COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Support at Home Program

(Public)

TUESDAY, 22 SEPTEMBER 2026

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Tuesday, 22 September 2026

Members in attendance: Senators Allman-Payne, Ananda-Rajah [by video link], Antic [by video link], Gatenby [by video link], Ruston and Whiteaker [by video link]

Terms of Reference for the Inquiry:

The Support at Home Program, with reference to:

(a) the ability for older Australians to access services to live safely and with dignity at home;

(b) the impact of the co-payment contributions for independent services and everyday living services on the financial security and wellbeing of older Australians;

(c) trends and impact of pricing mechanisms on consumers;

(d) the adequacy of the financial hardship assistance for older Australians facing financial difficulty;

(e) the impact on the residential aged care system, and hospitals;

(f) the impact on older Australians transitioning from the Home Care Packages Program;

(g) thin markets including those affected by geographic remoteness and population size;

(h) the impact on First Nations communities, and culturally and linguistically diverse communities; and

(i) any other related matters.

WITNESSES

WITNESSES

EDMONDS, Ms Samantha, Director, Policy, Education and Systemic Advocacy, Older Persons Advocacy Network [by video link]

GEAR, Mr Craig, Chief Executive Officer, Older Persons Advocacy Network

Committee met at 08:31

CHAIR (Senator Allman-Payne): Good morning, everyone. I declare open this hearing of the Senate Community Affairs References Committee's inquiry into the Support at Home program. I begin by acknowledging the Ngunnawal and Ngambri people on whose lands we meet today and pay my respects to their elders past and present. I extend that respect to Aboriginal and Torres Strait Islander peoples here today.

These are public proceedings being videostreamed live via the parliament's website, and a *Hansard* transcript is being made. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence.

Witnesses also have a right to request to be heard in camera. If a witness objects to answering a question, they should state the ground upon which the objection is made, and the committee will determine whether it will insist on an answer having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. I remind senators of their obligations under the Behaviour Code for Australian Parliamentarians to treat witnesses with dignity, courtesy, fairness and respect.

Welcome. Thanks very much for appearing before the committee today. I understand that information on parliamentary privilege and the protection and obligation of witnesses giving evidence to Senate committees has been given to you. I now invite you to make a short opening statement and then we'll go to questions.

Mr Gear: Thank you, senators. The proposition we keep returning to is that Support at Home is intended to realise older people's rights in practice and to provide care that is relational, responsive and centred on the older person. The foundations on paper of Support at Home made sense. OPAN was supportive of a separate AT-HM program so that older people didn't have to save for essential safety equipment. The restorative care pathway and the end-of-life pathway were all positive features of the design. So too were the high levels of care with the eight classifications. More importantly, the statement of rights and supported decision-making being part of the whole aged-care system, including Support at Home, was key to maintaining older people's autonomy and decision-making and the care and how their care will be delivered.

There were also positive experiences that should be recognised. In a recent survey jointly undertaken by OPAN and COTA Australia, which I'm sure they'll tell you more about shortly, yes, 51 per cent of people receiving services when they'd commenced reported having a positive experience of Support at Home, but that was once their support had started in place. That is success for that cohort and should be acknowledged, but what about the other half of participants? It means that half of those participants surveyed did not have a positive experience. What they report is, unfortunately, a program of support that was good in design and on paper but in reality is experienced by many older people as complex, hard to navigate, administrative, transactional and bureaucratic in nature.

Last financial year, OPAN members provided 64,491 cases of advocacy support. That was 23 per cent more than the previous year, which was already a 20 per cent increase on the previous year. About 60 per cent of those NACAP advocacy services related to Support at Home issues, despite Support at Home only accounting for 25 per cent of the aged-care population. In the previous year, it was 40 per cent of the cases of home care, so something is going on here.

The evidence that we bring today is from the lived experience of those people who have been supported by our network members, of older people who have come to us for information and advocacy support. Val Fell, someone who many of us know, provides a powerful example of how transactional the system can be and the trade-offs that older people are being asked to make. At 97, Val is having to manage the coordination of her own care as prices change and fees go up month on month. She is having to make choices between having her regular physio, which is keeping her mobile and in her home, or having meals, because her daughter is not available. A return transport journey for her to see her medical specialist once cost her $15 before Support at Home. It's now costing $64 from her package each way. While waiting for a reassessment, she has had to go back to CHSP to get an extra two hours of support. As Val puts it: 'You join a waiting game to get into the system, and, as soon as you start in the system, you join another waiting list to get the right supports. Now I wait for reassessment, as the prices mean I can't get the support I need.' And then she texted me last night because she wanted to also say: 'A cap on fees is urgently required now as fees are rising on a regular basis, causing concern. Why ask for a review if you feel that

you will either not get more help or not get a dollar amount that will cover what you need? Why bother with the hassle?'

Increasingly, price is determining what support people can actually access when the expectation was that an approved package would translate into the support a person has been assessed as needing. People are worried that they don't have enough money to get the support they were getting before. The minimum services offering with no end date are adding to these concerns, and so are the wait times in accessing higher levels of care, even after reassessment.

Two key pillars of the system—the assessment service and case management—are proving to be not agile and not focused. The analysis of advocacy cases highlights several consistent issues. Difficulty accessing approved Support at Home services was the leading issue in both the transitioned and new Support at Home clients. It was disproportionately common among people who were new to the Support at Home program, who faced additional barriers navigating this complex system. Inadequate care management was associated in one in three access and navigations for both new and transition clients that we saw since the start of the new Aged Care Act. Access and navigation accounted for 55 per cent of the issues of support around clients and 36 per cent for transition clients. The services people experienced particular difficulty accessing included assistive technology, domestic assistance, allied health and other therapeutic services. New Support at Home clients also experienced financial hardship and provider fees beyond their means. Nineteen per cent of the top 10 issues related to hardship.

These figures differ between new and transition clients, but the pattern is consistent. Being assessed as needing support does not necessarily mean an older person can access that support in practice. Rights can be lost at any point between first contact and actual service delivery. The pathway crosses multiple agencies, systems and providers. Public reporting does not give a single end-to-end view of whether assessed needs can be practical support, and, when problems cross organisational boundaries, it's hard to navigate. The burden of coordination can fall back on the older person or carer. We have provided you with a schematic from our submission, which demonstrates some of the interfacing and interacting issues.

There are many things we could talk about today, but we are keen to focus on four areas which we believe need improving: assessment, access and service availability; pricing and affordability; the approach to fee reduction or fee waiver, which is known by the government as hardship application; and, finally, case management. An older person should not need to understand the architecture of aged care to make it work. They should know what happens next, who is responsible, when it should happen and what to do when it does not and have a practical remedy, including access to advocacy, without being sent from one part of the system to the other. We have hoped for a Support at Home system that is agile and responds to older people's changing needs, an assessment process with meaningful human oversight and capacity to make immediate corrections or rapidly escalate decisions when they are wrong, and a system that communicates clearly and effectively with older people. That is what will turn rights and principles on paper into rights experienced by older people in practice. The system may work if your care needs are static, but we know in life that is not real life.

CHAIR: Thanks very much, Mr Gear. I might kick us off. You make an important distinction in your submission between being approved for care and actually receiving it. From what your advocates are seeing, where is the system most commonly breaking down between assessment, approval and services actually being delivered?

Mr Gear: I might hand to our director of policy and systemic advocacy.

CHAIR: Thank you for reminding me. My apologies, Ms Edmonds. With you being online, I missed that. I'll hand to you to answer that question.

Ms Edmonds: What we're seeing where the barriers are is—well, it's a range of issues. There may be a lack of provider availability, particularly in rural and remote areas or in specific areas where someone might need an Aboriginal and Torres Strait Islander provider or a culturally and linguistically diverse provider. There may be a lack of staffing, or the worker is not available, or the worker can't travel and provide that service. The service agreement might not have been signed, or the older person might not understand it. They might be trying to get advice and information around the service agreement, and that can pause things. The person might not actually understand referral codes and might get the referral code and not know that they then have to go in and find their own provider and what that means. Sometimes it's about the provider waiting for confirmation from the system itself to say, 'Yes, this person has been approved, and you can come on.'

We've always argued that there needs to be monitoring and reporting on the different wait times across the system as well, as part of this access. It's not simply from assessment to access. It's wait to assessment, wait from assessment to approval, wait from approval to allocation and actual service access. We think that should then be

broken down. This is probably a comparable issue. A person may access a service. Some services may start. But they then might be waiting for other services, but we're not picking that up. We're just like: 'Yes, they're in. They're getting everything they need.' For example, a person may be approved for allied health and OT support, but there might not be any OTs in the area, and they're actually not getting that service, even though they're in with a provider and getting other services.

We also feel that it's really important that the older person doesn't have to be the person that's constantly calling to find out where they are in the system, what's going on and why they can't access. There really needs to be a simplified, maybe one-point contact where they can get all that information. As I touched on in the beginning, it's also the skills of the provider. Do they have the language skills? Do they have the cultural safety? Do they have the trauma informed care that some particular diversity groups need as well?

CHAIR: Thank you. You've raised concerns about the integrated assessment tool and the lack of meaningful clinical discretion. Could you explain what happens to an older person when the tool produces an outcome that their assessor believes doesn't actually reflect their actual need?

Mr Gear: I might take that one. Particularly for the tool itself, we are concerned that some of the nuance which is captured in the text fields of the assessment tool does not feed into the algorithm. At the moment, the options for people are really—yes, there have been some recent adaptions to allow, where there are errors, for the assessment service senior delegate to adjust those. But there's a challenge for the older person to know about their rights in that system as well. So what is really happening is that people are given a classification, and they are then having to apply for either reassessment or, usually, for internal review or reconsideration, which has been an elongated process. In a number of cases where we've supported people, the department hasn't been able to complete their assessment at the time, the 90-day period comes to an end, and therefore that is deemed as having standing of that classification, so the person does not have any right. The only option for them is then to appeal to the Administrative Review Tribunal. Currently there is an absence of information about that right to be able to appeal the process, and there's the implication of fees. People are also not provided with the level of independent advice and legal support to be able to take that pathway. It's a very elongated pathway to be able to get the right level of care at the right time.

CHAIR: Thank you. I have more questions, but you did give us a very comprehensive submission, and I'm conscious of needing to share the call, so I'll go to Senator Ruston.

Senator RUSTON: Thank you very much. Yes, there was a very comprehensive submission, a comprehensive survey and a comprehensive introduction, so thank you. In your submission, you outlined the advocacy cases. I'm really keen to understand how long you actually think people are waiting to receive their full package.

Mr Gear: It is a variation between whether you're assessed at high or urgent. Obviously, for those categories, very few people seem to be falling into that level of prioritisation, so most people are sitting at the standard level. We're still hearing of cases that are coming through of people waiting nine, 12 or up to 16 months. In the reporting, because we were reporting means, it's difficult to see those outlier cases and those people who may be waiting more than six months. Obviously, our position, along with COTA, is that no-one really should be waiting any longer than three months from registration to service commencement. Ideally, that should be four weeks, because we know when people don't access those levels of services that they need, function deteriorates, cognition deteriorates and people end up needing higher levels of services.

Senator RUSTON: Do you think that the reporting that we're seeing from government is in line with what you're seeing from the people who you're speaking to?

Mr Gear: Samantha, would you like to talk about reporting?

Ms Edmonds: As I touched on when I answered the last question, I guess what we're seeing is that we sort of get a blanket report of the wait times, but we're not actually getting broken-down reporting of what those wait times look like across different aspects of the system. So we're not seeing, as I said, first phone call to assessment, assessment to provider access and then provider access to delivery. We're not getting the nuances of those wait times in the system and where people are getting caught up in those wait times. Is it at the start or at the end when they're trying to access the provider? We'd really like to see that broken down. We'd also like to see it broken down because it's sometimes difficult to see the demographics of the person or the particular needs of the person. Is that impacting on those wait times and why there is such a delay? Where do we then need to focus the changes or the funding of the system?

Senator RUSTON: Would you be able to provide—I don't expect you to do it now—what you think would be the most useful data in order for you to be able to support the people that you represent in terms of the granularity

and where the data needs to be broken down so that we can get an understanding of what's actually useful for you?

Mr Gear: I'm happy to take that on notice.

Senator RUSTON: One recent change we've seen has been the change in reporting around people who are not receiving their full package, which the government is now referring to as a minimum service offering or interim packages or whatever you want to call them. In your estimation, how long—or is this another piece of information you can't get—are people on interim packages or that 60 per cent package rate?

Mr Gear: From cases that we have coming to our advocates, it varies. For some people it is as short as five weeks. Other people are waiting between 12 and 15 weeks, depending on what time of the year that person is allocated. We were under the understanding this was a short-term measure in the previous financial year, but it continues to be an element of the system. We would like to see a legislated timeframe of a maximum time that people will be on the minimum service offering. That could be communicated to older people so that both the older person and the provider can plan for when support will step in. I can understand why someone who might be commencing on a package may need a short period of time where they're coming to the full need for their package, but they need to know when their full package and full level of support will kick in.

Senator RUSTON: Is there any pattern that says these sorts of people get their packages more quickly—these people who are classified at this area, category, urgency et cetera get them within this period of time—or is it ad hoc?

Mr Gear: We are unaware—it seems to be fairly opaque at this stage—how the minimum service offering is working and when people will come off that to their full package.

Senator RUSTON: How often are you receiving or seeing cases where the AIT algorithm has produced inaccurate results or classification levels?

Mr Gear: I would have to take that on notice to have a look at our data to see where AIT specifically on classification is an issue.

Senator RUSTON: Classification and urgency, I suppose.

Mr Gear: Yes. I know that advocates each week have raised issues around classification and the adequacy of the cases. On the exact number, we're in the process of analysing our data from last year, so I can take that on notice and see if I can provide you anything.

Senator RUSTON: It'd be really useful to understand whether there's been an increase in concerns around package adequacy or timeliness for home-care packages to Support at Home and whether there have been any other substantial increases not just related to the algorithm but more generally related to the implementation of the package that has changed significantly over that period of time. I'm more than anything just keen to get an understanding of the wait times and the waitlists—was the information that you were previously receiving adequate for you to get a better understanding than you currently have in relation to wait times and waitlists?

Mr Gear: I don't believe we had greater transparency. I think there has been some improved transparency on waitlists, but it's not to the level that we'd like to see. Obviously, in changing from a home-care package system to a Support at Home system, there are different nuances. Volume has increased. Probably the main difference that we've seen is the volume of people on the waiting list and seeking services, and seeking services at the right level of support. I do believe there have been improvements in the types of reporting, but further refinements are absolutely needed in the nuance that Samantha talked about.

Senator RUSTON: Explain to me your understanding. Previous to Support at Home coming into place, people often were receiving a package that was a lower level package than the one they'd been assessed to get.

Mr Gear: Correct.

Senator RUSTON: When it came to the priority system, were those people who were on packages that were lower than they'd been assessed for still on the priority system or did they come off?

Mr Gear: At that stage we were seeing that they were on the priority system and were remaining there. We could see those who were receiving a lower level of support than what they had been assessed for and when they would move to that higher level. I'm not sure whether we're seeing that level of detail now for those who are on the minimum-service offering, those moving to the higher level of support and those wait times to move to the full package.

Senator RUSTON: Let me understand. Previously you had the national priority system and you could see from the national priority system somebody who actually had a lower-than-assessed package on the system but

they were still counted as the numbers. But you're saying now, if somebody has an interim package, the system doesn't show whether somebody has an interim package.

Mr Gear: I don't believe that we're getting reporting to that level of detail.

Senator RUSTON: I suppose the question then is: do you believe that's because the reporting level of detail has decreased or that they've been taken out and are no longer in the national priority system?

Mr Gear: I think you'd have to ask government about how they're treating those cases. But I'm not seeing the clarity about particularly the wait times of people on minimum-service offerings and the spread of that.

Senator RUSTON: Finally, do you have an idea of the number of people that are on a minimum-service offering?

Mr Gear: No.

Senator RUSTON: Okay. Thank you very much, Mr Gear.

CHAIR: Senator Ananda-Rajah.

Senator ANANDA-RAJAH: Mr Gear, I want to talk a little bit about care navigation and where people seek help once they've had their assessment. My understanding is that there's My Aged Care, which is a phone service that has a pretty quick pick-up rate. But the government's funded OPAN and COTA to also provide some help with care navigation. Could you just talk us through what you think would make your service work better for older people?

Mr Gear: I will ask Samantha to add to this, but I think, yes, absolutely, our service, the National Aged Care Advocacy Program that we're funded by government to deliver, is for people who are seeking or receiving aged-care services. I'm happy to provide the split of our work in that area as well. There is My Aged Care. There are also care finders out there. There's information on the website. There have been some improvements. We have only around 200 advocates across the country, so for people to find us, to be able to come to us for information, we have a self-advocacy toolkit, which does help people who are able navigate the system. These are improvements and are helping people navigate the system. But further work is required to actually explain the various steps in the system in an easy, digestible manner for people, particularly for people in culturally and linguistically diverse communities, other diversity groups and Aboriginal communities. We hear that the information is not getting out to those communities. Samantha, do you have anything to add?

Ms Edmonds: The other confusion that sometimes happens is where My Aged Care refers someone to an advocate in order to get a service, seeing us as being able to get the person the service, which is not what we do. We can help advocate for that, but we can't jump any queues or assessments. Sometimes that causes further delays and confusions and frustrations for the older person.

Senator ANANDA-RAJAH: So you're principally providing information; you're not necessarily helping them with the form filling and the other bits and pieces. Would that be fair?

Ms Edmonds: No. We're doing that as well.

Senator ANANDA-RAJAH: And with the 200 advocates that you've got around the country, are you still recruiting or have you maxed out on that number? What proportion of those advocates, do you think, are working with communities or come from communities who are culturally diverse or non-English speaking? Do you have a sense?

Mr Gear: We do have a mix of First Nations advocates and culturally diverse advocates. They are, to be honest, small in number and very specialised. We are out in communities providing community education as well as education in residential aged-care services. The challenge is our funding is not keeping up with wage increases, so we are decreasing and actually having to lay off staff at the moment because indexation is not keeping up with wage rates, so we have a shrinking workforce at this stage as well; that is the particular challenge. We are looking at other digital, webinar aspects—other means of getting communication out there—but it's the face-to-face, non-digital aspects which older people are saying that they absolutely want. They need us out in the community to be able to provide them information along with other organisations such as COTA and other community organisations as well.

Senator ANANDA-RAJAH: With this hybrid model, given cost constraints—which, honestly, everyone is facing in this environment—are you looking at maybe initial face-to-face if feasible followed by more telehealth or digital options thereafter to try and develop scale?

Mr Gear: Absolutely. Our national aged-care advocacy line is a single pathway in that people can call, on 1800700600, and that is predominantly where we're providing that. We will provide face-to-face advocacy for hard-to-reach populations or people with diverse needs. We will continue to look at productivity improvements

where we can to make sure it's an efficient model, that is the right level of service to the right supports and that it's proportionate and risk based for that person. That means that they get the advocacy support that they need.

Senator ANANDA-RAJAH: Is there any role for AI in your work, or are you thinking about how you can incorporate it into your work?

Mr Gear: That is a topic of the day. We want to make sure that it is done ethically and safely for older people, that it meets their needs, that there is always a human that oversights that system and that it is not automated decision-making in advocacy, as happens in other parts of the system. We are exploring ethical ways to deliver that to improve efficiency, but we want to make sure there's always a human at the end of the line for those who need it.

Senator ANANDA-RAJAH: Okay. Thank you, Chair.

CHAIR: Mr Gear and Ms Edmonds, thank you very much for your evidence today, and, again, thank you very much for your really comprehensive submission with a number of recommendations. The committee will report to the Senate on 24 November 2026, and we've agreed that responses to questions on notice should be provided by close of business on Tuesday 6 October 2026. Thank you very much.

IRLAM, Mr Corey, Deputy Chief Executive Officer, Council on the Ageing Australia

YAZDABADI, Ms Gohar, Chief Executive Officer, Council on the Ageing NSW

[09:01]

CHAIR: Welcome. Thanks very much to both of you for appearing before the committee today. I understand that information on parliamentary privilege and the protection and obligations of witnesses giving evidence to Senate committees has been provided to you. I know that we have senators wanting to ask lots of questions, so I'm going to give you the opportunity to make a really short opening statement, and then we'll go to questions. Ms Yazdabadi.

Ms Yazdabadi: Thank you, Chair and committee members. I welcome the committee's decision to hear from a range of consumer organisations, and I'm delighted to appear alongside my colleague from COTA Australia. Council on the Ageing NSW is the independent peak body representing people aged 50 and over in New South Wales. This year we're excited to be celebrating our 70th anniversary.

We are a direct membership organisation and have approximately 8,000 supporters and members. Our authority to speak comes from our relationship with older people and the evidence they entrust to us. Their experience determines our priorities and shapes the positions we bring before this committee. For example, our lived experience group is exclusively for older people living in social housing, people renting privately on the aged pension and people living in specialist residential aged care who have experienced or are at risk of experiencing homelessness. They help set our agenda and hold our advocacy accountable to the realities of their lives.

At Council on the Ageing NSW, we believe that with the right support older people can live full and joyous lives. Our era of joy report brings together older people's own accounts of what gives their lives meaning, connection and joy. It invites us to consider what good policy should make possible and the role in support of this. I seek the committee's leave to table the report. I believe that, if we shift our approach to policy for older people towards what is possible, we could only imagine what we could achieve.

Today, my ask of the committee is to hold a mirror up and confront what the Support at Home program has meant for older people. The system has failed older Australians. A system that leaves people waiting for essential care until their health deteriorates and they enter hospital and die has failed in its most basic responsibility. This committee knows the statistics. Older people and their families live the consequences of those statistics. Behind the waiting times are people going without the help they need, and their families are trying to hold the arrangements together. Older people are spending sleepless nights stranded in hospital because there is no safe and supported way home. Promises of care have gone unfulfilled.

These failures demand accountability. Older people are entitled to expect that that support would be there when they needed it. They should not have to reach crisis before the system responds. Yet, even when they reach crisis now, the system is not there to support them. The success of the Support at Home program can be measured by whether old people receive affordable and appropriate support in time to make a difference to their lives. This is the standard against which the committee must hold the Support at Home program accountable.

While I appear before you as the CEO of Council on the Ageing NSW, I also appear before you with the lived experience of losing my father in February this year while he was stranded as a patient in the New South Wales hospital system. My mother passed away two months later. I know personally what it means for families to look at a system for help and find that it cannot meet even the most basic needs they were promised. I welcome the committee's questions in both my professional and personal experiences, and, in particular, I welcome your questions on co-payments and elder abuse, the experiences of older people stranded in hospitals, older people's experiences of trust in the current system and what we need to do moving forward.

CHAIR: Thanks, Ms Yazdabadi. Mr Irlam.

Mr Irlam: Thanks. I bring apologies from our chair, Patricia Sparrow, who's unwell today. I want to thank the committee for hearing directly from various people with lived experience throughout this inquiry in addition to representatives like COTA. Our evidence draws on the emails, calls, social media and research we conduct both directly and with partners as well as the national consultations we held around the country on both the draft act and the aged-care reform explainer sessions in every state and territory. Since our submission, the government has announced it will extend the Commonwealth Home Support Program until June 2029, and we welcome the certainty that maintaining two programs gives while government consults on how Support at Home and CHSP must work together as a continuum of care for older people in the future.

We'll take the 20 recommendations in our submission as read. There are many positive experiences that people have had with Support at Home, but in our remarks we want to focus on three things. First, older people need timely access to the support they've been assessed as needing. A woman in her early eighties in South Australia had a terminal illness and was trying to get a walker. She told us: 'I can't wait. I literally could die waiting.' For her, waiting times were not an abstract policy problem. We recommend that nobody should have to wait longer than 30 days from application to receiving the support they're assessed as needing. We acknowledge that the government has a goal of 90 days by mid-2027, but reporting has to capture the full waiting time period, including any time before assessment referrals are accepted 'at hand' and the time for individual services to first be delivered. We outline this more in appendix A of our submission.

What does it mean? It means strengthening the aged-care wait times report now, not waiting for a three-year review. Such a report must include CHSP ASAP. It has to include published waiting times for the completion of support plan reviews and reassessment, along with the wait that happens for any upgrades of funding to be allocated from that minimum service offer, right the way up to their full funding that they receive after their interim allocation. All reports must include, by region, the raw number of people waiting as well as the median, average and 90th percentile number of days of people waiting.

