the five stages should show volumes and actual wait times by priority, program, service type and region. Individual stage timeframes as well as a total timeframe in days should be reported for average (mode), median, as well as 90<sup>th</sup> percentile.

| <b>COTA Australia stages</b>                                                                                                                                                                       | <b>Current Australian Government description</b>                                              | <b>Currently available data</b>                                                                                   | <b>Service Programs excluded</b>                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Application</b> – applying via My Aged Care and assessment referral accepted                                                                                                                    | Not currently reported.<br>“Awaiting triage decision” forms part of assessment. <sup>42</sup> | Unknown                                                                                                           | People who ‘apply’ but following screening should be reported.                                                                                                               |
| <b>Assessment</b> – Assessment Referral accepted to triage decision<br><br>Triage Decision to assessment completed<br><br>Both New assessments and separately SPR & reassessment must be reported. | “Awaiting triage decision”                                                                    | ALL: 48,592                                                                                                       | People who are deemed as ineligible for an assessment.                                                                                                                       |
|                                                                                                                                                                                                    | “Assessments on hand”                                                                         | ALL: 98,606                                                                                                       | Transition Care Program (TBC)<br><br>Triage decisions should be separately reported, along with Eligibility / Assessment outcomes are not reported across specific programs. |
| <b>Allocation</b> – assessment to government funding allocation                                                                                                                                    | “Waiting for approved SAH classification or Transitioned HCP level”                           | SAH: 100,191<br><br>Note: Median and Average days waiting for AT-HM, EOL, RCP are reported, but not the number of | Residential Care, CHSP, Assistive Technology-Home Modifications scheme, End of Life pathway, Restorative Care pathway (as at March 2026 data).                               |

<sup>42</sup> COTA Australia believes that application period reported should be from the date a person contacts or refers themselves to My Aged Care (which for assessment applications made online may be a date prior to the date their record is entered into My Aged Care), until the date that the referral to an assessment organisation is accepted. The triage decision should be treated as a subset of the assessment processes.

|                                                                                                                |                                                                                                                              |                                                                                    |                                                                                                         |
|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
|                                                                                                                |                                                                                                                              | people.                                                                            |                                                                                                         |
|                                                                                                                | Period of time between Interim SAH funding and Full SAH funding                                                              | 53,718 have an interim package <sup>43</sup><br><br>Average number of days unknown |                                                                                                         |
| <b>Agreement</b> – funding allocation to agreement signed with aged care provider/s                            | ‘Entry date’ for Support at Home entry event / start notification submitted by the provider through ACP <sup>44</sup>        | SAH: 364,723                                                                       | Residential Care, CHSP, Assistive Technology-Home Modifications, End of Life, Restorative Care Program. |
| <b>Activation</b> – for each individual service type on agreed care plan – the first-time service is delivered | ‘Delivery Date’ submitted in Support at Home Invoice Bulk CSV by the provider through Services Australia’s ACP <sup>45</sup> | Unknown                                                                            | All programs (incl SAH) do not report the days waiting for individual services.                         |

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<sup>43</sup> 53,718 people (as at 31 March 2026) was reported as having been allocated interim funding and awaiting their full funding, outlined to [Senate Estimates on 2 June](#) (pg 54).

<sup>44</sup> See <https://www.servicesaustralia.gov.au/register-care-recipient-events-aged-care-provider-portal?context=20>

<sup>45</sup> Services Australia (March 2026) ‘Aged Care – Support at Home Invoice Bulk CSV v1.11’ Available at: <https://www.servicesaustralia.gov.au/support-home-invoicing-and-home-care-account-adjustments?context=20>

## Appendix 2: Contents and structure of a standardised aged care contract

The below structure summarises the types of things we would like to see in the Rules.