Secondly, the funding needs to translate to actual care that is affordable. A woman in her early 80s from New South Wales told us, 'I'm not able to contribute more and so I've had to cut back on what I need.' Aged-care funding should not be eaten away by either unreasonable prices, unexplained charges or contributions that people cannot afford.

We do not currently measure whether the Support at Home classification level of funding buys enough care to meet the assessed need that somebody has. When providers are allowed to set their own prices and the value of care hasn't increased to match those prices, what happens? The amount of care that a Support at Home classification can buy shrinks. While many Support at Home participants may be protected under the current no-worse-off principle and pay lower or, in some cases, no contributions, what we hear from discussions with older people suggests their concerns about fees have influenced the services people choose in their care plans, even for those who don't pay the fee. But we need to see some robust analysis around this. We need to assess the impact of prices and contributions on household budgets and services foregone. We need to distinguish in that research between people paying the new full rates and those on the transition protections, and we need enforceable pricing protections and simpler access to hardship assistance.

In addition, the way we design Commonwealth Home Support and Support at Home into the future must work together to protect affordability. We cannot repeat the same problems we had with home-care packages, where full cost recovery processes for CHSP funded services, such as transport or day therapy centres, made it completely unaffordable for people-on-package recipients.

The third thing is that people must have genuine control over their care and genuine choice. This means access to multiple providers from 1 2027 July, genuine support for self-management and access to choices across program boundaries. A Tasmanian woman in her 70s told us: 'I self-manage. As well as the 10 per cent management fee they take, they add a 10 per cent loading services on my invoices.' We say that additional clip of the ticket, that 10 per cent, takes away from the amount of care that somebody can purchase. Direct access to providers would give greater control and support price competition, which we argue is sorely lacking in many parts of the system.

The work towards 2029 must ensure that assessment and funding arrangements connect people with available supports that support their needs as they change. Someone approved for CHSP cleaning should not go without when there's also a home support provider in the area who could deliver that service, but, simply because their assessment says they're authorised to CHSP, they can't access it.

COTA Australia supports the new rights based reform. We ask this committee to make sure they recommend practical changes that will translate those rights into affordable care that actually reaches people. Thank you.

CHAIR: Thanks very much to both of you. I might start with Ms Yazdabadi. What has changed for New South Wales clients' out-of-pocket costs since moving to Support at Home?

Ms Yazdabadi: It's been a massive change across the board. The out-of-pocket costs that we're talking about are really causing a lot of distress for older people. As I mentioned in my opening statement, we're seeing a significant rise in elder abuse as a direct result of these out-of-pocket expenses for older people.

I'm sure the committee is familiar with the issue of inheritance preservation. We've seen this quite often from adult children who are preserving their inheritance. Often we see them holding back on care, especially when that care is as significantly pricey as it is at the moment. What I think is really interesting is that that's actually

shifting. We're seeing, from our experience and from other people's experience, that it's moving away from just adult children. We're seeing partners come into the idea of inheritance preservation as well, and this is directly because of the costs of the co-payments. They're frightened that their savings are going to be exhausted and they worry about paying for residential aged care for the person who needs it.

After they've finished the Support at Home program, you then have the issue of aged care into the future—residential aged care. Then the next part of it is: 'Well, what about me? I'm going to need that support at some point as well.' The partner's thinking, 'I need to make sure that I have enough of a buffer to be able to do that.' Financial fear is translating into one person denying care for another person. The fact that it's being driven by fear doesn't remove that harm. The older person's needs go unmet because decisions about their care are being driven by costs. I think it's really important to remember that these costs are being imposed at a stage in life when, for older people, there's no more money. You can't go out and get a side hustle or three or four jobs on the side to pay this enormous cost. This is it. This is where you're at when you're older.

I also think that the connection is really staggering. We're not just hearing it from ourselves. Council on the Ageing NSW is dedicated to the regions. I was out in Bathurst last week, and the Ageing and Disability Commission of New South Wales was saying the same story—that co-payments are pushing people into this sort of situation.

The other thing that we have to remember is that, while there's been a decision to remove co-payments for things like personal care and showering and that's been widely welcome, we have to remember that there are pensioners out there today paying co-payments. There are people on the seniors' health card paying co-payments. This is not a fair system. It is not the care that older people were promised. The goalposts have shifted so late in their lives that we can't call this fair or just.

CHAIR: Thank you.

Mr Irlam: The fear is a really important point. We need to get the department to publish. They now know how much co-payments are being charged. That has yet to come out in any kind of public forum. They should also know, because it's held by Services Australia, of those co-payments, which people are pensioners. Let's get some facts into the conversation, because we suspect that there is, right now, not the same amount of co-payments as the discussion and public perceives there is because of that no-worse-off principle, but that's unquantified yet.

CHAIR: Mr Irlam, one of the promises of Support at Home was greater choice and control. In practice, what's preventing older people from exercising genuine choice over providers, the self-management and the services that they purchase?

Mr Irlam: We haven't implemented the system that was designed. We were meant to implement multiple providers by 1 July 2027. We still expect government to do that. They're continuing the discussion through the consumer protection working group, but if we don't allow registered providers—we're not talking about the NDIS process of thousands of unregistered providers here; we're talking about registered providers in categories 1, 2 and 3 at a lower burden of compliance and at the same burden of compliance that we see in categories 4, 5 and 6. Currently, all providers have to do all categories; therefore, they're doing the higher compliance.

If we introduce that system that would allow for cleaners and for gardeners—Jim's Mowing et cetera—we'll see those prices go down. We'll be able to buy more hours with that care while still maintaining a level of quality compliance over the system in a way that we didn't see in the NDIS, which includes being able to ban people from the system if they're acting inappropriately towards older people, which is a really important feature that we need to maintain. If we actually do that, then what do we see? We no longer have the power dynamic of an older person beholden to their funds-holding provider who says yes or no as to whether they can have their preferred subcontractor because the funds-holding provider today has a legal obligation for all of those people to be their 'associated providers'. If we decouple that requirement and we allow the person to engage directly the person they want, then we'll see more competition than we see today in the system.

There is a question that needs to go through government around how care management works. What you often hear in this conversation is, 'Who's going to look after the older person holistically?' Well, the person may be 75 and have looked after themselves for the whole 75 years of their life. It's a little paternalistic to think that a provider having contractual control versus a provider having government legislated influence because they're in the role of care manager somehow makes a big legal difference when they're only going in perhaps two hours a week. So I think some of the arguments need to be tested and made robust. They just seem to be a little bit too much like protecting current providers versus opening up the market to what consumers want.

CHAIR: Ms Yazdabadi, you said in your opening statement you were keen to talk about trust. I want to give you the opportunity to speak to that.

Ms Yazdabadi: I want to start, in that conversation of trust, around loneliness. The committee might find that a bit of a strange place to start, but, at Council on the Ageing NSW, we undertook research into loneliness that involved more than 2½ thousand people. We used de Jong-Gierveld's scale of loneliness, and 60 per cent of our respondents were lonely, 50 per cent were socially isolated, and, shockingly, 25 per cent were at the most extreme level of loneliness. That doesn't mean anything until we understand the scale. People are asked to reflect on whether they feel empty or rejected, whether they miss having people around them and—this is important—whether they have people they can trust and rely on when problems arise. These findings tell us something really important about how older people feel supported and connected. That so many people are feeling this level of loneliness is heartbreaking.

Now let's consider what happens when they turn to the aged-care system for help and find a system that they cannot rely on either, so someone who already feels these feelings of loneliness, rejection and not having people around them for support then has to navigate a very difficult system. Navigation of the system is extraordinarily difficult. You lose trust at that point. I hold a bachelor's degree in law, a graduate diploma in legal practice and a master's in law. I worked in the federal public service for about 10 years. My sister is a dermatologist who works exclusively for the public system. Our experience of navigating the system was extraordinarily difficult. So, every day, I think: if that was our experience, what experience are other people having? That absolutely loses people's trust in the navigating. Then there is the prolonged wait and then the support that, once it arrives, they cannot afford.

This reinforces that feeling that there is no-one that they can depend on. I think that we often forget that older people have lived a life of a social contract with the government. Throughout their working lives, they've contributed through taxes with the understanding that there would be help there when needed. Every time the tax was taken out of their pay packet, they were told, 'This is for your pension when you grow older and this is for someone to support you when you grow older.' Now those people are going without essential care, and that promise has been broken.

I think the other problem with all of this, in terms of trust, is that those goalposts keep shifting. People who planned for retirement under one set of expectations now face costs and arrangements that they did not anticipate at all—and at a time, as I've mentioned before, when they have little capacity to be able to improve their financial circumstances. So we can't expect them to have confidence in the system going forward.

Then, for an older person, to realise that an algorithm is used to determine their funding adds to that loss of trust when people can't see how the decisions that reflect them, their circumstances or professional judgement can give them the adequate outcome that they require. Older people need confidence that somebody has understood their needs. This is a fundamental need for anyone interacting with any system, and, as I mentioned, the process of getting into the system is really quite awful.

But I think the really important thing for this committee to remember is that disengagement has serious consequences. Needs go unmet, pressures on families grow, and the problems that could have been addressed earlier are now becoming crises. And there is a financial cost to government of that as well. It's not good financial policy to create a system where older people don't engage and cannot trust in that engagement. So government should be deeply concerned when people become so disenfranchised. We cannot keep building a system where older people are alienated.

Whether or not that trust will return depends on the system that we build hereout and on whether people can access that timely support, whether there is somebody on the other side of it, where they're seen as being human and where they can interact with that. I really have to say that I don't think that it's asking much of any system—to be seen as human, to be interacted with as a human and to be engaged with on those basic needs that are required for older people.

CHAIR: Thank you. I have so many more questions for both of you, but we don't have enough time. Hopefully Senator Ruston will ask some of them! Over to you, Senator Ruston.

Senator RUSTON: I asked OPAN earlier if they would like to provide an outline of the kind of information they would find useful that currently isn't available. You went to some of the things that you would like more information about in both of your contributions, so I'd be really keen to get an idea of what the information framework is that you think would provide useful, transparent information around the systems. I don't like giving you more work, because I know you've already got enough.

Mr Irlam: I'm happy to refer you to appendix A in our submission. That outlines a five-step process to entering aged care. In addition to that initial process, there are a couple of branches. There's the branch when you get your interim allocation through to how long it takes you to get the full amount of your package. There's also

the minimum service offer, and then there's the reassessment support plan review. If you take that five-step process with those numbers by region, it gives you the core of what's needed by each of the subprograms.

Senator RUSTON: Absolutely—things like the interim packages et cetera. I'm happy to have a look at that, but do you want to add anything to it? I think it'd be a very useful recommendation for us to talk about the data that the government should be providing to make your lives easier.

In your submission, you make comment around how you'd like to see a funded strategy that would enable people to not wait any longer than 30 days. The government made comment that it believed that, by the end of next year, it would have the wait times down to 90 days. I'm keen to understand if you think that the government has provided any evidence of a plan or a strategy that they are using in order for them to get the waitlist or wait times down from close to a year at the moment to 90 days within the space of 15 months.

Mr Irlam: The short answer is what are they doing with CHSP's wait times, because theoretically that could be provided within 30 days. But the problem is that we don't know how long that is taking, and we suspect that it's probably a year that people are waiting.

Senator RUSTON: But I think they're talking about Support at Home when they're talking about the 90 days.

Mr Irlam: And what's unclear is that that announcement was made in the context of a policy environment where the two programs were merging together under the name of Support at Home. Clarity that the new decoupled Support at Home will still have 90 days, and around how it will achieve that, is something that we're looking for and why we asked for the strategy.

Senator RUSTON: So my question then is: do you believe that they have a strategy or a plan to deliver the 90 days to Support at Home that they said they were going to?

Mr Irlam: I'm not aware of any, but that doesn't mean that they don't have one.

Senator RUSTON: I'm only asking for what you know. How long, from the information you've received, do you believe people are receiving interim packages for at the moment?

Mr Irlam: We think, based on the evidence that was given to the Senate a couple of months ago, that all people as at 30 June would have had their full package and that all people since 30 June will still be on a minimum support offer.

Senator RUSTON: That was evidence given, but I'm talking about your experience.

Mr Irlam: The evidence hasn't clarified that yet, but we believe, based on that indication, that they were working towards it. The way we understand that the system works is that the financial year allocation will result in everybody having a full package. So, by 30 June, everybody will get it. The earlier in the financial year that you're allocated your minimum support package, the longer you'll stay on it. This is our assumption, based on what we understand of how it works. This is why we're asking every quarter for transparency on seeing how long people are waiting on the MSO for.

Senator RUSTON: So you're contending that, if somebody received an interim package on 15 June, they're probably very likely to have a very short wait on an interim package?

Mr Irlam: Or not at all.

Senator RUSTON: Okay, as opposed to if you got it on—

Mr Irlam: In order to control financial budget allocations.

Senator RUSTON: On 30 July, things might be slightly different.

Mr Irlam: Correct. But we don't know whether that will be all the way through to the end of the financial year or just a longer period within that financial year.

Senator RUSTON: On a slightly different tack, there has been quite a lot of commentary around issues with the Assistive Technology and Home Modifications program. I'm interested in what your experience has been about the major issues that you've encountered from the people that you represent.

Mr Irlam: We want people to get care as soon as they can. But ironically, because we don't have multiple providers, we've got providers who won't accept somebody who's got assistive technology funding being allocated to them prior to having their Support at Home funding allocated to them, largely because assistive technology doesn't have care management as a component of it but also because those providers who take on that client code, if you like, lock out everybody else from the system because there's only one single provider. You can't just go to a specialist AT provider and have them pick up your AT funding. You've got to go find somebody who will do everything—your AT today and your Support at Home when it comes in the future. Because people are unclear how long it'll be until Support at Home comes through, perhaps that will be longer than they want.

Senator RUSTON: Have wait times more generally blown out for access to AT and HM?

Mr Irlam: No. If anything, I think it has come down because of that earlier allocation, but they haven't actually published the amounts of time for the standalone AT and standalone home modifications—high, medium, low—yet.

Senator RUSTON: Do you believe that AT and HM are prioritised in terms of the issue of older Australians being able to stay in their own home?

Mr Irlam: I don't think it's fair to say they're prioritised. What I think is fair to say is government takes a whole bucket of money and they allocate it to different strands. One of those strands is assistive technology, which is different to Support at Home. Because of the rate at which people are approved in assistive technology and the amount of money in that bucket—all of these things impact how quickly that money goes out. What we've found is that people are largely getting their AT funding allocation earlier than they're getting their Support at Home allocation, putting aside people who are urgent or high priority and will probably get Support at Home quicker. But the challenge for them once they get that funding allocation is finding a provider who will deliver it to them, because of that lack of multiple available providers.

Senator RUSTON: So there's no capacity for them to just go directly with the funding to pay a provider.

Mr Irlam: No. You have to have a provider holding all of those six categories of Support at Home registered—doing personal care, nursing, everything—in order to be able to access a single dollar out of the system, because we haven't implemented multiple providers.

Senator RUSTON: We could talk all day about that, couldn't we?

Mr Irlam: And I will!

Senator RUSTON: You were at the same presentation from Natalie Siegel-Brown at the Press Club that I was, and that $50 pair of crutches that cost $1,800 still sticks in my head. I'm really keen to understand whether you have seen that sort of cost inflation in relation to the average person on the street who would go and seek to get access to these sorts of assistive technologies or home modifications and the cost that it actually ends up costing the individual when they get the bill through the system that has been implemented. I'm keen to get an overview about where you think cost inflation is going in Support at Home.

Mr Irlam: I want to break down the answer on two levels. The first level is the policy intent, and I don't know that the policy intent said, 'You should go spend $1,200 on an OT assessment for a $50 pair of crutches.' In reality, providers are interpreting the policy document in that way. And so in reality, yes. We end up spending that $1,800 for that $50 pair of crutches because they're going through the compliance process of having the documented evidence to need that piece of equipment to be able to then prescribe the right height and the right type of equipment, do all the safety checks and have that documented. That's not my understanding of what the policy manual intends it to be, but the wording—I agree with some providers—could be a little clearer.

Ms Yazdabadi: We're seeing that sort of inflation not just for assistive technology. This is something that happens across the board. It's gotten to a point actually where people are coming to us and saying, 'The level of co-payments that we're paying under Support at Home—we could actually just take the co-payment amount, go to a private provider and get a service that would probably be much better and much better suited for us.' Coming back to a couple of the points that you made about waiting lists and times and things like that, I think one thing that we really have to remember and keep at the front of our minds is that waiting lists are only for people who are engaged in the system and have taken that leap to be engaged in the system. We have an enormous amount of people living on the fringes who are not accessing the services that they are entitled to under Support at Home, for various reasons. But the very interesting scenario there—which I think research into would be imperative—is how many people are in fact not engaging with the aged-care system and what it would do if we did see them go on to the system.

Senator RUSTON: Yes. That's a big question. Just to finish on this, in your submission you said that you believe that, on average—I'm interested in what the average is—there had been a 29 per cent increase from the old home-care packages to Support at Home. Does that 29 per cent apply to all service types, or was that confined to a particular type?

Mr Irlam: Let me explain the 29 per cent. That's explainable. We previously had 20 per cent care management. Ten per cent is now care management, so you have a leftover of 10 per cent, plus 15 per cent of package management that was in the old system—overheads that are now being put into the unit price. Then in October we saw a five per cent increase in wages. About 80 per cent of costs are wages—therefore four per cent. Ten plus 15 plus four equals 29. You can explain that increase quite simply to somebody when you're going through into the system.

When you then look at travel cost, overhead, implementation, IT, the extra stress of building the new system that providers went through, their concerns around underutilisation and trying to put a margin in there that's inflated for fear that they won't be able to sell their products, those things are unexplainable consistently across the board, and each individual provider probably needs to be able to explain, above that 29 per cent, why their prices went up. If you look at Stewart Brown's increases, the five most commonly charged services that were published under home-care packages have had a nominal increase. Then you look at extreme increases in the ones where they can't track what the prices were prior in home-care packages.

You've got some analysis now coming out showing where those price increases are. But, again, one of the challenges that we see with discussions around unreasonable prices et cetera is that it's as if the world started for government on 1 November 2025. But, actually, all those people who were there on 31 October are starting from the old system and going, 'Is it reasonable to what the new system is?' Government regulations starting from the new system are going, 'Are the prices that have been built into the new system reasonable?' They're fundamentally different things.

Senator RUSTON: Yes. But it's still in the mind of the person facing it. Thank you very much, Chair.

CHAIR: Senator Whiteaker.

Senator WHITEAKER: Thanks for your time this morning. I've just got a couple of questions. One of the things that you've spoken to in your evidence and that we've heard in evidence from previous witnesses both today and in other hearings is the importance of helping older Australians navigate the system and understand where they can go, what supports they can access and how to get through what is a really complicated system. The government has funded OPAN and COTA to do some of this work. What can we as government do to make that kind of support work best for older Australians?

Mr Irlam: If you look at the work that was funded back before the pandemic, when we led a consortium of 30 different organisations doing the Aged Care System Navigator program, which then led to the care finder program, what you discover is a couple of things. One is that you've got to go to where the people are. You can't expect the people to come to you. What does that mean? It means accessing existing community structures like senior centres. It means going through local GPs.

The way we don't utilise GPs for either an assessment or a referral or just an information trail is astonishing to me. We should be running a concerted program with all GP practice nurses to understand how to help people get in, and we need to make sure that people understand that easy application pathway that's now being built with the GP referral pathway through My Aged Care. One of the sad things, though, is that we don't measure the day that that form goes in. We only measure the day that the assessment goes off. We need to capture that whole pipeline on the waiting list.

Once you reach out to people, there are two things that need to be done. One is just a little bit of information. Two is answering their very specific, very basic question. So, very often what we see in the care finder program, which is a beautiful program delivering great things for certain types of people with complex needs, is there is a great swathe of the population who don't have complex needs but they are still so confused by the system they just want to talk to somebody and say: 'I think it's this. Am I right?' They want that validation to build that self-confidence to be able to self-navigate through the system.

We find there is a cohort of people who want to hear that from their peer rather than from a professional, so it's how we do that peer support element. 'I've gone through this experience and I found it was easier for me.' One of the things that we're never going to tackle easily but we've got to recognise is that, for many people, when you say the words 'aged care', what they hear is a loss of agency, a loss of control, a loss of ability for them to choose their own pathway in life. They very often hear the words 'aged care' and they picture a nursing home. They don't necessarily hear the words 'aged care' and picture better support to help them remain at home and help them stay happily and healthily in their house.

Actually, we used to say to our navigators that saying 'aged care' itself was a barrier, and to actually start with the words 'home care'. 'What can we do to help you get into home care, to stay safe at home longer?' Then we'd talk to people about the benefits of registering early. 'Not because you say that you need it, not because you say you're getting frailer, but because, you know what, you could get ahead of the queue, be on the list just in case something happens, in case there's a fall or something.' All of a sudden, you have removed that emotional barrier towards accessing support and you've opened up a conversation that isn't about frailty but actually is about empowerment. That's fundamental to getting people to access and engage in the system in an early way.

Ms Yazdabadi: Every day I speak to older people in this situation where they don't know what to do and they don't know where to go. The fundamental problem for us is confusion for older people. What we found is

something very different. Older people have heard information from their peers, they have heard information down at the coffee shop, but what they're looking for is an authoritative stance where someone can tell them, 'No two ways about it, this is the path you take.' Not, 'I did it kind of like this,' or 'You might kind of need to do that.' That just adds to all of that confusion. We need simple, clear words and somebody there to guide someone through the entire process from end to end, which I think is really important.

As I mentioned, this process for me and my sister, from the backgrounds that we had, was so incredibly difficult. For somebody who doesn't have that support, I shudder to think how many people are sitting on the edges and the fringes because of that. I know it's not a cheap solution, and I'm sorry that I can't offer one to you, but if we really want to be serious about helping people navigate through this then we do need to help people get the right information. I think funds would be well spent in being able to help people from the get-go to get the right information, fill out the right forms, do them properly and have a much better experience in building that trust that I also spoke about before.

Mr Irlam: At a recent consultation I was quite surprised by how many older people were saying: 'We need AI. We need somebody on our side, who isn't the provider, who tells us the facts of the rules because we're so reliant on the providers to translate those complex legal documents to be able to tell us, basically, am I entitled to this or am I not?' Their solution was, 'Can I do a chatbot?' That's fraught with danger, error, hallucination and all those things that need to be managed, but it is an interesting use case to look at. Are we explaining things in plain English enough and is the way to access that, through a 300-page Support at Home manual, going to help somebody in that moment of crisis answer their black-and-white question.

Senator WHITEAKER: Thank you. I want to touch on something that you said earlier in your answer to my question. You talked about older Australians who perhaps are not quite in need of a package now being advised to go on a waiting list or get in the queue for when they do need it. That's something I've heard quite a bit in recent weeks. The tension there, for me, is that just adds to an already very long waiting list and creates problems as well—right?—if people are asked to wait around for something they don't necessarily need right now. I'm interested in your views on how we manage that to get the best outcome for people who really need a package quickly.

Mr Irlam: The distinction that I'm making versus what you're hearing is that I'm saying to an older person, 'Do it before you think you need it,' because the older person is often the last person to think that they need any support. It's sometimes too late, given how long it takes to get an assessment, or it's only at the moment of crisis after you've had a fall or had frailty that you come to that realisation. That is different from what you're saying, which is that the objective assessment says they don't need it. There's the distinction, which is about the screening, the front door and the assessment triage process as opposed to whether or not they should put their hand up to connect into the system.

Ms Yazdabadi: If I could add to that, this rhetoric—about getting onto a waitlist really quickly, being proactive and all of these things—is actually quite dangerous for older people. It can be quite demeaning for them as well. In saying this, I think stranded patients are a really great example of this. When you enter the hospital system as a stranded patient, one thing that you'll often see is a rhetoric that says: 'You should have been prepared for this moment. Why didn't you engage with the system sooner? Why didn't you do this? You should have been prepared. You should have known that this was going to come down the path.' I think that is extraordinarily unfair to the older person. It allows for this shifting of blame. The older person doesn't care whose fault it is. They know it's not theirs—and it isn't theirs—but they find themselves in these situations where once again the blame for their 'inadequacies' is being shifted back to them.

Senator WHITEAKER: I think that is an important point. We talked a bit about the co-payments and the costs on older Australians who are accessing care. I'm aware the government announced that from 1 October—so very soon—a range of personal care costs will carry no co-contribution. Can you talk to what difference that might make for some of the people that you represent and advocate for.