### **ALL AGREEMENTS**

- Summary of key information (top sheet)
- Standard Terms and Conditions (that all providers must include):
  - a commitment that all services delivered under any schedule in the contract will comply with the ACQSC Standards
  - a commitment that all fees and contributions will be charged in accordance with the requirements of the act, and that no fee or charge not included in the schedule to the contract may be charged without written consent
  - Alternative Dispute Resolution pathways
  - Explicit reference to Australian Consumer Law applying including reference to:
    - services must be fit for purpose [s. 61];
    - services must be delivered with due care and skill [s. 60];
    - services must be delivered in a reasonable time [s. 62];
    - the Provider must not act in an unconscionable way [ss 20,21,22];
    - no force must be used in the delivery of services [s. 50].
  - Explicit reference to the right to have your contract reviewed by a legal professional
  - Explicit reference to common law requirements for informed lawful consent (including specifically in relation to restrictive practices)
- Mandatory annexures to be included
  - A copy of all fees and charges that may be issued
  - A copy of the Statement of Rights
  - Information about restrictive practices
    - if they're used how informed lawful consent will be obtained
    - that in the absence of consent explanation of the common law requirements of 'imminent harm to the person or to others', including explanation of common law Minimisation of Restraint Principles
    - what steps may be taken if there is doubt or concern about the restrictive practices used by the Provider and its employees.
  - A mandatory information memorandum about their aged care contract that outlines:
    - their rights and recourse to consumer law protections, beyond those in aged care law
    - their right to seek a legal practitioner to review their contract and issue a certificate of advice to confirm they have had the terms of the contract explained to them
    - their right to resolve issues under this contract including

- making a complaint to the provider and how they'll handle complaints
- how to make a complaint to the Complaints Commissioner and to request a reconsideration of any complaint determinations
- seek a review of a Complaints Commissioner's complaint determination from the ART / Ombudsman
- that the Complaints Commissioner, or the ACQS Commissioner may lodge a compensation claim in the Federal Court following their investigation on behalf of individuals who are seriously harmed or injured
- how to seek remedy for breaches of consumer law via the state trade practices regulator
- to seek an alternative dispute resolution through mediation or arbitration clause in the contract
- reminding individuals that they have common law rights to seek remedy for breaches of the contract, breaches of consumer law or breaches of the aged care act directly with tribunals and local courts

#### **FOR RESIDENTIAL AGREEMENTS**

- Schedule of accommodation
  - Special terms and conditions relating to accommodation
- Schedule of care and services
  - Special terms and conditions relating to care and services
- Schedule of higher everyday living and any other private services delivered
  - Special terms and conditions relating to Higher Everyday Living
    - As per Act - schedule cannot be offered before Day 1 of receiving accommodation services, must have a regular review of services no less than 6 monthly, agreement to these services must have a cooling off period after it commences of no less than 21 days.

#### **FOR HOME SUPPORT AGREEMENTS**

- Schedule of Commonwealth funded aged care services
  - Special terms and conditions relating to home support services
- Schedule of Assistive Technology (if applicable)
  - Special terms and conditions relating to Assistive Technology
- Schedule of Home Modifications (if applicable)
  - Special terms and conditions relating to Home Modifications
- Schedule of private services
  - Special terms and conditions relating to private services

## Appendix 3: Supporting analysis

### A. Support at Home participant profile at March 2026

The March 2026 data shows that:

- 97.6 per cent of current Support at Home participants held transitioned Home Care Package classifications;
- 82.9 per cent of current participants and people waiting for Support at Home held transitioned classifications; and
- 62.8 per cent of current participants, people waiting and people awaiting assessment were in the transitioned cohort.

At March 2026:

- 364,723 people were receiving Support at Home;<sup>46</sup>
  - 355,795 held a transitioned Home Care Package classification;
  - 8,931 held a Support at Home classification;
  - Of these people, 53,718 have an interim funding allocation (60%)<sup>47</sup>
- 101,191 people were waiting for Support at Home funding;<sup>48</sup>
  - 29,404 were waiting for a transitioned classification;
  - 79,718 were waiting for a Support at Home classification;
- 98,606 people were awaiting an aged care needs assessment<sup>49</sup>
  - Including 48,592 people who were awaiting a triage decision;<sup>50</sup>
  - Of the 133,359 assessments completed in the March 2026 quarter, 80.9 per cent were comprehensive assessments and 19.1 per cent were home support assessments.