Ms Yazdabadi: I think it would make a difference for them, but I think it doesn't go anywhere near far enough when it comes to this. As I said, we have people on pensions in private rentals who are paying co-payments. That makes no sense to me. I don't know how they could possibly afford it. When you do the numbers and you run them through, there is nothing left for a co-payment for a person on a pension or somebody on a seniors card. While I welcome this kind of a change, it doesn't go anywhere near far enough.

Mr Irlam: It's interesting that the hardship application process requires initiation by the older person even when Centrelink knows this person is getting Commonwealth rental support. They're a full pensioner, they have no assets, they have no other money, and they already would meet the criteria. But being a bureaucratic process it has to be initiated by the older person, if they know that it exists, rather than a system that proactively reaches out

to support people of low means by saying: 'We're going to start this assessment process, but we need these two extra pieces of information. Could you please give it to us?'

Senator WHITEAKER: Finally, I understand that COTA have been involved in a working group on pricing, which met for the first time recently. Could you talk to what that working group is doing and what your engagement is with that.

Mr Irlam: I'm not the representative on the working group. It obviously has usual processes of confidentiality, but the government has publicly stated that the working group will look at a reasonableness test of pricing and other additional consumer protections that may be needed. We would argue that that should include things making complicated 60-page service agreements simpler and easier to understand. There are a broad range of protections that we'd look at there as well as this thorny issue of 1 July 2027 multiple providers. We think that's probably very critical to make sure that that doesn't slip again.

Senator WHITEAKER: Thank you.

CHAIR: Thanks very much, Ms Yazdabadi and Mr Irlam, for your evidence today as well as your submissions. The committee will report to the Senate on 24 November 2026. We've agreed that responses to questions on notice—I think you might have taken a couple, Mr Irlam—should be provided by close of business on Tuesday 6 October 2026. Thanks very much.

BUHAGIAR, Mr Saviour, Director, Seniors Services, Uniting NSW.ACT

HEPWORTH, Ms Patricia (Trish), Head, Government Relations, UnitingCare Australia

THOMAS, Mrs Cathy, Group Executive, BlueCare

[09:50]

CHAIR: Thanks, everyone, for appearing before the committee today. I understand that information on parliamentary privilege and the protection and obligation of witnesses giving evidence to Senate committees has been provided to you. I invite each of your organisations to make some short opening remarks, and then we'll go to questions.

Ms Hepworth: We will keep these short. We start by acknowledging today the Ngunnawal and Ngambri people, on whose lands we are meeting.

UnitingCare Australia is the national body for the Uniting Church's community services network, one of the largest networks of community service providers in Australia. Our providers deliver aged care, and I'm very glad to be joined by my colleagues from BlueCare and Uniting NSW.ACT today. We deliver care in every state and territory from inner metropolitan areas to some of the most remote areas of Australia, and in some of those communities we are the only provider of aged care.

We're here today because inequality should never decide who gets care, what kind of care or how long somebody waits for care. Right now, inequality does decide these things. Across our network, we know that people are waiting too long for care. We know that older Australians want to age safely at home, connected to their community. But without timely access to full Support at Home packages, we know that people become unwell, deteriorate, may have falls and can end up in hospital or prematurely in residential aged care. In worst cases, we have, sadly, seen across our network several instances of people passing away before they receive their packages.

We have three clear asks that we know will improve care for older Australians: we need to release enough packages so that nobody waits more than a month from approval to a full package—a full package, no more 60 per cent minimum service offerings; we need to streamline hardship applications so that administration is no longer a burden for people and that people of low income still receive the care they need; and we need to fund the Commonwealth Home Support Program properly. We welcome the recent announcement of the retention of block funding for the CHSP, but we also know that the need outstrips funding. The CHSP needs more money and more flexibility to support people.

The UnitingCare network is ready, willing and waiting to provide Support at Home for the Australians that need care. When the packages are released, we will work in partnership to ensure that nobody misses out on the care they need.

Mrs Thomas: BlueCare is one of Australia's largest aged-care and community service providers, delivering more than 3.1 million home visits a year to over 55,000 people across metropolitan, regional and remote Queensland communities. We currently support over 9,000 people accessing Support at Home. We are not-for-profit and we've been doing this for over 70 years, and we are absolutely passionate about supporting older people to be all they can be.

With significant customer and staff co-design, we have developed the neighbourhood model across Queensland. We now have 70 neighbourhoods, and growing, reflective of person centred care. They consist of self-managed multidisciplinary teams in local communities who work closely to empower customers. We see that the strongest green shoots are the system's underlying capability to deliver good care. Our workforce and the people working across the Uniting network and broader sector are maintaining outcomes through complexities, delays and transition pressures.

In responding to this inquiry, we have engaged with our frontline leaders, care partners and allied health teams across Queensland. We found that, more than ever before, our teams are acting as navigators, advocates and coordinators within a system that many older people find difficult to understand. Older people and their families are often relying on us to explain funding arrangements, challenge assessment decisions, co-ordinate services, support hardship applications, manage transitions and navigate reassessment processes. I will share one example of this.

In rural Queensland, we are supporting a woman who has a level 7 package. She has chronic wounds that require ongoing nursing and wound management. Her assessment identified nursing was needed to manage a chronic leg ulcer, pressure sores and catheter care, yet, when her Support at Home approval came through, the nursing care and nursing care consumable service types she needed were missing. This meant that she could not

use her package for these essential services and was at significant risk, and there were also limited other health supports in her area—being rural Queensland—so, to maintain her care and safety, this needed to be continued with support through CHSP while she was reassessed to get the service type she needed. The correction required months of back and forth and significant RN advocacy. Our teams had to walk her through each step of the process and what it meant for her. Following reassessment, the service types she needed were finally added, and she is now being supported to remain safely at home. Since 1 November, one in five of our Support at Home clients has required CHSP top ups to maintain their support and safety, a process also carrying additional administrative and navigation work across the two programs.

BlueCare also fully supports the asks that Trish has outlined. We call for greater flexibility within the Support at Home program to avoid unnecessary delays or gaps in care, reduce pressure on the assessment system and limit the use of CHSP for needs that should be covered under the right package.

We, alongside our industry colleagues and older people, are absolutely committed to Support at Home's success. We know and we see it every day. When we get the right level of support to people at the right time, we deliver great care.

Mr Buhagiar: Thank you for the opportunity to appear today. Uniting New South Wales ACT supports more than 27,000 older Australians through residential care, home care and retirement living in New South Wales and the ACT. Every day, we see both the strength of the system and where it is failing older people. Our central message today is simple: a system cannot be described as rights based if access to care is rationed. Older Australians should receive the care they've been assessed as needing when they need it, so we fully support that care within three months. Support at Home is a rationed system, and that creates some of the confusion that we've heard about already. Even when funding becomes available, some older people can't afford to use it.

Full pensioners who rent can be left with as little as $54 a fortnight after essential living costs, which is less than the co-contribution required for even a mid-level package. We have one of our First Nations clients living in rural New South Wales who's been assessed as needing Support at Home classification level 8 because of complex health needs, yet the required contributions are unaffordable for him. They have been deemed eligible for care but cannot afford to access it. That's the gap between rights in legislation and rights in practice.

We also reject the notion that provider capacity is a problem. Uniting routinely commences services within eight to 10 days of an older person agreeing to be supported. That's the kind of access we can provide once the package is approved and the person signs up with us. We understand it is a bold government that will future proof home and community care while also picking up the tab for a historically underfunded aged-care system. We are confident this government in this parliamentary term can act boldly. Frankly, it has no choice. If it doesn't, we will see the kind of confusion, we will see the kind of hospital blockages, we will see the kind of deterioration of older people that we see today, and, unfortunately, we will see the kinds of stories we today in today's papers of people dying while waiting for care. Rights that exist in legislation but not in practice are not rights at all.

CHAIR: Thanks very much, everyone. I might kick us off. I'm going to start with UnitingCare Australia. My first couple of questions are operational, and then I'll come back to the impact on older people. In your submission, you say that the 10 per cent cap on care management is insufficient. What work is currently being squeezed out by that cap, and what does that mean for older people with complex needs who require significant coordination?

Mrs Thomas: I think the 10 per cent is particularly not sufficient for complex clients and those clients that are requiring, from inaccurate assessment, reassessment or when their needs change regularly and they're needing reassessment. And that's particularly—we see that with people with dementia, often in our regional and remote areas. There's just the significant system navigation that is required. It is over and above the 10 per cent that is allocated for care management. It is substantial hidden work that is carried out on a daily basis by actually different levels of staff across the organisation to try and support people when and how they need it most.

CHAIR: And it sounds to me too that some of the requirements for this additional care are actually baked into the structure of the system itself. So, the fact that, for example, someone with dementia, for whom it should be foreseeable that they are going to need continual changes in the level of their care—that's not provided for in the way the system works, hence the multiple reassessments and people having to be reviewed because the tools are not functioning correctly. Would it be fair to say that some of this is actually being generated by flaws in the system?

Mrs Thomas: That's absolutely fair to say. And I think it's the flexibility of those service types within the package. People do need to go back for that reassessment more regularly.

CHAIR: If those things were to be fixed, it would take pressure off the navigating that you're having to do for clients?

Mrs Thomas: Absolutely. And it would be more responsive to people's needs because we do see the downward flow impact of this as well, of course, where people end up in hospital because their care needs aren't managed when and how they need them. And also we do see premature admission to residential aged care despite best efforts.

CHAIR: Thank you. This is a question for Mr Buhagiar. Are you able to expand on what billing or administrative requirement wastes the most staff time relative to its consumer protection value?

Mr Buhagiar: Yes, I think this is a really, really fascinating one for us and for us as a sector to contemplate. We've tried to build in a whole lot of protections against bad actors or against fraud and the like. I think we're seeing the downstream effects of that in terms of higher administrative costs and also a focus that moves away from focusing on the older person—things like case management and coordination of care.

We're focused on administration. I talk to our care partners, and one of their biggest gripes is that they're spending a whole lot of time on administrative processes and administrative tasks—so trying to think about how we reduce that so they can actually spend time working with clients, thinking about their changing needs and thinking about how they can help them navigate through the system.

It is a massive risk. It's a massive problem in the system at the moment. I get why we've done it. I get why as a sector we've chosen to do it—because we're worried about fraud and we're worried about bad actors, and that makes sense. But the administrative burden that we're creating is enormous. And I think it's partly why the costs are so high for delivering this sort of care.

CHAIR: Could you maybe take on notice and come back to the committee with examples of specific billing or administrative requirements that are wasting the most time relative to the protection that they provide to older people—so where there are things that you think could be improved.

Mr Buhagiar: I can do that.

CHAIR: Thank you. Coming back to UnitingCare Australia, we've heard in evidence from you and from others before you that the hardship mechanism is flawed. I'm interested in what you think a workable hardship pre-approval mechanism might look like and how it would prevent people from delaying care.

Ms Hepworth: Certainly across our network and all of our—we're very happy to talk to the hardship provisions. I think one of the challenges that we really have—there are two key areas. My colleagues can elaborate on them. One is that the current process of applying for hardship, which is highly technical, requires a significant amount of documentation and is particularly hard to support people through if they have English as a second language or are suffering cognitive decline. The actual process itself is an administrative burden on people accessing it. The second one is the types of people that are still being caught under the hardship provisions. I might hand over to my colleagues to talk on that one more.

Mr Buhagiar: I'd be happy to. We've done a piece of work that looks at people who rent as an example. That example I gave earlier about having $54 left—you need to use all of that for a mid-level package. We can provide that advice to the committee. Look for those triggers, but, in addition to that, think about what we heard from COTA just before about the indignity of having to put your hand up again. Someone says: 'Here's my hand up; I need help. And here's my hand up, for I'm under hardship.' If we can find a way to make that a bit easier and a bit more proactive and think about those triggers—maybe rent. Rent, I think, is a really obvious one, but there may be others. People on package level 8 are obviously people who we should reach out to as well because they're going to, most likely, have the highest contribution.

Look for those triggers, and look for ways to say—but we've put it very clearly in our submission, people who rent being an obvious trigger. There could be a way of saying, 'Hey, let's reach out to you proactively,' as we heard earlier from COTA, and to say, 'Can you provide me with this form and that form, and let's move the process on,' rather than waiting for that person to put themselves forward. Relatively speaking, it's a modest increase in the amount of money that might be needed. Obviously some people are applying for hardship, but this would be at least a better step into the system for older people.

CHAIR: Would you mind providing, on notice, the analysis that you've done around that.

Mrs Thomas: We absolutely support the direction that people, when they can afford to pay, be able to pay. But there is absolutely, as we've talked about, reluctance. Also, cognitive decline obviously really impacts how people apply for hardship. When we look at all of our BlueCare clients, 87 per cent of BlueCare clients are on a pension; 76 per cent are on a full pension, and 11 per cent are on a part pension. Of the 200 hardship applications

that we're aware of—that's the other thing; you're not always aware of the hardship applications—30 per cent have been rejected outright; 30 per cent still need to make a co-payment of an average of $100 a fortnight, with the highest being $350 a fortnight; and 40 per cent of the applications have received zero contributions. So, if these early trends hold—we're still seeing that 60 per cent of those people who apply still need to make a co-payment, and that does really impact, as we've heard before, things like cost-of-living pressures, fuel, rent et cetera.

We appreciate that the government is listening and trying to streamline digitising the forms. When you can access the social workers through Services Australia, they are great, but they are nowhere near enough. We are also observing downward trends in services with co-payments, which links to that hardship. Since the introduction of Support at Home, we've had a 40 per cent reduction in in-home respite, a 25 per cent reduction in centre based respite and a 13 per cent reduction in social support. This really impacts the care trajectory, as I mentioned before, with earlier admission to residential aged care and avoidable admissions to hospital. Carer burnout is another big issue. It does seem to really be affecting older women more—we can really see that trend coming through—and First Nations people as well.

Ms Hepworth: Can I add one very quick thing to completely pick up on these things and to add to my colleague Saviour's points about, in particular, things like pensioners who rent. One of the challenges I think we have with this whole process is that this is information that Services Australia already has. We are seeing this long and lengthy process—often unsuccessful and with copayments—but this is information that the government already has in more easily obtainable formats than we can provide.

CHAIR: Could you explain what the minimum service offering looks like from the perspective of an older person, what care they're actually receiving and what assessed needs remain unmet while they're on that arrangement?

Mr Buhagiar: It's disheartening. Let's just call it, very simply, what it is. It's very disheartening. You've waited X number of months for an assessment. You've waited X number of months for a package. Then you're getting 60 per cent of your package and you would've maybe got an ATHM before you even got that 60 per cent. It's just wait on top of wait, so it's disheartening. I can only describe it that way. We're seeing people who are saying, 'How do I make sense of this?' We talk about confusion and how we clear up confusion. To go back to what we were saying before, if you're rationing a system, it's hard for it not to be confusing, because the person knows what they need. Their families know what they need. Yet what we're saying to them is to wait again; wait again; receive an ATHM, a therapy and home maintenance service, for a little while; and then, by the way, receive 60 per cent of your package. This could be nearly two years into the person's journey after they've put their hand up. It's a long time. We heard earlier, I think rightly, that people wait before they even put the first hand up. So people are waiting. People grin and bear what they're doing at the moment. If we're serious about allocations and if we're going to maintain the system, which we seem committed to doing, at the very least we've got to get rid of MSOs. They've served no purpose other than rationing for a bit longer.

Mrs Thomas: If I could add that, of that 60 per cent which is the MSO, 60 per cent of new customers coming through to BlueCare are receiving an MSO. That really speaks to that increased navigation that you talked about before. They're on the lower package for at least a couple of months, and many of them are requiring that CHSP top-up as well, which does support them, but it adds to the confusion. There's also an equity issue because some providers don't have access to CHSP funding as well.

CHAIR: Thank you. Senator Ruston.

Senator RUSTON: Thank you very much for coming today. To follow up on some questions and some stuff you took on notice from Senator Allman-Payne, is there any way you could, or do you have any information to, quantify what the impact on the bottom line of this additional compliance has been in terms of reporting? It's probably difficult, but is there any way you could give us an idea of what it's actually costing your organisation in addition, because that's obviously additional money that's not being put into care?

Ms Hepworth: We'd be very happy to take that on notice.

Senator RUSTON: Thanks. In your submission, you talk in particular about Support at Home and CHSP. Do you know the proportion of your Support at Home clients that are also relying on CHSP for gaps in their packages?

Mrs Thomas: Absolutely. From a BlueCare perspective, it's 20 per cent.

Senator RUSTON: Are there particular things that they are relying on CHSP for? Is there a trend of the types of things they rely on?

Mrs Thomas: It is across the board, really, for all service types, but we are seeing some trending with the higher-level Support at Home packages that are coming through without nursing. Anyone who's receiving a higher-level Support at Home package usually needs some sort of nursing or allied health component, or, if they don't need it now, they will need it in the not-too-distant future, so we are having to top-up with CHSP when those people have an assessed need for nursing.

Senator RUSTON: So they're accessing nursing support through CHSP?

Mrs Thomas: Correct.

Mr Buhagiar: To complement that, we have some 600 people out of our nearly 3½ thousand that receive CHSP that are waiting for a Support at Home package.

Senator RUSTON: So they're using CHSP and nothing else?

Mr Buhagiar: That's all they've got at the moment, but they're waiting for a package. They've been assessed; they're waiting for a package. That's an enormous number that makes CHSP stifled, blocked, if I can use that language.

Senator RUSTON: Just give me those numbers. You've got 3½ thousand people at the moment that you support through—

Mr Buhagiar: Commonwealth Home Support Program. Six hundred of them are waiting for a package.

Senator RUSTON: Wow. That's 20 per cent of them. A natural question from that, then, is, if CHSP funding were no longer available to you as a top-up for those people, both the ones that are fully waiting and those that are partially waiting, what would happen to those clients?

Mr Buhagiar: We've advocated very strongly for it, and we're very grateful that the CHS Program has been retained. It's a really good decision. I think that that base foundation program is really critical. We've seen that in the disability sector—I'll use that expression 'foundational supports'. That ought to be complemented by state work as well on community health and GPs and primary health generally. That's an important part of supporting older people. If we don't get that foundation right, Support at Home programs, residential aged care or our hospital system doesn't work. So we need to get that foundation right, and part of that foundation in my mind is CHSP, but it's also community nursing, it's also hospital outreach and it's also GPs. We need to get all of that right in order for Support at Home to work and in order for residential aged care and/or the hospital system to work.

To me it's a critical feature, and I'm grateful that we've got a few more years to mature that and see whether we can improve that. It's a grants funded program. I think we all understand the problems with a grants funded program; people want to see good value for money and the like. But I don't think taking that away at this point in time, particularly with the kind of rationing we're seeing, is a sensible move, and I'm grateful that the decision has been made to delay that transition.

Ms Hepworth: Certainly, from our perspective across the network, if we didn't have CHSP, what we would see is people in hospital and people in residential aged care a lot more quickly.

Senator RUSTON: Yes. With the people that are relying either on CHSP as a top-up or on CHSP as their only care while they're waiting for their packages, how long are you seeing people use CHSP as a backup or a backdrop to getting access to their packages?

Mrs Thomas: It really depends on how quickly the assessment comes through, but it can be anywhere from a couple of months, if they're on an MSO, right through to a longer timeframe while they're waiting—so nine to 12 months.

Mr Buhagiar: We probably should be clear that it's not just CHSP they're relying on. It's their friends and their families. It's carers. So the pressure on them is also not something to be diminished. It is they who pick up the burden.

Ms Hepworth: One other area that we are seeing a lot of CHSP top-up to is when we've asked for reassessments under a package. Until that reassessment comes through, that's another area where we are needing to use CHSP to support that person.

Senator RUSTON: In terms of CHSP and your organisation, are you finding that it's adequate to do what you need to do?

Mrs Thomas: We are reaching the cap of our CHSP now, so it's going to get increasingly difficult. Also, it doesn't enable those people coming through at the other end for those low-level supports. Then you can't get those new people into CHSP for things like social support and domestic assistance that really help their trajectory. So it

is really difficult. I think we do really need to look at the volume of CHSP that's available and the flexibility within that program to continue to support older people.

Senator RUSTON: Yes, sure. Does the government or the department issue any guidelines in terms of their expectations around people accessing CHSP vis-a-vis Support at Home?

Mrs Thomas: My understanding, and I have to check this—I think the guidelines say around two months.

Senator RUSTON: That would be, by the sounds of your evidence, the minimum that you're seeing—

Mrs Thomas: Correct.

Senator RUSTON: whereas we're seeing it's significantly longer. When people receive the MSO, are you seeing those people also drawing on CHSP to make up the difference?

Mrs Thomas: Often.

Senator RUSTON: Okay. Is there an impact on your purely CHSP participants from the growth of people who are requiring access to CHSP and who otherwise should be in Support at Home but aren't?

Mrs Thomas: Yes.

Senator RUSTON: What's the impact on your solely CHSP non-assessed participants that have only been assessed for access to CHSP?

Mrs Thomas: Well, you're not getting the throughput of new CHSP customers, because you've got people who are accessing the dual program, and the two programs don't talk to each other, so you coordinate that in the background from the provider perspective.

Senator RUSTON: In terms of those new people, would you have a quantum of the number of people who are seeking to get services from you for CHSP and to whom you are unable to provide those services because you obviously have an obligation to fulfil the support needs of the people you already have on your books? Do you have any idea of the number of people that you would be able to look after if you had the capacity that is currently being taken up by—

Mrs Thomas: We will have it, but I'd like to take that on notice—

Senator RUSTON: Yes, sure.

Mrs Thomas: because we would need to go through our waitlist data just to get you a definitive figure.

Mr Buhagiar: And we'd also need to translate that 600 that we have waiting and work out, if they were all to gain Support at Home, what that would mean in terms of CHSP hours. We could do that work and provide you with that advice.

Senator RUSTON: Sure. That's great. Finally, we often hear from the government that the reason they're not releasing home-care packages or Support at Home packages is workforce constraints. If the government actually released all of the packages necessary to support people who had been assessed as needing one by the government themselves, how long would it take you to ramp up your service provision to be able to look after those people?

Mr Buhagiar: We've worked hard on trying to make sure our time to first service is as short as it possibly can be. We're currently sitting on about eight to 10 days that it will take once a person has agreed to sign up with us. That varies sometimes in regional areas, but workforce is not an issue. There's been some great work done in terms of worker wages, and that's been brilliant over recent years, both for residential aged care and for community care. That's made a difference to our ability to attract workforce. It's not easy—it takes a lot of work—but we are able to find people to do work and therefore able to allocate those packages relatively quickly. If we think about the alternative of not doing it, I don't think workforce ought to be our barrier. Constant, regular supply will give us, as providers, confidence to recruit people. I think part of the issue over recent years has been the bumpiness of supply of packages, whether they be home-care packages or even CHSP funding, for that matter, and now Support at Home. The bumpiness of that release has meant that your commitment to labour—to workers—has been episodic. So I would argue that, if we can just get a regular supply of packages, our ability to recruit—I think we've shown in recent times, whilst packages have, relatively speaking, flowed better over the last six or nine months, that we can find the workforce—is not a barrier.

Senator RUSTON: Can I take from that that you're saying that, if we had a system that said that demand would be what determined the release of packages, instead of government's budget bottom lines, you would find that (a) you could meet that need within a reasonably sensible timeframe; and (b) it would make your life easier because you would have consistency and certainty in terms of what you were doing to enable you to deliver on that service?

Mr Buhagiar: I'm not saying it's easy. Cathy, you may want to comment.

Mrs Thomas: I'd just say: absolutely. I will just say this from a national perspective. Two weeks ago, our aged-care CEOs—we have 13 aged-care providers across our network—met face to face for our annual meeting, and we asked this question of every single one of the UnitingCare providers in that room. All of them said that this is not the issue and that, when the packages are online, we can provide those packages. What we really need from government is some certainty around those packages actually coming, the ending of rationing of care and some easy things like giving us an indication of the geography and the likely flow of packages so that we can proactively build up the supports where they're needed. With some of those sensible constraints and more regularity, we are absolutely in a position to deliver for all older Australians.

CHAIR: Senator Ananda-Rajah.

Senator ANANDA-RAJAH: On the topic of workforce, would you be able to give me an indication of what percentage of your workforce were born overseas—in other words, are migrants in this country—and are providing this kind of care?

Mr Buhagiar: I'm happy to try. It's probably less so in home and community care, but I know in residential it sits at around about 30 to 40 per cent. In home and community care, it's probably a little bit less. It's probably sitting at around about 15 to 20 per cent, but we can confirm those figures for you.

Senator ANANDA-RAJAH: That would be great. I was just curious. Would I be right in saying that the majority would be female? Do you have a gender split?

Mr Buhagiar: Absolutely.

Mrs Thomas: The majority are definitely female, and we can take that number on notice as well.

Senator ANANDA-RAJAH: With the investments the government's made in supporting salaries amongst aged-care workers, have you seen a stabilisation of turnover in your patch? What does that look like?

Mrs Thomas: Yes, we definitely have, particularly in community. I think the investment in wages has definitely helped, but the other thing that has helped is providers committing to a program of reform readiness. I spoke in the opening statement about BlueCare's neighbourhood model. We have really, significantly uplifted our capability and capacity to respond as well as supported the workflows with a large range of technology changes, really making it easier for our people to work at BlueCare. We've had some pretty spectacular results from a customer satisfaction perspective, as well as a turnover perspective. We were nudging up to 40 per cent turnover pre reforms, and we're down to under 20 per cent turnover now.

Senator ANANDA-RAJAH: That's extraordinary.

Mr Buhagiar: I would echo that. The turnover has certainly improved, as well as the attraction. Whilst we really appreciate that investment, as I said in the opening statement, addressing a previous problem like a long-term underfunding of aged care—there's no doubt that moving away from rationing and the kind of approach that we're seeing still in Support at Home is a critical next step to leverage off that investment that the government's made in workers. I think that's important because they were historically well undervalued. I think we need to take the next step and actually think about those older people those workers are serving and delete some of that confusion and some of that inaccessible care that they're experiencing. I think that is a next step there.

Senator ANANDA-RAJAH: How do you define turnover? When you say you're down to about 20 per cent turnover, how do you define that?

Mrs Thomas: There's a particular calculation that we use that I can't repeat off the top of my head, but there is turnover and then there's a rolling turnover number that is a lot lower. I'm very happy to take that on notice.

Senator ANANDA-RAJAH: Yes, maybe on notice. I'm just curious more than anything. There are some political parties in this country who are intending on absolutely gutting migration, slashing it, sometimes into negative territory. What would that mean for older Australians and for your provision of care?

Mr Buhagiar: To be quite clear, that would probably hurt more in the residential aged-care sector and to some extent in home and community care, at least in Uniting NSW's experience. I think the critical shortage of nurses would be a problem, particularly in residential aged care. There's no doubt that we are reliant on overseas workers. We've also accessed the temporary visa program and the special visa class. They're all very valuable to us as a sector.

But, again, I think today's session is really all about how we support older people better, and our main point is to make sure we come back to that as regularly as we can. We don't believe workforce is the critical challenge at the moment. It's not easy, particularly in regional areas—I think Cath would agree—and particularly for specialised roles like nurses. It's not easy, but that is not our critical issue at the moment. It is access to care that is most critical.

Mrs Thomas: To your question about how it would affect older people, if we just think about it more from an individualised older person perspective, we work really hard to try and support people with their distinct person centred needs. So, sometimes, matching up older people with workers who speak the same language, understand culture et cetera is a really important part of our care and service delivery model, and we wouldn't want to risk that.

Senator ANANDA-RAJAH: Yes, I understand completely. I have a question regarding the tech investments you've made, which have improved, I think, the experience of your workers. You think it's helped improve retention, perhaps. Could you talk us through those kinds of investments and what they look like? Feel free to supply anything further on notice.

Mrs Thomas: We actually changed out nine tech systems all at once to really provide a much better experience. We talked to customers, we talked to our people and we looked at what was coming down the pipe from a reform perspective. This was a few years ago. It's everything, really, from clinical systems to billing systems; how we do straight-through processing, making it much easier for people; the phone system—we now have phones so that people don't have to go via a central call centre, as such; they get routed directly to their neighbourhood. It's really all about getting that service to that neighbourhood, where the people know the customers intimately, so they can support their needs. I think that's why we have had a 10 per cent uplift in our customer satisfaction. It wasn't bad to begin with.

I'm happy, certainly, to supply some more detail. It was very ambitious and quite nerve-racking, at the beginning, doing that. It felt pretty overwhelming, to be honest, but it has just paid dividends to really make it a lot easier for customers and a lot easier for our people. I couldn't imagine having to do the navigation piece that we're doing now on top of a clunky back-of-house system.

Mr Buhagiar: That's our world at the moment. In all honesty, investing in that space is really important for us going forward. The complexity of rostering, where you've got the needs of the person, the needs of the worker and the needs of the organisation—trying to balance those three, together, and primarily trying to ask, 'Do we get the right person to that older person, on time, and with the right skills?' is really complex.

We're going through some significant roster changes at the moment for how we do that matching process. That's not coming without its challenges. But, again, we're thinking about the medium- and long-term for some of those changes, and we need to think that way. Investing in change management, investing in tech—all those things are really important if we're going to get this right and be able to provide the kind of care that delights older people.

Senator ANANDA-RAJAH: I feel like there's a role there for AI, but I'll leave it there.

Mr Buhagiar: Yes, there is. But, again, with caution—because it comes with comes with foibles as well.

Senator ANANDA-RAJAH: Yes, for sure—with human oversight. Thank you very much.

CHAIR: Thanks very much, everyone, for your submissions and giving evidence today. I have visited the neighbourhood model at Deagon and can attest that older people, and the staff, really like it. The committee will report to the Senate on 24 November 2026. It's agreed that responses to questions on notice should be provided by close of business on Tuesday 6 October 2026.

Proceedings suspended from 10:33 to 10:48

CULLEN, Dr David, Non-executive Director, Hall and Prior

FIELDING, Ms Penny, Chief Executive Officer, Pearl Home Care Pty Ltd

HICKS, Mr Tim, Executive General Manager, Policy and External Relations, Bolton Clarke

PRIOR, Mr Graeme, Chief Executive Officer, Hall and Prior

WALLACE, Ms Ingrid, Head, Quality and Compliance, Pearl Home Care Pty Ltd

CHAIR: I welcome our next witnesses. Thank you very much for appearing before the committee today. I understand that information on parliamentary privilege and the protection and obligation of witnesses giving evidence to Senate committees has been provided to you. I know that senators want to ask lots of questions, so I will ask you to make some brief opening remarks and then we'll go to questions.

Mr Hicks: Bolton Clarke is Australia's largest not-for-profit aged-care provider. We have 87 residential aged-care homes, 42 retirement villages and around 6,000 Support at Home clients, and we reach tens of thousands of people a year through the Commonwealth Home Support Program. Our focus today is on making the most of the money that government's already investing. The key point that we want to make is something like 40 per cent of Support at Home funding that's being allocated is currently being given back to government as unspent.

At the same time, we have people missing out on key services—wound care, physio to rehabilitate after falls, personal care to reduce the risk of pressure injuries. These things arise because of delays in reassessment and package assignment in response to deterioration, minimum service offerings, underassessment, capped care management costs resulting in support needs not being identified and a range of other things.

These are complex challenges that will take time to resolve, and the people who need care now don't have that time. What we want to see is a simple solution that helps address all of these challenges. We believe that that is trusting the clinicians that are actually there caring for older people to reallocate some of those unspent funds that would otherwise be returned to government, to meet those unmet support needs and to ensure that people actually have the service-type approvals for the supports that they need. Those are our two key issues.

Mr Prior: Hall & Prior is a private, family based organisation that's been in operation for 40 years, mainly in Western Australia. We look after 42 services in Western Australia, New South Wales, the ACT and Queensland. We employ about 5,000 people and we have around 3,000 people with complex dementia in permanent care and a further 1½ thousand people in home-care support programs, predominantly in Western Australia and in country Western Australia.

I have a very brief statement here that I'm happy to table. Chair and senators, thank you for the opportunity to appear before the committee today. Let me begin with the words of the royal commission—and this is my key point:

At no point has the level of funding for aged care in Australia been determined by the actual cost of delivering aged care services to a specified quality standard. The amount spent on aged care services in Australia reflects the available funding envelope rather than the cost of delivering high quality care. This has had serious consequences for older people and the aged care sector.

That's for as far back as I can recall. The reality for older people and for aged-care providers is that the new Aged Care Act and the new Support at Home program continue with a deeply flawed practice.

Let me be clear and say that we understand that need is infinite and resources are finite. But a proper response to the central dilemma of the human condition is honesty about the limits of what can be funded, transparency about how scarce resources are allocated and a willingness to make those choices explicitly rather than distinguishing and disguising rationing as consumer choice. Consumers don't ration. They need care. They need personal care today.

I will summarise the recommendations we've made. We've made a very substantial submission to you. There are only four. I'll do this very quickly; I realise time is short. First, the Aged Care Act should be amended to provide older people with the right enforceable against the Australian government to funding for the care needs that have been assessed by the Australian government as those they are needing.

Second, the Aged Care Act should be amended to require the minister to ensure that the funding levels attached to each type of place and each classification level are sufficient to ensure that older people can purchase the services that they have been assessed as needing from efficient providers who are able to act compatibly with the rights specified in the act and to deliver the care at the quality required by the act at all times by the Australian recipient.

Third, the government should commission an independent review by the Inspector-General of Aged Care or the Productivity Commission of, firstly, the extent to which the regulatory burden imposed on aged care provided by the Aged Care Act and other Commonwealth legislation is proportionate to the risks faced by older people and, secondly, the extent to which the cost of meeting the regulatory burden imposed on aged care provided by the Aged Care Act and other Commonwealth legislation is appropriately compensated for in the funding arrangements.

Last, and fourth, the design of Support at Home should be significantly changed to improve its efficiency. There are a whole range of issues in there. In the words of two ministers for health in Western Australia, the new act—the new Aged Care Act—has fundamentally failed. Thank you.

Ms Fielding: Pearl Home Care is a home-care provider operating across five states and territories and caring for more than 4,000 older Australians, predominantly through a franchise network which brings deep roots within local communities. Pearl supports the objectives of Support at Home—ageing in place and individualised care—a program that allows older Australians to stay in their own homes. That is the right policy objective, and it's one we've built our services around for years. But I also acknowledge the need for change. We can no longer afford for older Australians to hold on to money that they're not spending on their services while other people are missing out. Assessment outcomes should be commonly understood and fair, providers should be accountable for taxpayer funds spent and services need to focus on supporting older people who are managing chronic disease comorbidities.

We must embrace reablement so that older Australians can continue to be active in their community and their family and for themselves. Not only is this consistent with our aspirations; it is also cost effective. Given the high cost of hospital stays and residential aged-care beds as well as the contribution made by older people in the community, this makes sense. You are only paying for care. But the way Support at Home has been done has been very difficult for clients, for staff and for organisations. Messaging has been unclear, and the administrative burden has skyrocketed. The system has become even more complex to navigate through, both as a client and a provider.

The Pearl Home Care model was developed in 2019 with a focus on improving service provision through local community connection. We are the largest Australian owned franchise home-care provider. Our guiding principle is that we provide large-organisation efficiency to smaller organisations with local community connections, whether to a church, a sporting group or a local neighbourhood. This approach provides for the maintenance of local community networks to deliver services. It knits people in their communities together. It is an important strategy to minimise social isolation.

Our carers are also people who live and work in the small franchise area. This means that clients and staff are mostly locals, their travel burden is less, there is an understanding of the community and our carer workforce is sustainable. However, the impact of Support at Home on providers—both at our head office and at the local franchise level—has been immense, estimated at more than an extra 320 hours per week in the head office for claiming alone. Trusted local providers were left to explain to their clients why their client contributions had changed. Local providers were also asked to explain why client statements showed double billing that had not occurred when Services Australia made an error they couldn't fix. Our back office, which should focus its time on system quality and innovation, has absorbed most of the administrative burden to shield the local franchise providers from this.

For every issue we raise in our submission, we've proposed a specific practical fix, most of which could cost government little or nothing to implement: assessment that focuses on the expertise of the assessor and the client's experience; care planning that focuses on client outcomes, not inputs; budgets that are transparent to the client and the provider; information that is accurate and timely; proactive notice before system changes; real communication between My Aged Care and Services Australia; and a commitment that, when an error is made, the government's own remediation doesn't create a second problem for providers and clients to clean up. I welcome the committee's questions.

CHAIR: Thanks very much, everyone. Senator Whiteaker.

Senator WHITEAKER: Thank you for all of your time this morning and for your very comprehensive submissions. I'm wondering if we can perhaps start with each of you talking through what is working better about the new system. I say that because I think there's broad agreement that what we had before wasn't working. We've heard quite consistently throughout this inquiry that there's pretty broad support for the intent of what the Support at Home program seeks to do, so I'm hoping you can talk to that and what you have found is better for older Australians under Support at Home.

Mr Hicks: I'm happy to start. I think the main benefit of Support at Home has been unlocking potentially higher levels of support for people. The maximum level of packages is higher. There are options like the palliative care pathway that can provide an intensive level of support to people that wasn't previously available. That is a key advantage. However, we need to get the details that sit behind that right in order to realise those benefits.

Ms Fielding: I would concur. The key benefit that we see is people who've been sitting on hundreds of thousands of dollars in a small community have now had that money move through much more rapidly. It makes it easier to have those conversations with clients and say, 'Someone assessed your need as being this for this service.' For many older Australians who may choose not to take services, because they want to keep on keeping on, I think it's an important driver for change. But I also think the real focus on transition care, end-of-life care and a reablement focus through increased allied health service availability and clinical care is setting us on the right pathway forward.

Mr Prior: I think it's really important to say that the Commonwealth Home Support Program is a substantial and a wonderful step forward in caring for older Australians. There's no doubt in my mind about that. That's evidenced through a substantial increase in Commonwealth outlays to care for people to try and keep the people at home. In your state of Western Australia, which you know I know extremely well, it's very hard to find viable care-providing provisions outside Perth and the four major cities—Bunbury, Albany and Geraldton. It's a wonderful step forward. What hasn't happened, and I'll come back and talk a bit more about the positives, is that—we need to link in the future care program for all Australians and bring together all the Commonwealth aged-care programs to be very much in sync with each other and help a community down to a community level.

I've spent 35 years in care, as you know. There's no doubt in my mind that this is a huge step forward—I think we should recognise that—by all of the parties in parliament and all members of parliament, when it first came through. But there's a lot more to be done. There really is a lot more to be done. It's now about fine-tuning. We've got a car on the racetrack. We've got to really fine-tune this big, big step forward, and what you do with CHSP, I think, is fundamental to getting very clear guidance for where the Commonwealth will go with the home-care programs. It is very hard to find viable care in the bush. It doesn't really exist, but it's a big step forward.

Senator WHITEAKER: That's a good lead to my next question, which is about regional challenges, which, as you've pointed out, are a real challenge in our state, in WA. What are the drivers of those challenges? One of the drivers that I hear a lot is, of course, workforce. The government's Regional, Rural and Remote Home Care Workforce Support Program funds about 4,000 additional home-care workers in these areas. What assistance does that provide, and what else do we need to do to boost that capacity in regional parts of the country?

Mr Prior: A lot, Senator. Let me talk to you a bit about that. We have 300 operational residential care beds in country Western Australia and about 500 staff that support that. You have to monitor and really care for that program to retain the workforce—because nothing for granted. Alongside that care program sits somewhere in the order of about 500 home-care packages across country Western Australia. That's where it's very hard to retain staff because there are so many attractions back in the city and our workforce is largely female, as you'd know, and their priorities are family as opposed to working in care.

The overlay, in my honest opinion, is that we shouldn't be looking for a viable, credible home-care program in every country town in Western Australia. It's never going to happen. So the way the Commonwealth department approaches this is through an economic tool called thin markets. In my view, the entire Western Australian state is a thin market, except for Perth. We need to approach it by saying, 'Maybe we can have a care program in Kalgoorlie but not in Boulder and not in Coolgardie,' for argument's sake.

There's a lot to do. A lot of work is required. If the funding is available then providers may provide the support for it. But we won't get a home-care program in the back of the Pilbara. Every town in the Pilbara won't get a home-care program. It's just never going to happen. I think we need to be really aware of that, particularly you as a senator and me as a provider. WA is a very tough place to operate a business unless you're BHP, Fortescue or Rio Tinto. We take up the crumbs on the table.

Senator WHITEAKER: Does anyone else have anything they'd like to add to that?

Ms Fielding: I do. We've been able to demonstrate in regional centres in New South Wales, Queensland and Victoria that real local community connection of services on the ground has been really important for us to overcome our workforce challenges. We have people in the community who are knitted in and want to support the older people who are in that same community. For us, the focus is really around two things. The thin market grant, as outlined by Mr Prior, has been very critical in stabilising our services in the regions. The second part is a real focus on providing training to staff in place. That takes a lot of effort and requires a lot of support by the provider but also by the client and the community in which people are living.

Senator WHITEAKER: I am interested in your views on price caps. We've heard mixed views about this over the course of this inquiry. The government, of course, deferred the introduction of price caps. We've heard just today though that particularly older Australians and their advocates would like them to be introduced very quickly. We've heard on the flip side, though, that the risk of a price cap is that providers will just lift the price up to the price cap. So, as providers of these services, could you give us your perspective.

Mr Hicks: I think the key thing to note is that there are a wide range of prices available in virtually every location. Certainly in major metro areas and in larger regional towns there are very cheap options available. There are very expensive options available. There are lots of options available in the middle. The primary protection from a pricing perspective that any person has for any service is the ability to choose which provider they prefer. There may be some sacrifices that come with going with the cheaper provider. They may have less availability in terms of calling up and speaking to someone in order to adjust an appointment or other aspects of the service. But the choice is there. People do have the option of cheaper providers if they want.

Structurally, there are too many costs in the system. We've talked about some of the administrative costs and some of the challenges. Some of those can be addressed through technology and hopefully will be addressed over time. Hopefully that will place downward pressure on pricing. I would say that it's a very competitive market. Providers are out there looking very strongly and very actively to attract new clients. If we look at the reporting so far on provider finances, it actually appears that even the current level of pricing isn't sufficient to provide a sustainable business for most providers across the industry.

Ms Fielding: We are just in the process of finalising our internal pricing review across all of our services so that we can really get a better understanding of not just what's driving price but how that impacts on business sustainability. With the changes at the beginning of Support at Home, we saw the transition to cheaper providers of a lot of clients—who have subsequently returned to our services, which are very marginally above average. That makes me believe that people are less price sensitive where there is a quality of service and they are connected into the community.

The other thing it has shown is that clients and their families don't understand the pricing methodology or policy position around that. For them, that communication around what the price includes is more important than that cap, necessarily. They don't understand why the price has gone up—so it's about spending that time with people and talking through what it includes, and clients then seem to have a better understanding of that. The other issue our review has identified is, if you look at the inputs as part of all those costs, if you make a mistake on the price you can end up being in a position such as that of one of our local community providers, who is providing great service but is doing it at a price that is costing him nearly $50 for every hour of personal care that he delivers over and above—and that's not sustainable.

Dr Cullen: As a former chief economist of the NDIS, I can tell you that price caps don't work. Price caps have two effects. The first is they act as a magnet, and everybody moves towards them. The second is that government then uses them as a way to cut funding and alter service quality. If you're giving people choice and control and if you're respecting older people, then you've got to respect the fact that they can choose what they want—and they do it every day. I don't see why they shouldn't be capable of making a judgement about the value of the care they receive, just as they can make a judgement about the value of everything else they purchase.

Senator WHITEAKER: Thank you.

CHAIR: Mr Hicks, in your submission you say that Support at Home has 'probably made ageing in place harder for most clients', despite the release of more packages. That's pretty significant. Can you talk about what's changed in the amount mix or flexibility of care that people are now receiving.

Mr Hicks: The primary issue is the decreased flexibility around the use of funds—so the need to get approval for access to specific service types. People who were historically accessing home-care packages got grandfathered approvals for most service types. But if they don't have any unspent funds and want to access assistive technology, they need a specific approval for that. That's made things significantly harder.

The complexity of the pricing and the billing have also gone up substantially. That means that things like specialist providers may not be interested in providing services through a home-care package because they have additional registration requirements. Because care management caps have come in, people are getting less support and navigation.

CHAIR: You've proposed allowing unspent funds in the CHSP to fill gaps while people are waiting for assessment or additional funding. Could you give us some examples of the deterioration or crisis that could be prevented if that flexibility existed?

Mr Hicks: Absolutely. A common case is that someone will have a fall, injure themselves and develop skin tears that require treatment—and that's relatively complex to manage because of their age. That often can't be funded on the level of package that they're already at, so that needs to be addressed one way or another. That can be addressed through going into hospital, going to the doctor and putting pressure on the primary health system, but that often requires a carer to come and take them in for an appointment, and there are various other pressures that that creates. In an ideal world, we'd be able to do that just through the package.

There is some capacity to do that through Commonwealth Home Support at the moment only in very limited circumstances. Essentially, it's an emergency funding provision which says that, if someone's needs have deteriorated and they're not accessing support at their approved level, then you can fund it up until they get the new package level. But that often creates a situation where, once someone's assigned the package level that they've been classified at, they actually end up receiving less support. Of course, that takes money away from the people that the Commonwealth Home Support Program was supposed to provide for.

It's primarily for sudden declines but also for situations where someone's on an MSO and they don't have access to the support level that they need for that initial period, and that can lead to deterioration that's completely avoidable and unnecessary. It's also for situations where the package level doesn't quite match. Sometimes it's just an extra couple of hundred dollars a week so that someone can get access to regular cleaning rather than having to ration it down to one fortnight a month. All these little things mean that there are a large number of people we'd be able to keep healthy, well and ageing comfortably at home if we could just use the money that's already being assigned to us.

CHAIR: Thank you. Mr Prior, or Dr Cullen, you suggested in your submission an independent national priority-setting body.

Mr Prior: Yes, we did.

CHAIR: What problem with the current allocation process would that address, and how would it make decisions about who receives care first more transparent or equitable?

Dr Cullen: It's actually not about who gets the care. It's about addressing the issue that solves the rationing problem. We have to decide what it is that we're willing to fund and what we're not. That's the bit that government's never been willing to have a public conversation about. As we say, needs are infinite; resources are finite. We actually have to have a public conversation about what we are willing to fund for people, and we think that we need a body independent of government which can have that conversation and set those sorts of issues. It's not about the individual; it's about actually trying to fix the problem of how we make a sustainable system where we have infinite needs and finite resources.

CHAIR: Can you explain what the 40 per cent reduction in interim funding means for somebody with significant or urgent care needs and why you favour a more flexible, needs based approach?

Dr Cullen: You heard earlier today that the 40 per cent is just a budget-saving measure. You've been assessed as needing X, so the government gives you 60 per cent of X. It doesn't make a lot of sense. But to give 60 per cent of X to everybody makes absolutely no sense whatsoever. There are some people who, given 60 per cent, may as well be given nothing. They're just as likely to end up in hospital or not. If we're going to keep that approach then, surely, we could be a bit more sensible about which people we give 60 per cent to, which people we give 40 per cent to and which people we give 80 per cent to so we don't just have this blanket rule which was stupid to begin with and absolutely stupid if it's a blanket rule.

CHAIR: I guess it begs the question: what's the point of a needs assessment if you're assessed as having a level of need and then you only get part of it?

Dr Cullen: Correct.

CHAIR: I have some questions for Pearl Home Care. You've raised concerns—as have others, I might note—about algorithm based assessment. From your experience on the ground, what kinds of needs is the current assessment process most likely to miss or underestimate?

Ms Fielding: It's so varied on the ground, and I think that's really the underpinning problem. A number of clients have had very, very strange assessment outcomes that have meant that they've ended up with less funding than they had before their review, which is nonsensical. The other issue, I think, is that, for people who don't want to engage in home care in a planned and proactive way, someone's convinced them that it's the right thing to do and it erodes their trust in the whole system, and then we end up having to make emergency and crisis decisions. I think that's the biggest risk that we see. But also there's a complete lack of understanding by care workers on the ground about how to manage that in a very short space of care-management funding. There's a flow-on effect there, really, which is about the loss of trust—the inability to have faith in the system by the person who is

wanting to access it—in addition to all of those opportunities that are, in some cases, very crisis driven but are the next-best step.

Mr Hicks: Do you mind if I make some comments on the assessment tool in response to that question?

CHAIR: No, I don't mind.

Mr Hicks: From our perspective, the key gap is in assessing the impact that the compounding factors have on someone's funding level, in particular, cognitive impairment and clinical need. Someone's clinical needs can be for daily support. They can require a nurse to manage their blood thinning medication daily. And if they get that support, they can stay at home in a reasonably healthy way. If they don't get it, they'll need to go into hospital. But it's not a functional need. And the tool at the moment is overly focused on those functional needs.