The data confirms that the current program is dominated by transitioned participants, while most new people waiting will enter the eight-level Support at Home structure.

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<sup>46</sup> Support at Home Program Data Report, 1 January–31 March 2026, Department of Health, Disability and Ageing, Tables 4 & 5 May 2026, <https://www.gen-agedcaredata.gov.au/resources/publications/2026/may/support-at-home-program-data-report-1-january-31-march-2026>

<sup>47</sup> Senate Community Affairs Legislation Committee, *Estimates*, 2 June 2026, Parliament of Australia, [https://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/29626/toc\\_pdf/Community%20Affairs%20Legislatio n%20Committee\\_2026\\_06\\_02.pdf;fileType=application%2Fpdf](https://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/29626/toc_pdf/Community%20Affairs%20Legislatio n%20Committee_2026_06_02.pdf;fileType=application%2Fpdf)

<sup>48</sup> Ibid, Table 7, 8 & 9.

<sup>49</sup> Single Assessment System (SAS) Quarterly Needs Assessment Data Report, 1 January–31 March 2026, p3 Department of Health, Disability and Ageing, May 2026, [https://www.gen-agedcaredata.gov.au/resources/publications/2026/may/single-assessment-system-\(sas\)-quarterly-needs-assessment-data-report-1-january-31-march-2026](https://www.gen-agedcaredata.gov.au/resources/publications/2026/may/single-assessment-system-(sas)-quarterly-needs-assessment-data-report-1-january-31-march-2026).

<sup>50</sup> Aged Care Act 2024 Wait Times Report: Residential care and Support at Home, First report, 1 November 2025–31 March 2026, Table 1, Department of Health, Disability and Ageing, published 12 May 2026, [www.health.gov.au/resources/publications/aged-care-act-2024-wait-times-report](http://www.health.gov.au/resources/publications/aged-care-act-2024-wait-times-report)

## **B. Pricing transition and explanatory factors**

COTA Australia can identify consistent factors contributing to the transition from Home Care Package prices to Support at Home unit prices:

- the former 15 per cent package management charge was incorporated into unit prices;
- part of the former care management allowance was incorporated into unit prices, with 10 per cent remaining as the separate Support at Home care management pool; and
- the October 2025 wage increase added an estimated 4 per cent to unit costs.

These factors explain an increase of about 29 per cent. Further increases vary by provider and may include travel and other costs, but there is no consistent national dataset explaining the difference.

## Appendix 4: Common prices per hour of key services at 1 April 2026

Data from Stewart Brown (unpublished)<sup>51</sup>

| Service                                                  | Service Type     | Minimum price | Maximum price | Price variation (\$) | % Price variation |
|----------------------------------------------------------|------------------|---------------|---------------|----------------------|-------------------|
| <b>Dietitian or Nutritionist</b>                         | Clinical Support | \$100         | \$380         | <b>\$280</b>         | <b>280%</b>       |
| <b>Exercise Physiologist</b>                             | Clinical Support | \$94          | \$350         | <b>\$256</b>         | <b>272.3%</b>     |
| <b>Podiatry</b>                                          | Clinical Support | \$105         | \$358         | <b>\$253</b>         | <b>241%</b>       |
| <b>Physiotherapist</b>                                   | Clinical Support | \$125         | \$350         | <b>\$225</b>         | <b>180%</b>       |
| <b>Assistance with Home Maintenance and Repairs</b>      | Everyday Living  | \$120         | \$290         | <b>\$170</b>         | <b>141.7%</b>     |
| <b>Occupational Therapist</b>                            | Clinical Support | \$161         | \$375         | <b>\$214</b>         | <b>132.9%</b>     |
| <b>Individual Social Support</b>                         | Independence     | \$67          | \$152         | <b>\$85</b>          | <b>126.9%</b>     |
| <b>Nursing – Registered Nurse</b>                        | Clinical Support | \$120         | \$270         | <b>\$150</b>         | <b>125%</b>       |
| <b>Assistance with Self-administration of Medication</b> | Independence     | \$76          | \$167         | <b>\$91</b>          | <b>119.7%</b>     |
| <b>Flexible Respite</b>                                  | Independence     | \$69          | \$142         | <b>\$73</b>          | <b>105.8%</b>     |