Similarly, with cognitive impairment, there's a range of extra supports that a person with cognitive impairment and their carer need that aren't captured just by the functional deficit. That's the missing piece in the assessment tool.

CHAIR: Would it be your position then that it's not just a case of we need to add in human override or have another review, but the tool itself needs work?

Mr Hicks: I think the tool needs to be refined. I think that now we have more than nine months of data on how the program is actually working and what people are using, it's common sense to go back and revisit the classification approach.

CHAIR: This is my last question, because I'm conscious I have to share the call. Just for Pearl Home Care, you noted in your submission that you've experienced portal instability and inconsistent administrative processes. To what extent are these implementation problems merely inconvenient as opposed to actually preventing or delaying care for older people?

Ms Fielding: It's definitely not just an inconvenience. We have, on a daily basis, clients whose funding has been withdrawn because My Aged Care and Services Australia are unable to process it by the time that it needs to be taken up. And that happens on a daily basis. That's more than inconvenient.

When Services Australia can't process a claim accurately, and then a client gets a statement that says something completely different to the service that they've received, that is more than inconvenient. That erodes, again, that trust between the care provider and the client. And when you're going into someone's home, it is a very trusted and privileged relationship. On a more fundamental basis, we've actually ended up having to pay actual dollars back to clients where negative balances have been drawn down, and you can't expect a client to pay for a service that they didn't know was going to take them into the negative.

There are some really—sounds small, but if you overlay that over 4,000 clients, and that's not even a big amount. But if you overlay that over the experiences of many Australians it's administratively burdensome for the client. But we also have a whole lot of very trained and skilled aged-care workers exiting the system because they don't want to be focused on data entry and coercing or cajoling My Aged Care or Services Australia to look again at something. I do think it is actually very critical.

CHAIR: Senator Ruston.

Senator RUSTON: Thanks very much for your submissions and also giving up your time to be here today. Perhaps I can start with you, Mr Hicks. I think I'm correct to say you've previously described that the administrative requirements of Support at Home—I think the word you used was 'astronomical'. I'm keen to understand if you are able to quantify, in terms of Bolton Clarke, what that figure means to you in terms of its quantum? Have you got some practical examples where you can describe where those astronomical administrative burdens are actually denying your ability to deliver care?

Mr Hicks: Let me come at that at three levels. First, there's a huge burden on our care partners that are supposed to be our care managers that are supposed to be looking after clients and responding to their needs. They spend an enormous proportion of their time on My Aged Care, checking whether someone's package has been updated and checking whether new information is available. We haven't done a formal time and motion study, but anecdotally I've had it estimated at about a day a week as time that they spend—

Senator RUSTON: That's 20 per cent.

Mr Hicks: checking My Aged Care.

The second layer is essentially in terms of the claiming. That's a burden not just on us; it's a burden on all our suppliers needing to be registered as associated providers. One of the effects of that is that, if you're a specialist service provider in allied health, you don't do many older clients, and, if someone has a particular need, you're probably not going to be willing to jump through all the hoops that are required for you to be an associated

provider with every age-care provider you might deal with in order to provide one hour of service a month to the client that needs it, but that's really important for that person. That person misses out. Of course, centrally for us, we need enormous teams to manage that associated-provider burden. And I'm not sure that the safety benefit to clients, particularly where someone's already an Ahpra registered professional, is really adding up.

Then there's the actual finance, claiming and invoice processing itself that takes an enormous central team to do. I don't have the headcount off the top of my head, but it is significant. And then there are the ICT costs. That's all embedded in the cost that we pay for our new care management systems, our billing systems, because of the complexity of the system that those software providers need to embed in their product.

Senator RUSTON: You also said in your submission that the central program is not lacking funding; it's just lacking efficient expenditure of the funding. I think you were backed in very strongly by the previous inspector-general, Natalie Siegel Brown, to that effect in her Press Club address. You've outlined some of the challenges. Are there any places where you think it would be easy to implement better efficiencies? Is there anything structurally wrong with the program as it currently is that could be changed to enable a greater efficiency to be delivered in terms of actually getting care to people?

Mr Hicks: One big challenge is service type approvals. For someone to access a service under Support at Home, that service type needs to be explicitly approved by the assessor. We frequently find that new clients will come through with obviously missing assessments and inconsistent information in the person's support plan—in their assessment. We understand that the reason why those assessments are required is the constitutional basis of the new legislation, the way it's been established, but we think there are certainly process changes that could be made to automatically approve people for certain service types based on pretty obvious clinical triggers. We think that's a relatively straightforward change that could actually improve access to care and reduce the burden on the assessors—because, when we get a missing assessment, we have to go back and ask for a review. That, plus being able to reallocate unspent funds to where we see need, just as we do already with Commonwealth Home Support, would allow us to meet most of the unmet need we see within our existing client cohort.

Senator RUSTON: Wow. In your submission you say that a shift to recovering costs through pricing has caused substantially high unit prices. My question is twofold. Firstly, what share of a typical unit price is now administration or management? Secondly, do you think it's better to have management fees and service costs separate, as was the case under the home-care program, in terms of transparency?

Mr Hicks: I have to take on notice that question round the share of cost. Roughly speaking, prices had to go up by about 40 per cent sector-wide to recover the monthly fees that had to be incorporated into the unit price on an equivalent basis. Some of that's admin; some of that's other things. Another thing that impacts the unit cost is the productivity of our staff—how many hours of service they can deliver versus hours they spend travelling. All these things are connected. Sorry, Senator, I think I've forgotten your original question.

Senator RUSTON: I asked whether you thought the previous system—

Mr Hicks: Whether the system was better. I think the key is choice. I think that people should be absolutely permitted to bundle all their prices into the unit cost. If that's the pricing model that clients prefer, then they should be able to take that option. Equally if providers think it's better to have monthly fees as a balancing item that should be an option that they should be able to choose. I would say, though, that we're a very long way down the path that we are on at the moment, and I think it would be very difficult to unscramble the egg at this point.

Senator RUSTON: I'd be really interested to understand how much of the price changes can be attributed to a different way of presenting the cost, and how much is actually price inflation because of the additional things that you are required to do that do not deliver care.

Mr Hicks: I think when you look at the unit price growth, it's almost entirely due to restructuring plus a small amount of normal inflation.

Senator RUSTON: That would be interesting. I'll be really quick, Chair. Mr Prior, you've outlined that you believe there's a need for a needs based planning framework that sets out the future of aged care in line with demand. I'd like to understand what you mean by that, particularly in relation to the new means test that's currently in place with regard to its ineffectiveness and inefficiency. I'm interested in your long-term vision for fixing it and the challenges that you currently see in means testing in terms of the inefficiency and ineffectiveness, which I'm assuming is leading to your recommendation.

Mr Prior: Dr Cullen will talk to some specific issues, but if we look at what was announced yesterday by the Treasurer about our long-term outlook as a nation, aged care was a huge part of what the Treasurer was talking about. How do you fund that? How do you create a sector deliver that? Productivity is a massive part of what the Treasurer is talking about. The aged-care sector is notoriously inefficient. It is run by too many firms and has no

price signals. There are no price signals in residential care. If you were to introduce a cap that would destroy any chance of price signals coming into the marketplace because, as Senator Whiteaker said before, [inaudible] take the price to your cap. So we have to help design and continually shape the aged-care world to be highly efficient, provide excellent care and be very accountable. At the same time, it needs to be very efficient otherwise the Commonwealth will pay for inefficient outcomes the whole time.

On means testing, I don't understand why we don't have more significant means testing. I don't personally understand why we don't have more significant means testing requirements in the aged-care program for our recipients. It's almost a free ride. I was talking to Rita, a lady at a home in the country last year at Christmas. She's 96 and on a frame. She's a very happy lady. She couldn't afford home care at home—neither could her family because it's far too expensive—but she could keep her home and come into permanent care. There's something wrong with that system. Going forward, how do we fund the long-term aged-care requirements of this country? I think means testing and pricing signals have to be front and centre as you redesign and continue to redesign our sector. I hope that answers your questions. Dr Cullen?

Dr Cullen: On the technicalities, I'll just do means testing really quickly. The Support at Home means test is economically illiterate. That's the best thing I can say about it. It lacks what I'll call horizontal fiscal equity. Two people with exactly the same income can be asked to pay vastly different fees because one is receiving more support. Who is mostly likely to give up their package—the person who's got a $50,000 package or the person who's got a $25,000 package? Under the current means test, the person most likely to give up their package is the person with the larger package. Who is most likely to go into residential care if they give up their package? The person with the largest package.

Somehow, we have designed a means test which defeats our own purpose. The result of the current means test is that it will force more people, the exact people you want to keep out of residential care, into residential care because you're asking them to pay far too much, and the hardship situation just doesn't fix that at all. I'm sorry. I've been saying this since the taskforce first had this idea. I told them it was a stupid idea, and I'll continue to tell people it's a stupid idea. I have no problem with means testing—we can do a lot better on means testing—but the current means test, which basically says the sicker you are the more you should pay, is just not how any sensible system works.

On the needs based planning framework—let's be real. We've had one from 1985 right up until last year. What the needs based planning framework does is it lets providers know where there are likely to be places released in the future, where they should invest and where they should do things like that. Even if you're going to have a rights based system, which we don't have—the Aged Care Act gives participants absolutely no rights whatsoever—even if we had a right to care, that care can be predicted and government can be upfront.

You probably know I spent two years on the royal commission, and when I look at what people did in response to the royal commission I just wonder whether they ever read the report. What we actually have in the new act is, before the minister determines how many places should be released every year, he has to talk to the Minister for Finance. That is precisely what the royal commission said not to do. So providers have no idea from one year to the next whether there will be growth in the sector. They can't make investment decisions on the basis of that uncertainty, and older people can have no idea whether there's a chance. What we need is a rights based system to care, which we have to prioritise—we can't afford it all, but let's have an open conversation about what we are affording to fund—and then predict where that's going to happen and have some sort of commitment from government about where it will fund things in the future so that providers can make the investments they need to meet that need. That's what I mean when I talk about the need to return to needs based planning.

Senator RUSTON: Thank you very much; that was very thorough. Ms Fielding, you may well get some questions on notice.

CHAIR: Thanks very much for your submissions and for making time available to appear before the committee today. We really appreciate your evidence. The committee will report to the Senate on 21 November 2026, and it's been agreed that responses to questions on notice should be provided by close of business on Tuesday 6 October 2026.

CHADWICK, Ms Natasha, Founder and Chair, NewDirection Care Group; and Founder and Chair, Synovum Care Group

CHRISTIAN, Ms Jayne, Member, Lived Experience Network, MND Australia

CHRISTIAN, Dr Julie-Ann, Member, Lived Experience Network, MND Australia

LYNCH, Mr Scott, Physiotherapist, Australian Physiotherapy Association

MAURY, Dr Susan, Policy and Advocacy Manager, MND Australia

SULLIVAN, Ms Clare, Chief Executive Officer, MND Australia

UTRY, Ms Katherine, General Manager, Policy and Government Relations, Australian Physiotherapy Association

[11:40]

CHAIR: Welcome. Thanks very much to everyone for appearing before the committee today and for your submissions. I understand that information on parliamentary privilege and the protection and obligation of witnesses appearing before Senate committees has been provided to you. I will need you to tell me the capacity in which you appear.

Ms Sullivan: Julie is living with MND, and Jayne is her carer.

CHAIR: I'm conscious of time. We have a fairly large panel, and senators who want to ask questions. I'm going to invite each organisation to make some short opening remarks, and then we'll go to questions. I'll now go to MND Australia for their opening statement.

Ms Sullivan: People are dying prematurely. People are ending up stuck in hospital. People are being forced into residential aged care prematurely. Support at Home is not fit for purpose, and it is immoral for this program to continue as is.

Most people who need Support at Home are not affluent; they're pensioners living just above the poverty line. Support at Home helps them with things like toilet seats—so they can safely use the toilet—and showering. For people with MND, they're already facing the most horrendous disease, with a rapid deterioration of their bodies; devastating impacts on their families, their carers and of course themselves; and a torrent of medical bills.

The highest level of funding secures just two hours a day of care. That's enough to get out of bed and have a shower. There's no help with anything around the house. There's no respite for their carers. There's no help with moving, being repositioned or with turning during the day.

I'd like to acknowledge the government's recent decision to provide people with MND faster access to Support at Home, but getting faster access to inadequate funding doesn't solve the problem. There are many, many issues plaguing Support at Home, but I'd like to highlight just four. The funding does not reflect the real cost of caring for someone with MND. Glenn Rowan has advanced MND. He receives the highest Support at Home package, level 8, at $70,000 a year. It's about $1,500 a week. The cost of his care is $8,000 a week. That cost is being met by his family.

Secondly, the allocation is meaningless unless they can turn it into care. Provider prices and administrative charges are eroding the funding base. Our analysis found aged-care prices for comparable services were between 24 and 94 per cent higher than the NDIS rates.

Thirdly, non-invasive ventilation is not covered by Support at Home. For people with MND, non-invasive ventilation, NIV, is the only thing that gives them more time—18 months more time. A ventilator costs about $5,000, and it's not covered by Support at Home.

Finally, the integrated assessment tool is not working. We analysed 75 people with MND and their assessments. We found that 60 per cent received level 4 or below. That equates to four hours of care per week. That's not even a shower every day.

We've broken one of our most basic social contracts—that people, as they age, will be supported in their homes. Support at Home is broken, and it is immoral if we don't urgently fix it. Today I have with me Julie, who is living with MND and receives support under Support at Home, and Jayne, her daughter, who is her carer. Julie and Jayne are proud Baramadagal living in Wurundjeri country. They can speak about the inadequacy of the program. They can speak about the possible funding and system to try and get ventilation support. And they can talk about the emotional toll that they are weathering just trying to navigate this system. Thank you.

CHAIR: Did you have a prepared statement? You're just here for questions. Thank you—just checking. NewDirection.

Ms Chadwick: Thank you for the opportunity to appear before the committee today. At NewDirection Care, we're primarily focused on residential care. However, we also provide Support at Home to a small number of people, as well as wellness services, which are focused on living well and delaying the need for residential care, where that is possible.

The microtown is an innovative care model that fosters independence and inclusivity, regardless of the person's support needs. We have completely transformed aged care from the built form to the care service delivery through to our workforce. We have been recognised nationally and internationally through numerous awards for our work in transforming aged care. Our approach to care looks at the whole person, with the aim to foster as normal a life as possible. We believe there are opportunities for this to be happening more frequently in both residential and Support at Home services.

Aged care has long measured success through the lens of maintaining baseline function. While this is well intentioned, it subtly caps expectation. Our sector needs to shift in focus away from disease management and towards the individual's strengths and promoting optimal quality of life. My evidence today will therefore be focused on the need for investment in innovation through building better communities that support living well rather than on the numerous issues that older people utilising Support at Home services and their providers are currently experiencing, many of which are also being felt by our Support at Home recipients, who are still waiting sometimes nine months or more for funding to be provided so they can access increased services or aids and assistive technology that they have been assessed as needing and are still waiting for, meaning, unfortunately, that they are declining more rapidly than they should be.

Our primary concern with the Support at Home program is that it must deliver sufficient levels of clinical and non-clinical support to ensure that individuals can remain at home. In both design and practice, we believe more needs to be done to ensure the appropriate levels of support are available for individuals to maintain their wellbeing. We also believe that there are opportunities to better do this by bringing together Support at Home and residential aged care to improve connections, not only for physical health but to enhance community.

Aged care has been shaped by an assumption that decline is inevitable and that the role of care is to manage loss safely. As a result, many systems have become highly proficient at protection, compliance and risk control at the expense of autonomy, movement and identity.

A better approach would be to focus on building wellbeing through prevention, and that means older people living healthier and more fulfilling lives. We have seen in our results this approach actually delivers. It is arguably more important for this approach to be prioritised in the delivery of Support at Home. The program should facilitate, not restrict, access to valuable allied health supports. A robust preventive approach to wellbeing could see an older person accessing multiple allied health services on a regular basis.

We frame this as innovation because it is not the done thing in aged care. The fact that this is the case is concerning, and it should be concerning to all of us. If the sector viewed care in this holistic way, it would see better wellbeing outcomes and better quality of life as well as lifespan, and also undoubtedly would improve the condition people are in when or if they do need to enter residential care. If the reliance is on older people alone to seek support, allied health or community connection, there's actually a far higher risk that deterioration will go undetected. Allied health providers must be empowered to proactively work with recipients rather than be focused on episodic clinical intervention. Social connection is not a tick box. Our social needs as human beings require relationships, social roles and social engagement. Finding more opportunities to bring all parts of the system together in delivery would support better outcomes for everyone. Again, thank you for the opportunity to appear today, and I look forward to answering any questions.

CHAIR: Thank you. I will now go to the Australian Physiotherapy Association.

Ms Utry: Thank you, Chair and members of the committee, for the opportunity to appear today. The Australian Physiotherapy Association represents 50,000 physiotherapists nationwide, Australia's fourth-largest regulated health workforce. Every day our members help older Australians maintain their independence in their own homes. The APA strongly supports the goals of Support at Home—helping older Australians remain at home for longer through early intervention, prevention, reablement and person centred care. Physiotherapy and other allied health services are central to achieving these goals, enabling older Australians to maintain function, prevent falls, avoid hospitalisation and delay entry into residential aged care.

Our concern is that key pricing and implementation settings do not currently support these objectives and are not fit for purpose, as our colleagues have already noted this morning. Reablement depends on timely access to

clinical supports, yet assessment delays, funding limitations and pricing arrangements that do not reflect the true costs of care continue to constrain access. The consequences are already emerging. Brokerage arrangements are under pressure, consumer choice is narrowing and services are becoming less viable. These pressures are felt most greatly in rural, regional and remote communities, where workforce and travel costs are highest. A sustainable Support at Home framework must reflect the full cost of safe, high-quality care, recognise thin markets, protect consumer choice and enable older Australians to continue receiving care from clinicians they know and trust. Future pricing decisions must be transparent and based on a genuine bottom-up assessment of service costs. The evidence should be published, providers meaningfully consulted and proposed caps tested before implementation.

This committee has an opportunity to ensure that Support at Home's implementation is aligned with its objectives. Achieving that will require pricing and implementation settings that support timely access to physiotherapy and other clinical services that maintain function, that support independence and that prevent avoidable deterioration. Our message is simple: Support at Home can achieve its goals only if it properly supports the clinical care that helps older Australians remain independent in their homes for longer.

CHAIR: Thank you, everyone, for your opening statements. I will kick us off with questions. First of all, can I say thank you very much, Dr Christian and Ms Christian, for appearing before the committee today. I will ask you, first, to outline for the committee your experience in interfacing with Support at Home and the challenges that that brings when you're trying to care for and live with MND.

Ms Christian: Thank you. I apologise for my voice. It's not helping me today. I'll read from my submission in relation to our experience trying to access a BiPAP machine first. There's an issue here between EnableNSW and having a federally supported funding package. Each level of government believes the other is helping when neither is helping.

When we were first told by mum's respiratory specialist that she needed to go from a CPAP to a BiPAP machine, he said, 'Contact EnableNSW, but I don't think they'll help you.' Then we went to the sleep clinic at the chemist, and she said, 'Oh yeah, you're probably best to put in an application, but I don't think you'll get it.' Already, it's this merry-go-round, and we don't have time for merry-go-rounds.

I rang EnableNSW. They said that they can't assist to fund BiPAP machine when people are in receipt of a federal government aged-care package. I asked the care partner to reimburse the cost of the machine because EnableNSW was unable to assist. Our care partner declined and said:

Unfortunately, this item cannot be covered under the Support at Home funding, as it is excluded due to alternative government programs being available to fund this type of equipment. I have reviewed suitable options and identified the Home Respiratory Program (HRP) through Enable NSW, which provides equipment for long-term respiratory support. I have attached further information for your reference—

This was all very helpful, but, if they're not going to help, it's not that helpful. The care partner also said:

Additionally, under the Assistive Technology guidelines, respirators are listed as excluded items (page 17). As the BiPAP does not meet oxygen-related criteria, it is also not eligible to be funded under nursing consumables.

I have attached the relevant documents for your reference. I apologise that we are unable to support the BiPAP request. I have had both my Team Leader and clinical team review this to ensure accuracy.

I then rang EnableNSW again and said that, as the item isn't eligible under either the aged-care package or the AT-HM scheme funding and their website states applicants must 'not be eligible to receive assistive technology through another government funded program', I intended to apply and provide the information from the care partner confirming that my mum is not eligible for assistance from another government funded program. That representative from EnableNSW told me that, if I did make an application, it would be rejected, as their internal policy further states that they are to reject anyone who is in receipt of an aged-care package, seemingly even when the package isn't providing very much, let alone life-saving equipment. We ended up buying a machine for $4,600 ourselves, without any support, while each level of government argued.

That's also important because there's no cure for MND, as we know, and BiPAP machines are really the only thing we have access to to prolong life, which can be by 18 months. To know that that's what your loved one needs and that type of financial cost stands in between puts carers in a terribly helpless position.

CHAIR: Do you mind me asking how long this merry-go-round took? How much time did you lose in having to ultimately come to the decision that you had to pay for the BiPAP machine in going through this merry-go-round and ascertaining that that was, in fact, not going to be provided at either level?

Ms Christian: It was in March that I started making those inquiries, and, by May, we had purchased one because we weren't prepared to lose the time.

CHAIR: So three months of going round and round to be told no.

Ms Christian: Yes. The other big issue is that the assessment tool is just not built to understand what living with MND is like. Of all the questions they ask, there are ample examples of how it's debilitating and life altering. None of that translates into an answer that understands urgency.

Unrelated to MND, Mum got registered with My Aged Care in 2018 because she fractured her wrist. It was helpful at that time. I spent a month back home looking after her and set that up so that there was some minimum support once I went back to my life. Mum has been diagnosed with PLS, which is one of the 40 subtypes of MND. I say we're lucky because we haven't had to deal with the 27-month lifespan that many people have to. Mum says, 'I get to suffer at home longer.'

From 2020, we knew that we needed more than level 1 help, which is what we started on. There was a period there from 2023 through to January 2025 where they were telling us, 'Yes, you've been deemed to meet level 3, but we can't allocate it.' For the level 3, we went through appeals and reassessments. The tool wasn't understanding the urgency. Even when we did the internal appeal of that, that was where I expected that human discretion would at least be present, but all they did was go back to the same criteria that the tool looks at. There was no discretion. It's very frustrating because we know that in law and policy there's a spirit that it's meant to embody, and it's the job of people working in the system to make sure that the lived realities align with that. There is just such a disconnect between what people are living with, what people think is happening and what's happening in between.

My mum is now on level 8, which equates to $78,000 per annum of funding. We know that that doesn't even meet a third of the actual costs of living with MND. In our lives, that looks like 90-minute support four mornings a week, a half-hour session with a physio four days a week and the lawn mowed once a month. Everything else we just have to work out ourselves. My mum has just submitted her PhD on the intergenerational trauma of our people, and having to deal with these bureaucratic systems is so triggering for Aboriginal people. But we know that it's not just us. There are many people who have been institutionalised and abused by government systems that this dynamic will have impacts for.

The other thing that we understand is that urgency seems to be calculated on homelessness, cognitive impairment and Aboriginality. Even as Aboriginal people, whether we were Aboriginal or not, what we're living with—no-one should be left out in the rain. The questions that are being asked aren't even relevant to the reality that everyone with MND is living with.

Another issue that really does impact us is the Assistive Technology and Home Modifications scheme. Our OT told us that previously there was $30,000 that could be spent on what was needed. Our house—to qualify for home modifications, there has to be something in the wall or in the roof or something that has modified the home. We don't need that. Our need isn't that; it's the assistive technology, and yet we can only access half. We've been approved for the full amounts, but realistically we're never going to need the $15,000 of home modifications. So, even when the funding is there, you're constantly made to feel like you're naughty for putting your hand in the cookie jar when these are genuine needs.

The issue of respite possibly needs to be raised. We live in Wagga Wagga, Wiradjuri country. Our traditional country is Baramada in the Western Sydney area. Returning-to-country trips are an important part of social and emotional wellbeing. Mum had COVID back in February and, since that time, she's needed the powered wheelchair. We've had to buy that ourselves. We've had to buy a car ourselves to put it in. We did that because it enables us to get back to country and be part of community events. The very first trip after she'd had a hospital stay I looked into residential aged-care respite, and I was only able to access it that one time, in March. They only allow bookings within two weeks of when you need it, so you can't do any forward planning. We were paying $65 a day, and a minimum stay was two weeks. So that's at least $900 to access any respite, and I wasn't even accessing it to get away from Mum. I picked her up every day. It was just to have the safe environment.

Because we couldn't rely on that, I reached out to the cottage respite. We were encouraged to use that. Then after we used that a couple of times they rang and said that we couldn't have the next visit because they were fully booked. When I asked some real questions about that, they weren't fully booked. They just would have had to have rostered on two people to look after mum. They weren't even giving us that option. We were paying $91 a day for that support when I was still picking mum up and looking after her through the day. It was just to have the adjustable bed. So we've since done trips back by ourselves. I take a Sara Stedy, a commode chair, a walker and a powered wheelchair and we juggle it in a motel room because the alternative is we don't get to go back. At some point we won't be able to go back, so we need to use the time that we've got to do what we want to do.

But there are no respite pathways that address our needs as a carer or someone living with MND. If someone happens to die the week that you want a room in an aged-care centre, they'll let you use it. That's not good enough. I spoke to the *Daily Telegraph* at the beginning of the year and there was a woman who had also spoken

to the journalist who had said, 'I think I'm going to miss my son's wedding in Perth because I can't leave my mum and she can't travel that far, and there's just no respite.' I'm a qualified lawyer. I'm not working. I'm not accruing superannuation. I'm accruing costs because the government doesn't have a dignified bottom line and everything just gets left on the family and carers. What I find unforgivable is that voluntary assisted dying is an option—and I'm glad that it's an option—but shame on the government when people are given no other option and they still call it 'voluntary'. That's the final gaslight that we get in this life, and it's just absolutely abhorrent. I'll stop there.

CHAIR: Thank you. I really appreciate you bringing this lived experience into this hearing. My mum died of MND and I totally understand the challenges that you're facing. I have some questions for the other organisations who've appeared before us as well. I'll go to NewDirection. You've made the argument in your submission that loneliness should be recognised as a clinical risk. What consequences are you seeing when social isolation is treated as an optional wellbeing issue rather than something capable of accelerating physical and cognitive decline?

Ms Chadwick: There is a lot of research around what loneliness does to people in particular around health and their longevity and wellbeing. We are seeing greater deterioration in people who don't have the ability to have connections, that don't have the non-clinical support services that we're asking for, that aren't able to get to activities and that aren't supported to actually continue connections or to make new connections. So what we see instead are greater deterioration and, I believe, a quicker move into residential aged care instead of being able to be supported at home with wellbeing and quality of life.

CHAIR: You've also warned in your submission—I think I've got this right—that Support at Home can sometimes delay a necessary move into residential aged care. How can a policy intended to support ageing at home become counterproductive when a person's needs have reached the point where home's no longer the safest setting? I'm wondering if you could unpack that a bit more for us.

Ms Chadwick: It's very much around that connection and deterioration. If a person is no longer safe at home and they are deteriorating because they don't have connection and they don't have community, then if they're being kept at home simply because there are Support at Home services available to them then there is a real impact. What we see when people come into residential care, particularly when they may have been kept at home for longer than was probably better for them, is this immediate ability to connect with people. We see an absolute move in mood and in use around antidepressants. We see changes in the person themselves around their mobility, for example.

Someone might have been staying at home, didn't have the connections and wasn't getting out into the community; therefore, mobility becomes an issue as well. They come into residential care—in particular, where we are at NewDirection Care, we have a wellness centre, a hub, where we provide all of our allied services—and they're mixing with people from the external and visitors to the community and being provided with all of those services. All of a sudden we see people who weren't able to walk at home, now, back to their baseline mobility, if you like, and functionality. So we see a huge increase for a lot of people, and that's what I mean when I talk about them not being placed in or admitted into residential aged care, when it probably was the best thing for them as an individual.

CHAIR: If we're thinking about residential aged care being the most expensive part of the aged-care system, would you agree then that it speaks to the idea that, in Support at Home, people having the biggest co-contributions for those things that aren't clinical but enable them to get out into the community and be connected is actually a false economy?

Ms Chadwick: Absolutely. As I said, at NewDirection Care, we have a wellness centre. It has every allied service that you could imagine, and we operate it as a hub for the whole of the community. What we believe is that there is a greater opportunity for more investment in developing similar hubs at residential aged-care communities, retirement villages—support or community support, particularly in thin markets. We believe that we need to invest in community based prevention and early intervention. That would be inclusive of individual and group programs. Group programs bring people together, create community and create that connection.

The things that we would target are strength and balance, falls prevention, chronic disease management, nutrition, health literacy and education. Those are all the things that we're able to demonstrate, at NewDirection Care, actually work and stop people from coming to that front door of residential aged care too early because they do have those connections. We really believe that this could be built on and achieved by extending the CHSP. CHSP already recognises wellness, reablement and early intervention, and from our perspective it would mean extending and expanding on the CHSP services and opening up those markets to new providers like ourselves. We currently don't have access to those funds, but we provide those services.

We also believe that that would provide an opportunity to build on what CHSP was actually intended for: to achieve and to make prevention a more deliberate, accessible and measurable component of the broader aged-care system. We really believe that we can layer support for people—particularly people who are waiting for assessment, or they've had their assessment but the funds haven't come through—so that they can commence their individualised services. It wouldn't replace individual care, but it would provide earlier intervention, mitigate deterioration—really mitigate it—and make more efficient use of a constrained workforce. We're all dealing with that issue. Group based programs provide the additional benefit of, as I've said, social connection, routine and community participation.

CHAIR: This committee had the opportunity to visit the active ageing centres in Singapore that they've set up. What you're talking about sounds very similar to that. It was really clear that it provided a really great focus for people for early intervention and re-enablement. It's an interesting concept.

Ms Chadwick: Absolutely. If you create that environment—with cafes, with stores, with a real community feel—then people come and go and it doesn't feel like a residential aged care community; it feels like a community hub.

CHAIR: Ms Utry, the stated objective of Support at Home includes re-enablement and maintaining independence. Why does the APA believe the program is drifting away from that objective in practice?

Ms Utry: Our concern is that the delays to assessment, the rigidity of the assessment tool and the very tightly capped settings for restorative care are holding it back. What we're finding is that it's becoming a reactive rather than preventative program. With the—was it 20,000 packages across the country? I don't have the exact numbers. Some modelling was discussed with me recently around the number of packages that would really, genuinely meet the need for older people. Scott, I might ask you if you'd like to speak more specifically about restorative care from a clinical perspective if you'd like to do that.

Mr Lynch: In practice, we see several barriers there, especially when comparing this to the Home Care Packages Program and that transition. I can speak to both hearing from members of the APA but also leading an allied health organisation that delivers as an associated provider and as a registered CHSP provider as well. With respect to the restorative care program, when we compare that to the previous short-term restorative care program, some of the differences that we've seen are probably the assessor knowledge base, the interaction of that with the IAT and knowledge of an assessor of when to and how to trigger that as an RCP. We see that as a barrier of referrals. They're flowing differently and at lower numbers than we saw at least in our region for the organisation that we led before—real knowledge at an assessor level.

Some of the barriers that I would also say for allied health, physiotherapy and others—I represent a multidisciplinary organisation as well—are on pricing and that transparency and confusion for the participant on how prices have changed with the package management fees and administration changing so drastically. We see in good data from StewartBrown across organisations how much direct service fees have changed. Bolton Clarke spoke brilliantly to how you could almost attribute all of it, bar nominal interest, solely to that.

CHAIR: From a physiotherapist's perspective, what are the consequences of an assessment tool failing to recognise somebody's restorative potential? Are we at risk of funding ongoing support while failing to fund interventions that might actually preserve or improve independence?

Ms Utry: This is again something that I'll throw to Scott to respond to as a clinician.

Mr Lynch: There's a lot of research on falls, and rightfully so, for the flow-on through to the health system—particularly hospitals, long-term care and residential. We know from lots of data across all countries that we see a reduction in falls of anywhere between 30 and 50 per cent in community-dwelling adults with the right programs. Those are typically multifactorial. They're not just physiotherapy. We see that across allied health. We see that across nursing. We see that in the great value of a care partner supporting that.

When you don't have enough investment in restorative care, there's a problem of not catching someone early enough. The restorative care pathway has the potential to be something brilliant in our system because often somebody does not want to enter—at least we see this in practice—the Support at Home program early because of the whole bureaucracy around how much care they need. We see that in the flow-on interaction of CHSP and Support at Home at that early stage. A lot of people will delay entry or uptake of the classification until they have more complex needs. Restorative Care Pathway and CHSP are this wonderful foundational level for someone to enter, get supports for a time limited piece to uplift their function to meet this—I've always loved the government's goal for people 'to live longer and better at home'. I really love that statement. And Restorative Care Pathway, with enough packages, funding, and enough knowledge in the IAT process at an assessor level of how to trigger that and flow through, is a great opportunity for people to live longer and better at home.

CHAIR: Thank you. I'm going to share the call. I'm going to go to Senator Gatenby.

Senator GATENBY: Thank you all for appearing and for your opening statements. My questions firstly go to MND Australia. Ms Sullivan, I might let you respond, from those attending. I also want to say thank you to Julie-Ann and Jayne for your perspectives today. How is the integrated assessment tool affecting people living with MND? Are you seeing people consistently receiving incorrect classifications from the process?

Ms Sullivan: The integrated assessment tool is not working for people with MND. Our analysis shows no correlation between the packages they're allocated and their disease progression, their circumstance and their care needs. It just doesn't marry up the assessments that people are getting with what we know they would need. There's no relativity in even the spread amongst them. So it doesn't make any sense and it doesn't reflect what people need. Jayne, you've had some interesting experiences with the IAT.

Ms Christian: Yes. I've got no respect for the tool. At times I've rung the ACAT and said to them, 'Are you getting paid to send me these letters and tell me that my mum doesn't need more help? Are you really taking money to do that?' They freak out and they say, 'Can you please make a noise, because we try in here, and our management just ignores us and tells us it's not our problem. So can you make a noise?' So, on top of the full-time care for my mum, navigating the bureaucracy, can we also make a noise because the people who are getting paid to do the work aren't being listened to either.

Senator GATENBY: Is that noise within My Aged Care or is that in the MND priority pathway itself within that? Just explain for me what you're having to deal with.

Ms Christian: It's in terms of getting assessment, which then determines which level of care you need. That's in the Support at Home system, whether or not you have MND, and that's where the tool is being applied.

Ms Sullivan: And the noise is raising complaints. The assessors, the people you talk to, are suggesting that people make complaints, because they know the system is broken.

Ms Christian: We've spoken to the *Daily Telegraph* and ABC News. To quote the former inspector-general, Natalie Siegel-Brown, Australia doesn't have a funding problem; it has a values problem. What I know is that, when somewhere like Australia doesn't have values, what it values is public shame, and that's why we just make a noise.

Senator GATENBY: I'm sorry to hear that. Ms Sullivan, in your view, has the government's MND priority pathway—it doesn't sound like it's been implemented effectively. Are people actually getting the care in a timely manner—are some or a proportion, or are you seeing delays for everybody in that sense?

Ms Sullivan: The priority pathway in the NDIS program is actually working pretty well for people with MND. They're getting their plans turned around in about a week, and the funding is broadly adequate.

The recent government announcement was to prioritise people with MND's assessments through Support at Home to be in the urgent category—so within a month. These people have about 12 months, on average, from diagnosis. So a month is still too long, but it's a lot better than nine months. The faster access is a step in the right direction, but it's faster access to inadequate funding—grossly inadequate funding. Glen tallied up the cost of his care, and it's about $400,000 a year, and the maximum available in Support at Home is $78,000. But what we're seeing is people with really advanced MND being assessed as level 4. It doesn't reflect reality. It's not working. We can't find the logic in it. When we interrogate it with people with MND, with service providers and with the department, we can't make sense of it.

Senator GATENBY: Are the people that you're seeing that are experiencing those delays, even if it's a month or thereabouts, able to access the essential technology, the assistive technology and home mods—particularly ventilation equipment—at least in that short period of time? Or what are you seeing there?

Ms Sullivan: With the faster access to Support at Home, the government has sped up the AT and home mods funding as well. So that's assessed in a month. Ventilation's not covered. You can bounce around state health systems. For people within the NDIS, it's sort of similar. You've got all of these government systems that should be supporting people that are blaming each other. Support at Home, the federal system, will not cover ventilation. Ventilation is the only thing that gives people with MND time, and it's really, really expensive.

Senator GATENBY: On top of that, I'm just interested to know the relative quantum of that—or what other changes to the Support at Home care in terms of equipment might be under things that you're advocating for as well at the moment?

Ms Sullivan: A person with MND could need up to 30 different pieces of equipment during their disease journey. They could need three or four different types of wheelchairs from a walking frame to a powered wheelchair. An advanced powered wheelchair could cost $70,000. The funding is inadequate. They would benefit

a lot from allied health and occupational therapy to stay in their homes, and physiotherapy to promote moving and to ideally stave off some of that physical decline. The carer support is absolutely essential.

People with MND are diagnosed in their mid-60s. Their partner is usually in their mid-60s, often frail, often with their own health conditions. The physical burden of looking after someone with MND—I use the word burden carefully. It's shocking. You can't expect someone to lift their partner in and out of bed and move them around the house if their partner can't move, so they need support. They need help doing that, but they also need a break. And, at the moment, residential aged care is really hard for people with MND to get into. Most of the time they're clinically declined because their condition is so complex. Respite is really hard to get into. Generally, they're clinically declined as well.

There's no support for the carer, and what I see in the community is the emotional toll, the physical toll, the financial toll. Families are being financially crippled, if not bankrupted, by MND. But you see it in the carers faces. They age decades because of the physical toll, and Support at Home doesn't go anywhere near to addressing any of those things that someone with MND needs.

Senator GATENBY: Thank you for that.

Ms Christian: May I add to that—to give you an example, for the assistive technology funding that we got approved in March, that was assessed pretty quickly, like within a month. We got told that we had access to the funding. Then our care partner took months to draw the funding down. But we spoke to the provider who could provide a bed and an air mattress like mum had access to in hospital. And since March, we've been renting an air mattress for $100 a week from the provider in Wagga because they say they can only be imported from overseas. There's a shortage. Even if you're successful in getting the money allocated on a reasonable basis, then there's access to the things that you actually need and the expense, $100 a week, to prevent the pressure sores and that that would otherwise happen.

Another thing to be aware of—I only recently became aware of cough assist devices, and I know of people with MND under 65 who've been able to access that—it's at least $11,000. I think it's a bit more—within five weeks on NDIS, whereas people over 65 who really need one of these because the muscles have weakened and they need the assistive device to clear a cough would only have access if they were admitted in a hospital. If they can't pay that $11,000, there's no way of getting one at home. These are the types of things where the cost is significant and the experience of life is so greatly altered.

Senator GATENBY: In your submission, Ms Sullivan, there were substantial increases in aged-care provider costs. It sounds to me like those cost increases are affecting availability and affordability for people with MND. Is there anything you want to add to that?

Ms Sullivan: I think you've articulated it really well. We did some desktop analysis before and after the reforms late last year. Across the board, the costs have gone up dramatically. When you look at the administrative and regulatory burden on providers, I think you can understand, to a degree, why that is. When we mapped the charges that someone receiving Support at Home funding would get as opposed to the NDIS for comparable services, the prices in the aged-care system are dramatically higher, and I can't explain that or tell you why. But, yes, there are no price caps yet. It would appear that prices are going up before the price caps come in.

Senator GATENBY: So, in summary, the changes to the Support at Home funding and pricing—what do you think is needed to ensure that people with MND can continue to get the care they need? It sounds like more funding and better oversight of costs is what you were leading to there.

Ms Sullivan: I think faster access to funding, more discretion for an individual or their carer to choose where that funding is used and about three or four times as much funding. Jayne, what would you do to improve the program?

Ms Christian: Definitely the funding. I think funding early intervention to stay at home was another thing that we could take from Natalie Siegel-Brown, who said that support at home funded in the early part shortened stays in nursing homes to 13 months, which is significant when a stay is, on average, two years, and that it's more expensive to have to fund one person in an aged-care centre than giving supports early to stay at home. I think the evidence is there to support that. Even if people didn't care how it affects people of the public, it's in the government's interest financially, so do it for that reason. When we talk about the human discretion, I think it needs to be informed by lived experience networks. So often I hear MP Sam Rae defend the system, and I don't know what access to lived experience advice he has, but what he says most of the time doesn't make sense. It's not enough just to have any old human applying discretion. Make sure it's informed.

Senator GATENBY: Thank you for that. I'm conscious of time, because we're about to wrap up. I was hoping to ask some questions to NewDirection and also the Physiotherapy Association, but I might put them on notice. I'll foreshadow those if that's alright, Chair.

CHAIR: Thanks very much, Senator Gatenby. Thanks very much, everyone, for your submissions, for your lived experience evidence and for making the time to appear before the committee today. It is very much appreciated. It's very important for the committee's deliberations. The committee will report to the Senate on 24 November 2026, and we've agreed that responses to questions on notice should be provided by close of business on Tuesday 6 October 2026, noting that Senator Gatenby has indicated that he will be sending some questions through. Thank you.

Proceedings suspended from 12:33 to 13:20

BROER, Mrs Sharyn, Chief Executive Officer, Meals on Wheels South Australia, Meals on Wheels Australia [by video link]

BROKAW, Mrs Cassandra, Head of Partnerships, Lite n' Easy

MARTIN, Mr Andrew, Director, Eat Well Health

SADLER, Mr Paul, Chair, Meals on Wheels Australia [by video link]

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection and obligation of witnesses giving evidence to Senate committees has been provided to you. Do you have any comments to make on the capacity in which you appear?

Mr Sadler: I'm also the co-convenor of the CHSP Alliance.

CHAIR: I invite each of your organisations to make some short opening remarks, and then I'll go to senators for questions. I'll start off with Lite n' Easy.

Mrs Brokaw: Lite n' Easy is proud to have been providing healthy, nutritious meals to Australians for 40 years. Over that time we have supported people at many different stages of life, including older Australians who are trying to stay well, independent and living safely at home. Since 2020, we have served more than 240,000 clients who have used their home-care package funding across all six states and the ACT. We currently support 165,000 home-care clients through approximately 900 providers. Our longstanding success has been built on listening to customers and adapting to their needs at different stages of their lives.

We are proud to bring that experience to our work with older Australians through Support at Home. Support at Home is a vital program. Collectively, we have an opportunity to improve the program and ensure it is serving its intended purpose—a fairer system, improved access and better support for older Australians to live healthier and independent lives at home. Our recommendations are informed by both our work with providers and direct feedback from the customers we support. We prioritise engagement with the older people we support to ensure we understand their experiences and challenges.

In my evidence today, I would like to focus on the two primary levers we believe should be prioritised to deliver the improvement needed in Support at Home. First, Support at Home should be reframed to focus on prevention and access to preventive health programs. A balanced, nutritious diet is fundamental to health, strength and independence as people age. One of the biggest risks for older people is the gradual loss of muscle mass, strength and function. A balanced diet, particularly one that supports adequate protein intake, can play an important role in helping people maintain their health and continue living at home. Ensuring people can access high-quality protein-rich meals early is one practical way to help delay decline and reduce avoidable health impacts.

We know from our customers that access to healthy, nutritious food is key to helping them continue living independently at home. In our recent survey of almost 4,000 Support at Home customers, 71 per cent of respondents said that nutritious, prepared meals were very, or extremely, important to helping them maintain independence. More than 62 per cent identified everyday meal preparation as a major barrier to healthy eating. If nutritional needs are not met, there can be significant flow-on implications for an individual's health and wellbeing, potentially resulting in a greater reliance on the healthcare system and avoidable early entry to residential care. Under Support at Home, preventive supports, such as nutrition, are becoming more difficult to access and are not being prioritised strongly enough. We think there is a clear opportunity for the committee to correct this path, so that prevention is not treated as peripheral, but, rather, as central to the purpose of aged care at home.

Second, the co-contribution model must be redesigned. We agree that the aged-care system needs to be financially sustainable. However, sustainability should not come at the cost of people declining faster because they can no longer afford the supports that keep them well. In practice, we see people make decisions based on what they can afford rather than what they need. This is a real concern and creates a serious risk. When food services are treated as optional or as something people cut back on to make their package stretch further, the system risks creating higher costs later through poorer health, increased frailty, hospital presentations or earlier entry into residential care.

Our customer feedback also highlights the vulnerability of this group. When asked how they would respond if they lost access to subsidised meals, more than one in 10 said they were unsure how they would manage and many said they would simply skip meals more often. We need to pivot to focus on support systems that help recipients live healthier lives in their own home, and to reduce their reliance on more costly residential-care services or, as we are seeing, extended hospital stays.

The intent of Support at Home is right. With targeted changes to prevention and co-contributions, the program can better meet its potential, supporting older Australians to remain well at home while also improving the long-term sustainability of the aged-care system. Thank you again for your time, and I welcome the opportunity to answer any questions.

CHAIR: Meals on Wheels.

Mr Sadler: Meals on Wheels services are primarily funded by the Commonwealth Home Support Program, the CHSP. We largely operate as associated providers or subcontractors in the Support at Home program. We have found some significant problems with the design of Support at Home, including major delays with the assessment process. If there's one takeaway from our evidence today, it is that older people can't wait to eat while they are waiting for an assessment or for a package to be allocated. Secondly, there are significant inefficiencies in the Support at Home program's design, including registration requirements and claiming processes. Thirdly, older people are refusing Support at Home services and opting to stay on the CHSP because of what they perceive to be unaffordable participant fees.

In our submission, we provide evidence that meal services in Support at Home are roughly 40 per cent more expensive than equivalent meals delivered through the CHSP. We've provided 10 recommendations to improve care at home for older people. I'm pleased to note that the government has already acted on the first of our recommendations—namely, to retain the CHSP separate from Support at Home. We urge the government to reinvest in the CHSP to prevent people's needs increasing such that they require higher levels of aged-care support.

Our recommendations to improve Support at Home include introducing streamlined assessment and referral pathways for low-risk preventive services, including community meals; limiting Support at Home co-contributions to a maximum percentage of income irrespective of levels of service mix or use, thus avoiding penalising the frailest people; re-categorising meal services into the independence category; removing the 60 per cent interim funding allocations and reinstating full funding when a person is first assigned a Support at Home classification; and reviewing Support at Home administrative requirements to ensure that regulatory obligations are proportionate to actual service risks. We're happy to answer any questions the committee may have.

CHAIR: Eat Well Health.

Mr Martin: Eat Well Health provide nutrition screening and dietitian services and supply prescribed nutrition support to older Australians. We are paid for our products and services, and obviously we declare that. Our submission makes four recommendations. Today I will press just one—require Support at Home providers to screen every client for malnutrition risk. We're not alone in asking. Dietitians Australia's submission also calls for universal malnutrition screening for people on Support at Home. Like the meal providers on the panel, we are food first. We differ in one way: we don't actually supply meals. We screen for malnutrition and supply prescribed nutrition support shakes to be taken alongside meals. We also supply appropriate dietetic services when people are identified as needing further assistance and support.

Around one in three older Australians receiving home care are at risk of malnutrition and close to one in 10 are already malnourished. That's 42 per cent. It means falls, hospital stays and an earlier move into residential care. The entry assessment comes down to one nutrition question: have you lost weight? Nothing has to happen when the answer is yes. After that nobody looks again. The rules require a provider to know what a client likes to eat. Nothing requires anyone to check whether the client is actually eating it. We check the menu every year. We never check the person. The solution is simple: screen, then support the people you find.

I'm mindful of the pressure on providers. They have told this inquiry that 10 per cent for care management is not enough. I'm not asking to add to that load. Malnutrition screening is clinical care and it can be light. The screen is a short questionnaire. Many older people or their families can complete it themselves, and those who need help can be supported through it. It's not theory. Anyone can complete ours today, at no charge, online or through our app. With their consent, the result goes to their provider, where that provider is registered with us. I'm asking you to require the screening, not our tool, and it needs no new money. The dietitian and the prescribed nutrition support are already on the Support at Home service list with no co-contribution. That funding is there to be used. What is missing is the requirement to look.

This asks little of the system, is easy to adopt and could materially improve the wellbeing of more than 330 older Australians on Support at Home. It would also reduce hospital costs. The Commonwealth's own safety and quality commission puts each episode of hospital acquired malnutrition at about three extra weeks in hospital and about $44,000. I've tabled a short paper on the simplest way to mandate it, and I'm happy to take questions.