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<sup>51</sup> StewartBrown Home Care/Support at Home Financial Performance Survey Report (May 2026) Unpublished.

|                                             |              |      |       |             |             |
|---------------------------------------------|--------------|------|-------|-------------|-------------|
| <b>Continence Management (Non-clinical)</b> | Independence | \$71 | \$142 | <b>\$71</b> | <b>100%</b> |
|---------------------------------------------|--------------|------|-------|-------------|-------------|

Appendix 5: Comparison Australian Government Indicative Support at Home price data and StewartBrown industry price data

| <b>Service</b>                                      | <b>Aus. Gov.<br/>median<br/>price</b> | <b>Stewart<br/>Brown<br/>median<br/>price</b> | <b>Median<br/>price<br/>difference</b> | <b>Aus. Gov.<br/>upper<br/>price</b> | <b>Stewart<br/>Brown<br/>upper<br/>price</b> | <b>Upper<br/>price<br/>difference</b> |
|-----------------------------------------------------|---------------------------------------|-----------------------------------------------|----------------------------------------|--------------------------------------|----------------------------------------------|---------------------------------------|
| <b>Chiropractor</b>                                 | \$99                                  | \$196                                         | <b>\$97</b>                            | \$148                                | \$325                                        | <b>\$177</b>                          |
| <b>Exercise<br/>physiologist</b>                    | \$132                                 | \$219                                         | <b>\$87</b>                            | \$212                                | \$350                                        | <b>\$138</b>                          |
| <b>Art therapist</b>                                | \$120                                 | \$200                                         | <b>\$80</b>                            | \$249                                | \$280                                        | <b>\$31</b>                           |
| <b>Podiatrist</b>                                   | \$165                                 | \$214                                         | <b>\$49</b>                            | \$215                                | \$358                                        | <b>\$143</b>                          |
| <b>Diversional<br/>therapist</b>                    | \$150                                 | \$195                                         | <b>\$45</b>                            | \$200                                | \$339                                        | <b>\$139</b>                          |
| <b>Acupuncturist</b>                                | \$150                                 | \$195                                         | <b>\$45</b>                            | \$182                                | \$281                                        | <b>\$99</b>                           |
| <b>Osteopath</b>                                    | \$154                                 | \$195                                         | <b>\$41</b>                            | \$195                                | \$325                                        | <b>\$130</b>                          |
| <b>Allied health<br/>therapy<br/>assistant</b>      | \$130                                 | \$160                                         | <b>\$30</b>                            | \$160                                | \$300                                        | <b>\$140</b>                          |
| <b>Continence<br/>management<br/>(non-clinical)</b> | \$82                                  | \$111                                         | <b>\$29</b>                            | \$149                                | \$142                                        | <b>\$-7</b>                           |
| <b>Physiotherapist</b>                              | \$194                                 | \$220                                         | <b>\$26</b>                            | \$224                                | \$350                                        | <b>\$126</b>                          |

## Appendix 6: Examples of consumer price regulation in comparable sectors

Australian policy already uses a range of regulatory tools where consumers have limited bargaining power or public subsidies are at risk:

- **private health insurance**, the Commonwealth controls premium increases by requiring insurers to apply for Ministerial approval before increasing premiums, with the Minister able to refuse an increase if satisfied it would be contrary to the public interest<sup>52</sup>.
- **energy**, the Australian Energy Regulator sets the Default Market Offer as the maximum price retailers can charge electricity customers on standing offer contracts<sup>53</sup>, and it also approves annual network pricing proposals<sup>54</sup> and network charges<sup>55</sup> against regulatory determinations.
- **groceries**, the mandatory Food and Grocery Code now prohibit very large supermarkets from engaging in excessive pricing of grocery products<sup>56</sup>.
- **postal services**, Australia Post must notify the ACCC and the Minister before increasing notified ordinary letter prices<sup>57</sup>, with the Minister able to object.
- **telecommunications**, the ACCC continues to monitor telecommunications prices and retail price controls can be reintroduced if significant price increases or regional price differentiation occur<sup>58</sup>.
- **childcare**, the Commonwealth does not set centre fees, but it limits public subsidy exposure by applying the Child Care Subsidy to the lower of the provider's hourly fee or the government's hourly rate cap<sup>59</sup>.

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<sup>52</sup> Private Health Insurance Act 2007 (Cth) s 66-10; Department of Health, Disability and Ageing, Apply to increase private health insurance premiums, <https://www.health.gov.au/topics/private-health-insurance/operating-rules-for-private-health-insurers-and-providers/apply-to-increase-private-health-insurance-premiums>.

<sup>53</sup> Australian Energy Regulator, The Default Market Offer, stating that the DMO is "the maximum price that retailers can charge" residential and small business customers on standing offer electricity contracts, <https://www.aer.gov.au/industry/retail/default-market-offer>

<sup>54</sup> Australian Energy Regulator, Pricing proposals and tariff variations, explaining that electricity distributors must submit annual pricing proposals and that the AER checks those proposals against the National Energy Rules and each distributor's five-year revenue determination, <https://www.aer.gov.au/industry/networks/pricing-proposals-and-tariff-variations>

<sup>55</sup> Australian Energy Regulator, AER approves 2026–27 pricing proposals for electricity distributors (24 April 2026), confirming the AER published approved annual pricing proposals and network charges for 2026–27, <https://www.aer.gov.au/news/articles/communications/aer-approves-2026-27-pricing-proposals-electricity-distributors>.

<sup>56</sup> Australian Competition and Consumer Commission, Food and Grocery Code of Conduct, stating that from 1 July 2026 the Code prevents very large retailers from engaging in excessive pricing of grocery products for retail sale, <https://www.accc.gov.au/business/industry-codes/food-and-grocery-code-of-conduct>

<sup>57</sup> Australian Competition and Consumer Commission, Postal services price notification and monitoring, stating that Australia Post must notify the ACCC and Minister of proposed increases to notified letter services and that the Minister may object, <https://www.accc.gov.au/by-industry/postal-services/postal-services-price-notification-and-monitoring>

<sup>58</sup> Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts, Phone bills and charges, stating that the ACCC still monitors telecommunications prices and that retail price controls can be reintroduced if significant price increases or differentiated regional pricing occur, <https://www.infrastructure.gov.au/media-communications-arts/phone/phone-bills-and-charges>

- **NDIS**, the NDIS Code of Conduct prohibits providers from charging or representing a higher price for goods supplied to a NDIS participant than they charge other customers for the same or substantially the same goods, unless there is a reasonable justification; and the NDIS Commission’s fair pricing guidance states that major unjustified price differences between NDIS participants and other customers for products or services may breach the Code of Conduct<sup>60</sup>.

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<sup>59</sup> Department of Education, Child Care Subsidy, stating that a family’s CCS rate applies to the lower of the hourly rate cap or the hourly fee charged, and listing the 2026–27 hourly rate caps, <https://www.education.gov.au/early-childhood/providers/child-care-subsidy>

<sup>60</sup> National Disability Insurance Scheme (Code of Conduct) Rules 2018 (Cth) s 6(2); NDIS Quality and Safeguards Commission, ‘Fair pricing’, updated 9 February 2026. The Commission states that fair pricing means there is no major price difference between the cost of a product or service for an NDIS participant compared with other customers, and that unjustified higher pricing may breach the Code of Conduct