CHAIR: Thank you very much. Senator Ruston will kick us off with questions.

Senator RUSTON: Mr Sadler, I note that Meals on Wheels is very heavily reliant on volunteers, and you serve around 200,000 older Australians. I'm interested to understand how the shift to Support at Home has affected your volunteer numbers and the viability of your local operations.

Mr Sadler: The shift to Support at Home in and of itself hasn't made a significant difference to the willingness of people to volunteer for our services. The reality is that that was one of the reasons we were pushing so hard, with the committee's support, to retain CHSP funding, which makes up between 65 and 80 per cent of the funding that our services now receive. We would view the retention of CHSP as pretty critical to that. I might pass to my colleague Sharyn to comment on whether she's seeing any impact of the Support at Home program on volunteer numbers more broadly.

Mrs Broer: As Paul said, the impact on our volunteers has not been due to the change in the Support at Home program per se, but other changes that arose with the new act and requirements for volunteers to be undertaking additional training and record keeping have been somewhat problematic. We're not seeing that flow through, though, to reduced intention to volunteer or more people resigning as volunteers at Meals on Wheels SA.

Senator RUSTON: I would just be interested to know—maybe not now because I know we're going to run out of time, and I've got so many questions—what the impact of those additional requirements has been on your organisation. That would be useful. You reported a reduction in participants using meal services. Maybe this should go to you, Mrs Broer. In South Australia, have you been able to quantify the number of people who previously were getting meal services that have chosen not to continue to get them under Support at Home?

Mrs Broer: I can tell you that for July and August this year there's been a net reduction of 60 older South Australians receiving meals through either the Support at Home program or the Commonwealth Home Support Program compared to what we expected based on our regular customer trends. So it's 60 fewer people at a time when we've got increased Support at Home budgets being released.

Senator RUSTON: Mr Sadler, is that reflected across the country?

Mr Sadler: Yes, it is. Some of our services don't provide as much support through the Support at Home program as Sharyn's service does in South Australia. So the impact is different on different services across the country, but the net effect is similar. We're seeing it come through in two ways. The first is people just refusing any service from the government funded Support at Home program. The second is people choosing to remain on CHSP and forgo a level of service which they've been assessed as needing from the support program. That's largely driven by the level of participant contribution that will be required.

Senator RUSTON: You made a comment in your submission and you made it again in your presentation, Mr Sadler, about a 40 per cent difference between the delivery of a service under CHSP as opposed to Support at Home. Have you got any documentary evidence that actually digs into the detail of that change and where the additional costs are being incurred? I'm assuming you're the same service with the same volunteers, the same drivers, the same cars and the same food. But this one costs 40 per cent more than this one. Is that pretty much what you're saying?

Mr Sadler: Yes, it is. We've got some details in the attachment to our submission. It goes through what our services around the country are reporting to us. We think it's largely because the Support at Home program, being an individual funding program, just has additional overheads over the top of a block funded program like CHSP. So you have the claiming process that providers have to go through. You've got other administrative overheads which inflate the cost of the service ultimately to the government and to older people.

Senator RUSTON: Okay. I might go to you, Mrs Brokaw. Are you equally seeing an increased number of people cutting meals because they're saying they can't afford them?

Mrs Brokaw: When the referral comes to us, basically the client has worked with the provider and they've agreed that they will have meals as part of their package. One of the things that we are seeing is probably a 10 per cent reduction in the number of those referrals compared to the same time last year, which would indicate that fewer people are getting meals given the larger number of packages that have been released over the past 12 months.

Senator RUSTON: I'll give you the opportunity to listen and respond to this. There was some media reporting some time ago, probably months ago, where a customer said she'd seen her regular order for seven Lite n' Easy fruit smoothie pouches jump from between $17 and $19 to $118. I'm wondering if you'd like to respond to that. Are we still seeing examples where previous costs have been incredibly inflated as a consequence of this government policy?

Mrs Brokaw: Yes. Under Support at Home, the providers must show the price of the services that they're providing. In the case of meals, they can set the price of meals independently, regardless of what the cost is for

the associated provider to provide them. In the instance of that smoothie example, perhaps that provider hadn't taken the time to set the cost of meals and maybe had said, 'We're going to charge $22 for each meal,' regardless of the actual cost of the meal underneath. Lite n' Easy may charge the provider $7 to provide each of those individual meals, but it's being charged to the package, for example, at $22. It's incorporating the cost that previously would, maybe, be under care management that they had there, and, because the provider is required to push those costs across to their unit costing, it creates confusion for those people.

One of the questions we asked in a recent survey, which had 4,000 respondents, was about any confusion they had. Many of them were very confused about the costs they pay to us, which is the cost of ingredients, and the additional costs they're then asked to pay later on, which don't necessarily bear any resemblance to the cost that we're charging to the provider. They're very confused. It's about the messaging that goes across to those participants.

Senator RUSTON: You say the single provider model creates extra administrative burden, which I think you've just demonstrated. Are you in a position to provide clear examples with costings that show, across the board, how that extra cost might be translating through? It seems to me that an awful lot of taxpayer money is being spent on administration instead of being spent on delivering care.

Mrs Brokaw: Yes, we can. We've got a number of lived examples from customers. We had one customer, for example, that had been getting weekly deliveries from us for three years. When the co-contribution model came in, she said, 'I can't do that anymore. The cost of my package is too much,' and she stopped getting meals delivered. We've got a number of those examples that we can provide. We can also provide examples of the difference between the cost that we're charging versus the cost that some providers are charging. We understand it, because what they previously charged under care management is now being translated to other costs. It's no different to the other examples that people are giving where costs increased 30 or 40 per cent under Support at Home compared to Home Care Packages.

Senator RUSTON: It does beg the question why they're not going directly to you.

Mrs Brokaw: Yes.

Senator RUSTON: This is my last question as I'm sure the chair wants to wind me up. Mr Martin, I'm just interested in your recommendation, obviously, around making sure that nutrition is placed first and foremost in regard to the food that is being provided to older Australians. In your opinion, how well is nutrition risk understood and managed as a general concept under the Single Assessment System?

Mr Martin: I don't think it's very well managed or identified at all, and, hence, that is why we're here. We've had a nutrition business for 15 years. The way I came to this was through my mother, who's on a Support at Home plan. I'd worked out that she wasn't eating particularly well. I said, 'Mum, you need to have some protein.' So, of course, I gave her my protein. She also has Lite n' Easy. I wondered, 'Maybe this can be funded.' I tried to work through the process to get that done. At that point in time, she had to go and see a dietician or her GP to get a recommendation. She then had to take it to her provider, who really didn't know what was happening, and they'd said, 'Go to the pharmacy,' or do this and reclaim or do those sorts of things. It was difficult to organise. I found it frustrating, and I am capable of doing this.

We identified this system. Initially, we screened people online. Dietitians we've worked with have developed a system to do that. We provide an online recommendation based on that screening result through a clinical protocol signed off by dietitians, which then give them the recommendation for protein powder or a formulated meal replacement, all of which comply. But also what we do through that process is identify people who genuinely need to see dietitians. We then provide a pathway, either through their provider who may already have a dietician or we supply our own dietitians where appropriate. But the awareness within the network is very low.

We have challenges talking to providers about nutrition. It's not something which is part of the system. As I almost tongue-in-cheek said in my submission, they're actually required to assess the tastes and requirements for their meals and whether they're nutritious. But no-one actually checks whether they're eating them or whether they need them, which is somewhat counterintuitive.

So the awareness is low. It's quite easily fixed. We screen people on our portal for free. We send it to their provider. There's no cost. What we see in our numbers pretty well supports exactly the percentages that I talked about. Our numbers show that about 46 per cent of the people we screen are at risk or malnourished. It's slightly higher than the numbers quoted in the study, but I would imagine that people who come to us are genuinely aware that they've got an issue, so we're likely to be skewed slightly higher. But the evidence is there that it's a significant problem and it has a significant impact on people's health and people's lifestyles.

As I said, I have an elderly mother. I'm completely aware. Older Australians do not like it if you ask them, which I think is in the assessment, 'Are you eating properly?' My mother's always eating properly. So's my father. But they're not. And I'm sure that all of us who have parents have probably experienced that same thing. You need to be a little bit more sophisticated than ask, 'Have you lost weight?', or, 'Do you have trouble preparing meals?' It's really an unidentified problem, and it's so easily fixed.

Senator RUSTON: Thank you.

CHAIR: My first question is for Meals on Wheels. Meals on Wheels describes itself as a preventative service, not simply a food delivery service. I'm wondering if you could elaborate on what else is being lost when an older person drops out because Support at Home has made the service less affordable or harder to access.

Mr Sadler: Sure. I think the key thing is that older people who drop out of receiving services—whether it's just meals that they don't pick up via Support at Home or whether it's refusing any Support at Home service—run the risk of having the level of help they do access not being sufficient to meet all their needs. That in turn raises risks of falls, hospitalisation and potentially premature admission to residential care. It's the cumulative impact of those decisions.

That's why Meals on Wheels Australia, via the CHSP Alliance, is supporting a 'no wrong door' proposition—so that people who do approach a Meals on Wheels service can get a meal very quickly without having to go through the full My Aged Care assessment process. In our minds, that would be particularly for low-level, entry-level services. If you need more complex care then it makes sense to require a full assessment at that time, but we know that some older people who end up using Support at Home level services only really need one or two services to be provided to them. But they require them frequently, and that's often the trigger point that sends them towards the Support at Home service instead of just a CHSP-level service.

CHAIR: Mr Martin, you've raised in your submission the problem of nutrition information being lost when somebody moves from hospital back into the community. Could you elaborate on what that fragmentation means in practice for an older person who's already nutritionally vulnerable?

Mr Martin: The evidence shows that people who leave hospital are generally at a greater risk of malnutrition or malnourishment when they leave, and there's no process to pick that up. There's a study in my submission which talks about the number. There's also evidence to show one in 10 people leave hospital with a nutrition plan at the time they leave, and the consequences of that are significant. Our point is simply that if, as part of that process, a provider was made aware of that then it would pick up that risk. Once again, it's not an overly complicated process. I accept that the providers are under pressure in terms of their management and those sorts of things. But nutrition support is a clinical service, so there is no issue in terms of them doing more. It's funded. We just need to link it. It's particularly simple, I think.

CHAIR: Ms Brokaw, you've probably answered a lot of the questions that I was going to ask. Senator Ruston's covered them. If we could only pick one recommendation from your submission, what would be the thing that you would like changed first?

Mrs Brokaw: Based on feedback from customers, we think it would be the co-contribution impact, especially for those that are most at risk—if they're a full pensioner. It sounds really easy to say that everyday living is a 17.5 per cent contribution, but I think the unintended consequence of the way pricing has been done, when you inflate that pricing, suddenly it's 17.5 per cent of a bigger number and there's not a lot left after the pension for them to be able to afford things. Previously, when showers were not covered, they were literally making choices between 'Can I have a shower or can I have a meal?' in that particular week. We shouldn't have people having to choose between those things.

CHAIR: I'm going to pass to Senator Whiteaker.

Senator WHITEAKER: Thank you very much for your time and for your evidence. Just indulge me for a moment. I want to say to Meals on Wheels that my grandmother was a dedicated Meals on Wheels volunteer for a very, very long time. It brought her great joy and purpose, so yes, I am really pleased to be able to hear your evidence today. I've got a couple of questions. One of the things you've all spoken to is this tension between the Commonwealth Support at Home package system and the extra expense that brings et cetera versus CHSP. The government's, of course, announced that we're extending the period for Commonwealth home support packages and that we're open to conversations about what that will look like into the future. In your view, for your organisations, how could we make these two programs work alongside each other if we were to make a decision to continue to run them both?

Mr Sadler: Through the CHSP alliance, we've done a lot of work on how the system could work, not only with Support at Home but also with residential aged care. We published as an alliance some thought papers on

that question: How could the systems work together? What can you do to focus on older people's needs as a primary driver of the system? How can we improve integration across the whole of the system? Hopefully, that thought leadership we provided goes a long way to answer your questions. I think the really critical thing is that we need access to CHSP services for people who have relatively low-level needs to be much faster than it is today via the My Aged Care assessment process, and that's the no-wrong-door proposition that we're arguing for. We're arguing a case for GPs to be able to socially prescribe a CHSP-level service, and we're arguing for, if the older person knocks on the door of a Meals on Wheels service, our service to be able to accept the person, register them with My Aged Care and, for those simple services, start them the next day. For services such as our service or community transport, where you need a trip to a medical specialist, they can't wait a month or even, in the worst-case scenario, 10 months for a Support at Home package to be allocated. It's a need to get access to the services quickly, which is critical. In turn, that quick access to these services will prevent people's needs accelerating such that they require more complex care, such as a full Support at Home package, further down the track.

Mrs Brokaw: One of the obvious ways, as Paul alluded to, is that the CHSP is designed to be entry-level assistance for people looking to have support. One of the things it does really well, under that multiprovider model, is its people are able to specialise in particular services, whereas for some of the providers across Support at Home their focus may be on allied health or nursing services, but suddenly they're expected to provide across the whole range of services—so, by nature, they must have other associated providers. I think one of the obvious ways that the CHSP and Support at Home can work together is making use of specialised single providers, as the CHSP does, across Support at Home—which we sometimes lose. That's what Paul was alluding to; it costs more under Support at Home to provide that because you're trying to meet all those compliance needs under Support at Home for a different provider other than the person providing the services.

Senator WHITEAKER: Are there benefits, though, to being able to provide that individual-level attention to what someone needs? I accept that there's an additional cost and that that's a challenge. Notwithstanding that, do you have greater flexibility to cater to an individual older person who might have specific needs for Support at Home?

Mr Sadler: That's the theory behind Support at Home. The trouble is that the way the government designed the system reduced the flexibility that providers used to have under the Home Care Packages Program—so, now, providers don't have flexibility to move the types of service around within the package; they have to follow the prescribed services dictated to them by the assessment service via their notice of decision and the support plan that is developed by the assessment agency. The older person's ability to choose what services they wish to have is limited, but so is the flexibility of the provider. In theory, an individual budget model should produce the outcomes that you describe and allow a service to be tailored for the individual's needs, but that's not how the system has been designed and implemented.

Senator WHITEAKER: You talked about some of the challenges in terms of nutrition and how we ensure that older Australians are having their nutritional needs met in a genuine way, rather than just providing them with a meal and saying, 'Well, there you go; that's our job done.' I'm particularly interested in CALD communities. We've heard quite a bit of evidence over the course of this inquiry about some of the specific challenges in those cohorts on accessing care and services that they provide. I'd be keen to hear from you about how you manage that in your services and what the particular challenges are for those communities.

Mrs Broer: In terms of program design for meal services, I don't see there being significantly different access and service delivery challenges than there were in the previous system in the meal service space. In South Australia, we have a number of culturally specific delivery meal services that work across the aged-care system, and they can continue to provide services there. My understanding is that the unit price of those organisations delivering services tends to be a little higher, partly because of reduced scale. They can't spread their fixed costs across as many outputs. But there are also some additional costs that may be required to ensure that the person can understand the information that's being provided to them. There may be higher costs incurred in providing meals that are familiar for the person. A cuisine that they enjoy and grew up with is often what those people are seeking. My sense is that the input costs for an Italian speciality meal, a kosher speciality meal or an Indian speciality meal aren't significantly different to what they are for a more Anglo-Australian dietary mix that you would see. Most providers are in fact building out their offer so that people do have a range of cuisines to choose from, not just the Anglo-Saxon model that we might have been familiar with in Meals on Wheels in particular in years gone by.

Senator WHITEAKER: Not just meat and three veg on offer?

Mrs Broer: Absolutely.

Senator WHITEAKER: You might not know, but I'm just interested in this. If there are challenges with getting older Australians to meet their nutrition needs—I've certainly observed it in some around me—I imagine it must be even more difficult if they're not able to access the kinds of meals that they are used to eating or enjoy eating. It's just another change in a period when they're already going through significant change, and that can be really distressing. I'm interested in reflections on that as a problem.

Mrs Broer: I certainly feel that it would be creating an extra barrier if a suitable meal isn't provided through one of the delivered meal provider options in a location. I know that the further you get from the capital cities the harder it becomes to meet those specific requirements unless the service is being delivered through informal community supports, informal family carers or other systems.

CHAIR: I thank all of our panellists both for their submissions to the inquiry and for making the time to appear before the committee today. We always really appreciate your evidence. The committee will report to the Senate on 24 November 2026, and we've agreed that responses to questions on notice should be provided by close of business Tuesday 6 October 2026. Thank you very much.

CAVE, Ms Joanna, Chief Executive, Carers Australia

[14:04]

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection and obligations of witnesses giving evidence to Senate committees has been provided to you. I invite you to make an opening statement, and then we'll go to questions.

Ms Cave: Thank you very much for the opportunity to appear before you. Carers Australia is the national peak body, representing more than three million unpaid carers in Australia. Today I want to give voice to the carers of older Australians who rely on Support at Home.

Unpaid carers are husbands, wives, partners, parents, daughters, sons, grandchildren, relatives, friends and neighbours who step in every day to care for people living with disability, chronic conditions or poor health. Unpaid carers are so called because they often combine their caring roles with employment, raising children and other responsibilities. Unpaid carers are largely a volunteer workforce. In their 2020 report Deloitte assessed the annual value of the care they provide as being worth $78 billion a year—the equivalent of $94 billion a year today.

Unpaid carers are the main source of care for older Australians, and are key to enabling older Australians to remain independent in the community. Of those older Australians requiring support, 72 per cent receive assistance from unpaid carers. This means that the majority of Support at Home participants will be relying on an unpaid carer. With an ageing population and many older Australians preferring to age at home, it is critical that in-home aged-care supports are accessible, affordable and effective. The government's answer to this is the new Support at Home program.

Carers Australia supports the intent of the Support at Home program—enabling older people to live safely, independently and with dignity in their own homes for as long as possible is a hallmark of a civilised society. However, and while we accept that the program is still quite new, it is very clear to us that Support at Home is not delivering on this intent.

Every year Carers Australia conducts a national wellbeing survey of carers. This year, because we received an overwhelming number of inquiries from carers worrying about the Support at Home reforms, we undertook an additional survey and asked them about their experiences thus far of the new program. Their answers are confronting: 85 per cent of unpaid carers reported an increased caring workload, and almost 50 per cent reported a decline in their own wellbeing. Carers told us that they are experiencing increased stress, financial hardship, reduced workforce participation and a growing risk of burnout since Support at Home was introduced.

Carers of older people receiving Support at Home told us there is a large gap between their lived experience of this new program and its stated aims. In fact, Support at Home is full of gaps—gaps while people wait to be assessed, gaps while people wait to receive their packages, gaps because their packages don't provide sufficient support. Unpaid carers fill those gaps, but there is a human limit to how many of those gaps carers can fill. Unpaid caring has no defined hours. There is no annual leave. There is no sick leave. Ironically, there is no carers leave. For many people, caring becomes relentless, 24 hours a day, seven days a week. Carers become exhausted, their own health suffers and many reach burnout. When this happens, the person they care for cannot continue to live at home, and inevitably enters residential aged care earlier than they might otherwise have, or end up as stranded patients in hospitals.

There is no doubt that Support at Home is what the community wants; the policy intent is sound. But our central message to you today is simple: Support at Home cannot succeed unless it also recognises and supports the unpaid carer.

Supporting the carer to support the person they care for also makes sense financially. The annual cost of an average Support at Home package is $30,000. That is a fraction of the cost of permanent residential aged care, averaging at about $130,000 a year, and it pales into insignificance when compared to the cost of keeping a frail older person in hospital for a year, which can reach a million dollars. Even at the highest value package of $80,000 a year, Support at Home represents great value for money when compared to the other options. So providing support at home for older Australians makes absolute sense, not only because it's the least expensive way of supporting people in old age but also because it helps manage the demand on the more expensive services upstream.

During this inquiry, you've received evidence about lots of ways in which Support at Home is failing to achieve its policy intent. I'm going to focus on three of these from the point of view of the unpaid carer. First of all, the wait times for aged-care assessments and access to the Support at Home program are far too long. You have heard extensive evidence about wait times for both assessments and access to services blowing out under this program.

The average wait time is 12 months. That is far too long for older Australians needing support. It is also a far cry from the government's commitment to reducing wait times for in-home care to three months by July 2027. Carers responding to our survey spoke about the older people they care for deteriorating while waiting and about older people being admitted to hospital, being prematurely placed in residential care and, in some cases, dying before being assessed or receiving the services.

Extended wait times also impact negatively on carers. While carers step up to fill the gaps, this often involves significant personal, emotional and financial cost to them. Carers may be required to reduce working hours or quit work altogether to pick up the caring load. And, with women making up 70 per cent of carers, they are more likely to bear more of the costs when supports are delayed or not available. A program that requires frail, elderly people to wait 12 months to access services and rely on unpaid carers in the meantime does not help older Australians to live safely and with dignity at home for as long as possible.

Secondly, the Integrated Assessment Tool fails to capture and consider the role of the carer. From the evidence you have heard from Dr Kathy Eagar, you know that, when an older person is assessed by the Support at Home program, the outcome of their package is largely determined by the algorithm at the first stage of this process. In his evidence, you heard Mr Ian Yates describe this 'funding first, care needs second' approach as a back-to-front assessment. We agree. The existence of an unpaid carer is not considered at this critical stage of the assessment.

Indeed, it is not until the second and third stages of the assessment process, when the support needs of the care recipient are considered and the significant compounding factors are measured, that the assessment tool asks questions about the existence of an unpaid carer. Two hundred such questions are asked at this point. They are good, detailed questions that appear to consider carefully the role played by the unpaid carer. However, we now know from Dr Eagar's evidence that the answers to these questions have virtually no impact whatsoever on the outcome of the assessment, which has already been determined by the algorithm before the questions about carers are asked. This is a terrible oversight.

Furthermore, we also learned from Dr Eagar that, to the extent that the existence of an unpaid carer counts at all, the care recipient is in fact penalised by the algorithm for having a carer. At first glance, you might regard this as a reasonable outcome. If an older person has support, surely their care needs are less acute than a person who is completely alone. This might be true in some cases, but what Support at Home fails to do is consider the capacity, capability and sustainability of the carer.

Take this case, where the care recipient is 85 years old, weighs 90 kilos and needs assistance with personal care such as showering, toileting and dressing. He answers yes to the question of whether or not he has the support of an unpaid carer. The assessment tool judges his support needs as lower because of this, but no questions are asked about the carer, who, in this case, is his wife, who is also 85 years old, but who weighs 52 kilograms and has deteriorating eyesight. How likely is it that she will be able to continue to provide care and support her husband to remain at home under the program? We don't know because the assessment tool didn't ask. The carer and the care recipient must be assessed as a team. Keeping the unpaid carer in the picture and understanding their needs and limitations, in addition to those of the care recipient, is essential to the success of Support at Home. As Dr Kathy Eagar said in her evidence, until we consider both their needs, we won't get Support at Home right.

Finally, the reduction in the purchasing power of packages is a real concern. Under Support at Home, available funding does not stretch as far as it did under the former Home Care Packages Program. Higher service costs and co-contributions reduce the support that can be purchased and increase out-of-pocket costs. Carers Australia has heard about service prices rising by between 30 and 50 per cent without corresponding increases in funding. As an example, a carer told us that increased prices meant that he had to cut cleaning services and take on most of the cleaning himself. Others report the cost of Meals on Wheels doubling under Support at Home and purchase prices of simple mobility aids being three times more expensive under the program. Again, unpaid carers are often left to fill the gap. They report either covering the costs themselves or making do without. Older people and carers both feel like they're getting a bad deal under Support at Home. Older people are getting fewer services because of higher costs and carers are stepping up again to do more caring, taking them ever closer to a tipping point.

I'll turn now to what Carers Australia recommends. Support at Home must be needs driven. We must invest more in aged-care assessments and the Support at Home program to reduce the amount of time older Australians are left languishing waiting for supports they need to live safely and with dignity at home. This doesn't necessarily mean more money overall. Natalie Siegel-Brown, the previous Inspector-General of Aged Care, recently pointed to modelling commissioned by her office showing that redesigning home care around timely, coordinated and assessment-led support delays entry into residential aged care and could deliver billions of dollars of savings to the taxpayer.

We can also borrow from innovative solutions to these problems, which have been solved by other countries facing the same challenges. For example, in the UK, the Carefree Scheme releases unbooked hotel rooms to those unpaid carers who provide more than 30 hours of unpaid care a week for a short break. This responds to the needs of carers and is backed by research that shows that short breaks can assist a carer to continue caring. The scheme is much less expensive than traditional respite, is more readily available and is more flexible. In Australia, a scheme like this could be delivered via the existing Carer Gateway service.

In our submission, Carers Australia put forward seven recommendations for improving the Support at Home program. They are to reduce waiting times, improve accountability and program performance, improve affordability, increase flexibility, improve access to respite and make it fit for purpose, review assessment processes and properly recognise and support carers as partners in care. These are not peripheral improvements. They go to whether Support at Home can achieve its fundamental purpose. If Australia wants more older people to live safely and with dignity in their own homes, then we must confront an unavoidable truth. We cannot build a sustainable aged-care system on the unsustained efforts of unpaid carers. Carers share the commitment to helping older Australians remain at home for longer, but the current system is increasing pressure on older people and on the people who care for them. The wellbeing of older Australians and the wellbeing of their carers are not competing objectives. They are inseparable and unless Support at Home recognises this in its design, funding and implementation, it will not deliver the outcomes Australians were promised

During this inquiry, you have heard evidence from many experts demonstrating how Support at Home is failing older Australians. Support at Home is also failing carers. Carers are paying the price for a system that does not recognise their role, a system that does not value their role, a system that does not sustain their role. Unpaid carers are not unwilling but they are unsupported. We implore you to rethink how carers can be better supported so that Support at Home achieves its policy intent for the benefit of Australian society.

CHAIR: Senator Gatenby will start us off with questions.

Senator GATENBY: Thank you, Ms Cave, for your opening statement and the submission from Carers Australia. I want to go into a little bit more detail on a couple of the matters that you raised. How has Support at Home affected unpaid family carers supporting older people at home? You mentioned the increased workloads—I think 85 per cent of people surveyed said the workloads had increased and they had lower wellbeing and more stress—and the impact on the workforce. Is there anywhere where it's more particularly acute that you've seen since the beginning of that program?

Ms Cave: Thank you for your question. It's generally acute, and I make that point because we survey carers every year. The survey that I quoted to you is additional to our annual survey, and we undertook it because we were overwhelmed by the number of questions and comments we received when carers knew the program was coming onstream. We undertook a survey just about the impact of Support at Home, and we were really shocked. Our annual survey is a bit of a dispiriting read at the best of times because it does show declining wellbeing of carers generally, poorer health outcomes for carers generally and poorer financial status for carers generally. The additional survey we conducted around Support at Home accentuated all of those things. So there is no question that this reform is pushing carers to a tipping point. They were already standing on the edge of the cliff, really, and our concern is that this might tip them over.

Senator GATENBY: You mentioned in your opening remarks that the funding doesn't stretch as far as the previous home-care packages did. Can you provide some examples of why that might be. I know you mentioned Meals on Wheels and increased costs of cleaning, but are there any other factors that are really driving that, do you think?

Ms Cave: My understanding is that there's less flexibility with the personal budgets than there was previously. That's one factor. The change to the carry-forward provisions means that, if there are unspent elements for whatever reason, they can't be carried forward and spent later on when perhaps they're needed. And we're bumping into that old issue of price caps having the unintended consequence of driving the costs of things up. Many of the things that people can buy quite affordably outside of the program are hugely inflated within the program. There are several factors creating a perfect storm around the budget issue, but the feedback we get is that everyone feels much poorer under the Support at Home program than they did before.

Senator GATENBY: I picked up that you support the intent of the program, but it appears, particularly from what you've told us today, that carers are not reporting overly positive comments on choice or the person centred care focus. Is there any other specific feedback or are there things you're hearing from carers about those particular issues? Is it the control of their own budget or the change to the carry-forward or anything else in particular?

Ms Cave: To be honest, what carers need more than anything is to be recognised and valued in the system. If that happened right from the very beginning and the care recipient and their carer were treated as a team, or as a dyad as Dr Eagar called them, it would have the potential to transform things significantly. Carers are invisible in this whole system and it's a false economy to overlook them and ignore them. That's the No. 1 request from carers—recognise that we exist, recognise that we know a lot about the person we care for and recognise that we play a very important role and are willing to keep doing that but we need support to do it.

Then, if you were to ask me about the practical measure that carers ask about the most, it is probably in connection to respite. The current respite system is fairly inflexible, offers three- to four-week breaks for the care recipient and the carer that often have to be booked quite a long time in advance, and is very patchily available across the country. It gets thinner in regions and rural areas, so it's not evenly offered. Often what carers need more than anything else is short breaks that are available, often, at short notice—not always, but sometimes—that enable them to recharge, refresh and attend to other parts of their lives so they can keep caring. The current respite system doesn't really address those needs at all, and it tends to only think of the care recipient as needing respite, when in fact the whole point of respite is that it's to provide a break for the carer as well. So there are two things, to answer your question: recognise carers, take account of their role and support them to do it and keep doing it; and probably the No. 1 thing they would like to see improved is respite.

Senator GATENBY: I'll come back to the hotel example you gave before, but we hear a lot about just navigating the system and confusion, especially as people are new to it or it's coming on at a very stressful time in their lives. Where is the confusion in the process most acute for carers?

Ms Cave: Our survey did report carers finding the system extremely difficult to navigate, confusing, complex, overinvolved and having less time with human beings—those sorts of complaints. I can certainly take on notice the question if you want more detail about that, because the survey does provide it, but, yes, there is most definitely a strong theme around the program being difficult to navigate for sure. Bear in mind it's very often the unpaid carer that's doing the navigation, so it needs to work for them.

Senator GATENBY: If there's anything in addition you're able to provide on notice, that would be great.

Ms Cave: Absolutely, yes. I certainly will take that on notice and bring it back.

Senator GATENBY: Thank you. We'll get into the hotel, but I think you recommended increasing investment in assessments and the Support at Home program to reduce wait times. Have you done any costings on additional capacity or what you believe is needed, like that hotel example? Is there any estimated cost from that example you've provided that we could benefit from or—

Ms Cave: Sorry, the estimated cost of what?

Senator GATENBY: The UK program you had as an example and how it may be applied in the Australian context. Have you looked into that at all?

Ms Cave: The UK example is fascinating, and I think we could really learn a lot from its success. Certainly the findings are that it is a fraction of the cost of traditional respite. Carers in the UK system are asked to pay a very modest admin fee to access the program—37 pounds, I think it is—and they get one or two nights in a hotel a couple of times a year. That's extremely meaningful, backed up by lots of evidence that that's what they need. That is a fraction of the cost of traditional respite and the model that we offer here in Australia, which is for those longer breaks.

I should mention that traditional respite often requires the care recipient to go into an aged-care setting. The UK hotel system provides in-home replacement care for the care recipient so that the carer can have a break away from home. So it's quite a different model in that the care recipient stays at home and receives the same sort of care he or she would ordinarily, albeit from someone else, and the unpaid carer has the night or two nights in the hotel at a fraction of the cost. You'll be fascinated to know that the hotel chains donate their empty rooms to the scheme free of charge, so that helps it become so cost effective.

Senator GATENBY: I'm conscious of time, but I know that you've called for the assistive technology and home modification approval process to be revisited or looked at again. What are the main problems that carers are encountering with that, just at a high level?

Ms Cave: The back-to-front assessment is the big problem. The funding package gets determined at the beginning, before the true needs are assessed of the care recipient. That makes no sense to us whatsoever. But obviously, from an unpaid carer's perspective, the fact that the questions are asked about them but the algorithm takes them out of play is a consideration is completely illogical.

Senator GATENBY: I think I'm going to get the wind-up from the chair any second. In terms of an education program—that goes back to that aspect of confusion and navigation. What do you think are the biggest information gaps for older Australians and carers when they're facing this new system?

Ms Cave: Again, I'd probably have to take that question on notice, but I can tell you that we see significant shortcomings around how this program is communicated and placed before First Nations carers who have a requirement that it be culturally safe and appropriate for them. We think that's a big gap at the moment, and that's also for CALD carers. I know you've heard evidence on this issue earlier today. There are some significant gaps there in terms of making this program accessible to the broader Australian community, for sure.

Senator GATENBY: Thank you very much.

CHAIR: Thanks, Ms Cave. Some of my questions have already been asked by Senator Gatenby, which is very helpful, so I won't ask them again. I might go to this one. You report poorer outcomes around choice and person centred care under Support at Home. I'm wondering if you can describe what that means from the perspective of a carer who's trying to put together a package that responds to the actual needs of the person they're trying to support.

Ms Cave: That can show up in lots of different ways. But it's often those awful, constrained choices that carers have to make. 'Do we cut the cleaning service because it's now unaffordable, so that we can keep Meals on Wheels? Okay, that means I have to do the cleaning'—which might sound fine, but it depends on what that carer is like, including how old they are and how capable they are.

We talk about carers being faced with constrained choices the whole time. They're often a carer through a situation that we would describe as a constrained choice. Exactly the same applies to the program. It's all the time weighing up: 'What can we afford to do without? Do we improvise a bit of equipment? Do we not bother with it? Do we manage without it? Do we cut some services?' And whenever that happens, whenever it's a question of service, it is the carer that steps in to deliver it—every time.

CHAIR: I'd like to come back to the comments you made around the integrated assessment tool and the way in which it on the one hand considers carers but on the other hand doesn't. And I'm interested to understand—I take your point where you've said that it asks if there's a carer, and then automatically, as Professor Eagar has indicated, you get thrown to the lower levels. But then when it asks all these detailed questions about the carer, that doesn't really factor in and doesn't help you get further back up the levels. You've already been thrown to the bottom of the tree. Do you think the carers should be considered at that point? Let me rephrase that. From my perspective, there are two ways that the tool could deal with that. The first way is that those detailed questions that get asked at the end get front-loaded into the system so that there's more consideration given. It also occurs to me, though, that that also expects that people need to be doing unpaid caring in some respect. I just wonder, would it be a better process if the tool didn't ask a question at all about whether there was a carer, so that the assumption is that if you've got someone who wants to help from time to time—great. But it's removing the burden on people having to provide that care.

Ms Cave: I think it's really, really important that carers are recognised in this system, because they'll always be in it. You heard about the value of unpaid carers. Is the government going to find $94 billion a year to replace that? We don't think they are—apart from which, carers are not unwilling. They often have an emotional connection to the person they're caring for, so they're absolutely willing to provide that support.

Where it goes terribly wrong, and how this program will fail, is if their part in it is not recognised. So we would say put the questions about carers in the assessment at a point where it counts for something. It's perfectly reasonable to consider that if someone has an unpaid carer, that's helpful support. But what is critical is that we understand the capability, capacity and sustainability of that person. You heard the example I gave. If we were doing that assessment, we'd probably all take the view that it would be foolish for us to rely on the wife in that situation to be able to keep supporting the person to live at home.

If the objective is to keep that person at home—and you heard Dr Eagar say two years is the average—then we need to extend the average to three or even four years of an older Australian living at home, in order to manage the costs of the much more expensive services that happen upstream. In that case, there is no way of achieving that without unpaid carers, and there is no way of achieving that successfully without assessing the needs and limitations of those unpaid carers.

Put the questions in a place where they count for something. We would most definitely say: ask about the carer, understand their role and support them appropriately. If respite service would help them to stay caring longer, that's a good outcome for everybody. It keeps the person in the home, it keeps the carer from burning out and it manages the impacts on those more expensive services.

CHAIR: Do you have data from your specific Support at Home survey on how many of the people who are providing unpaid care are partners of older people as opposed to children and younger people who potentially have had to come out of the workforce to provide that care? Because I would imagine that they're two quite different scenarios; someone having to leave work to care creates quite a different kind of burden to a retired couple where the other partner is providing care.

Ms Cave: We do have that data. I don't have it here, but I'm very happy to provide it to you. You're right; they're two differently shaped problems. If an older Australian is depending on an older Australian for unpaid care, you can see the potential limitations of that arrangement. That's why we say it's very important for that to be accurately understood.

If an older Australian is depending on the support of one of their adult children, the sustainability of the practical caring arrangements might be more feasible. But if that person has to leave the workforce to do it then we have a whole other problem. What does it mean for productivity? What does it mean for the community if people are having to make those choices? They're two differently shaped problems. Both are important to understand in the context of unpaid care.

CHAIR: If you could provide that breakdown, that would be very useful in helping us understand the context around who's doing the unpaid care.

Ms Cave: Absolutely.

CHAIR: You talked in your submission about the performance and accountability framework. I'm wondering whether you have a view on the specific outcomes that a performance and accountability framework for Support at Home would need to measure to actually be meaningful. We've heard from other submitters. We know that the department is calculating how many people are on the waitlist and who gets a package. What's your view on what other information really needs to be understood?

Ms Cave: We would agree with those comments. What seems to be a little bit missing in all of this is true transparency around accountability. We would really want to understand the true shape and size of wait times in all their manifestations—whether people are waiting to be assessed or are on interim packages and are waiting to be reassessed or are waiting for services. I think that should be transparently communicated to the community.

We would like to know what kinds of compromises are consequences of the program. That forms part of the accountability assessment. With those difficult and constrained choices, what are the consequences on the intent of the program—to enable the older person to stay at home—and on their health and whether that deteriorates? What happens to them as a consequence of those constrained choices?

Then, in common with other programs that impact on unpaid carers, we would really like to see closer attention paid to pricing. We think pricing caps can have an unhelpful, unintended consequence of creating a race to the top, and we've seen that we've got stacks of examples in the survey of people paying over the odds for things that they can buy outside of the program much more inexpensively. That's not good value for the taxpayer, and it's another constraint on the package. So there are some areas that we would really like to see under the microscope a bit on that accountability piece.

CHAIR: I note in your submission a view that the current quarterly carryover cap fails to enable carers to manage fluctuating need. I'm wondering if there's a view from either your organisation or the people you've surveyed as to a limit that would work better. Are people suggesting removing the caps on what can be carried over? Are they suggesting a different percentage? What sort of information are you getting?

Ms Cave: Remove the cap please, because some of those costs require long-term planning. Respite is a perfect example. You can be tripped up by the carryover limits. So remove the cap.

CHAIR: Thank you. That's all I have for questions. I'm just going to double-check—I don't think any other senators have questions for this panel. No? No-one's jumping in. Ms Cave, thank you very much for both your comprehensive submission and making time to give us evidence today. The committee will report to the Senate on 24 November 2026, and it's agreed that responses to questions on notice should be provided by close of business on Tuesday 6 October 2026. We'll now suspend for a short break.

Proceedings suspended from 14:41 to 15:02

BOWEN, Mr Timothy, General Manager, Policy, Ageing Australia

SYMONDSON, Mr Tom, Chief Executive Officer, Ageing Australia

CHAIR: Welcome. Thank you for appearing before the committee today. I understand that information on giving evidence to Senate committees and the obligations of witnesses has been provided to you. I'm going to invite you to make some short opening remarks, and then we'll go to questions.

Mr Symondson: Thank you for the opportunity to appear today. We all know that Support at Home was supposed to carry a simple promise, which is that people would get the care that they needed when and where they needed it. We hope that that is still the intent. It's certainly, from the provider sector's point of view, absolutely the intent of the reforms. But, with over 100,000 people waiting having been approved for a package, around 100,000 people waiting for an assessment just to get onto that list and more than 50,000 people only receiving 60 per cent of the funding of their package level once they get to the front of that queue, I do not think we can safely say yet that people are getting access to the care they need when and where they need it.

We have seen waiting times come down over the period of time since 1 November, but we still believe we are far too far away from the recommendation of the royal commission, which was that nobody should wait more than a month, and also the government's own benchmark, which is three months. That is still a long way below that median, which we are now seeing, at the end of June, at 297 days—and that is a median, so there are obviously a very large number of people who are waiting longer than that.

We know that the longer people wait for appropriate levels of care—if the assessment process has awarded them appropriate levels of care, which is not always a safe assumption—the greater their needs become, particularly those with high levels of need waiting long periods of time. Unfortunately, the knock-on is why we are seeing such an increase in the number of older people in hospitals and the demand for residential care not declining in any way.

We have put forward a number of recommendations in our submission that you will no doubt have seen, but essentially what we want is to see qualified clinical human judgement at the centre of deciding what level of care someone needs and should get. We want to make sure that urgent circumstances, whatever they might be, result in urgent access to care. We want to ensure that, when funding is allocated, all of the funding is allocated. The minimum service offer should not still be in place. We need to make sure that care is affordable and it does not deter people from seeking that care or deter providers from providing it in the first place. For the first time in the history of home care, home-care providers are now on average losing money on every single package. We are still extremely hopeful that the promise will be realised. But, unfortunately, for far too many people at the moment it is not being. I'm happy to take any questions.

CHAIR: Do you want to kick us off, Senator Ruston?

Senator RUSTON: Yes, sure. Thank you very much for your incredibly detailed submission. I don't know how much time your organisation must spend writing submissions to inquiries of this parliament. I'm really keen just to get a broad overview. What are the most significant operational challenges that your members are telling you they are facing under the Support at Home program?

Mr Symondson: There are a lot of operational challenges. Some of those have died down a bit since 1 November. There were huge issues with claiming in the early months. There is still a bit of that. We have worked very closely with Services Australia to try and sort that out. There are still problems. Now the bigger concern for the average provider is the huge fall in utilisation rates of packages, which, I think, is largely behind why those profitability figures have now gone negative. It's because people are using less of the package.

We still struggle a great deal with care management. In the first quarter of someone being provided services by a provider, they cannot claim any care management and that's the time when you need it the most because you're onboarding people.

The minimum service offer at 60 per cent is also causing a big problem, particularly if someone has waited a long time to get that package or they have been reassessed and they're going from, yes, a lower package but actually potentially to a lower amount of money in their new package because they're only getting 60 per cent of it. So you're seeing people come in with much higher needs than the package is designed to meet because those people have declined in the time it took for them to get a package. That's causing an awful lot of challenges for staff to deliver care to the level of quality that they are required to deliver within a very small funding envelope. That's particularly in that first quarter but actually ongoing because we're seeing people coming in with a lower level of package than their needs suggest they should be getting.

Senator RUSTON: You said there's been a huge fall in utilisation rates. Have you had the ability to quantify that to any degree?

Mr Symondson: There isn't any government data on this that's yet been released. We would very much encourage the government to release it as quickly as possible because it's unhelpful not having it. But StewartBrown have assessed it at, I think, 62 per cent. That compares to a number pre 1 November hovering around the high 80s. It's only up to the end of March, so there are some provisos around that. The system was new. People might have been behaving differently than they will ongoing in terms of what services they take up. But that's still a very significant fall.

Senator RUSTON: Absolutely. You've made a recommendation that the national objective should be that people only wait for four weeks to receive access to care—that's from point of assessment to actual receipt of care. In your analysis of your members, do you have any line of sight over the current waiting times—mean, median, average and outliers?

Mr Symondson: Only what was publicly released in early August, going up to the end of June, where the median time had come down to 297 days, which is still 10 months. It means that obviously a very significant number of people are waiting longer than that. So we're a long way off getting to the government's three-month target. We'd be delighted to see them get to that. We still think that is too long. It should be 30 days, but ten months is the median. We still hear cases of people waiting much, much longer than that, even for very high levels of care.

Senator RUSTON: That's why we need to understand the outliers as well and the reason for the outliers. Is it your understanding or do you know—previous to the change to Support at Home, if you were on a package that was lower than the level you'd been assessed as needing, you remained on the national priority system until you actually had been allocated the package that was at the level which you'd been assessed as needing. We now no longer do that, and we go with these MSOs. I'm interested to understand whether you know if, when somebody is granted an MSO, they remain on the national priority system or if they come off at that point in time?

Mr Symondson: My understanding is that, when they get an MSO, that just converts into 100 per cent and you're no longer waiting, technically, which is why they're not included—

Senator RUSTON: So you would no longer be on the list? My question then is, if you've got—we know there are about 52,000 Australians at any time that are on a minimum-service offering. That's 52,000 Australians who previously may have been receiving a package that was of a lower level, but they still would have been on the national priority system. Do you have any idea of how taking people who, previously, were staying on the national priority system—they're now doing exactly the same thing to them, in effect, but they've taken them out of the national priority system. What might that do to the wait times that are being listed as the times that people are waiting? If you take 52,000 people out of the national priority system and pop them on a minimum-service offering, they're not waiting on the system any longer. What's that doing to the statistics? Are the government really telling the truth when they say that the wait times have dropped?

Mr Symondson: There are 53,718, as at the last report, that are on an interim funding—

Senator RUSTON: How many?

Mr Symondson: 53,718, and those people are not included in the—I think it's gone up to this—107,000 on the waiting list as at the end of June. They're also, as far as I'm aware, not included in waiting times data. It's quite difficult—we think that the average amount of time people spend on the 60 per cent is 10 weeks, but we know that some are on it for a lot less and some are on it for as much as 18. That's a completely separate number. It's why, when we quote the waiting list, we will include those people. In our view, they are still waiting.

Senator RUSTON: So the 10 months that the government claim that they've got the wait times down to—in effect, there are another two and a half months, if you actually put these people that were in there previously back into the system.

Mr Symondson: We would like to see those 53,000 or so people included in public data so that people can make that judgement, because, at the moment, it's quite challenging.

Senator RUSTON: It does seem a little tricky, to say the least. You're also calling for stronger accuracy, clinical oversight and urgent access under the single assessment system and IAT. Based on the feedback that you've got from members, what percentage of people, anecdotally, do you believe are receiving inaccurate results either in relation to classification or prioritisation?

Mr Symondson: In terms of classification, I only have anecdotal evidence. I don't have any data I'm afraid. We do regularly hear of people appearing to have a lower level of package than their needs would dictate. Some

of that will be because they've waited a long time, and so the assessment was 10 months ago, and their needs have increased in that interim period. Some of it is because they got a lower level of package than they should have. We've, I think, quoted some cases of people who get reassessed, and they might only go up one level, and then that package doesn't include something that was included in the previous package, like physiotherapy. You have to get it back in again through a convoluted appeal process. We are seeing it.

I'm told that the average value of packages post 1 November is similar to the average value of packages awarded pre 1 November. The problem with that is they probably weren't high enough pre 1 November. That's why we added higher level packages under the new reforms. I don't think that's a good metric. The sense that we get is that a lot of people are coming in who need more than we can provide. Some of that is because the package values haven't gone up as fast as the cost of living has. Some of it is because they were underassessed. Some of it is because they've waited too long. But it is very difficult to tell which one it is, because the data is relatively poor.

Senator RUSTON: Yes, absolutely. Do you have a view or a framework of the kind of data that you believe would be beneficial for you to be able to make the necessary assessments and have the level of transparency to really understand what's going on? I've been pointed to by COTA a series of points. There are different sets of data in terms of the waitlist for Australians. There appear to be all sorts of places where the data is incomplete, so you actually can't get a genuine number of people or a time from the point at which the person requests an assessment through to when they actually have somebody walk through their front door to start delivering care. Because of the various opaquenesses of the process, you can't get that. Do you have a structure that you would like to see the government provide in terms of the data that you think is missing?

Mr Symondson: The first start is for what data is currently released to be released much more regularly. There are three very different stages. They're how long it takes you to get assessed, how long it takes you to get approved for a package, how long it takes you after you get a package to receive services, and, if you're on a 60 per cent MSO, how long you're on it for. We get medians. Sometimes we'll get ranges. We don't have geographical data. Is it better in Melbourne than it is in Sydney? Is it better for certain types of service than others? Are level 1 packages more?

I've recently heard of an example of someone who had been approved a level 8 package. Very few people are, by the way. I think many more people should get a level 8 package. They'd been waiting eight months for that package. My view is that if you're approved a level 8 you are probably by definition urgent even though the urgency categorisation doesn't think you are unless you tick certain other boxes.

We want to know all of those things. The other thing we as providers need to know is—we can't just ramp up our services on the hope that someone will apply for a package. We still don't know where packages will be released. We know on average how many are released each week or each month. We don't know whether there'll be more in Perth or more in Hobart. Getting national figures is relatively unhelpful for a provider to know whether to put on more staff. With that decline in utilisation rates, we're potentially in a position where we might have to let staff go because we haven't got enough utilisation to keep the people we have got.

We need to understand where and when. What we're told is that it's based on the priority queue. That's fine, but we don't know who's on that queue or where they're from. Some weeks, we get feedback from WA providers. There have been a lot of packages released this week in WA. We don't know why. Forward planning on that is very difficult, and we think that the government should help us with that.

Senator RUSTON: Support at Home is a standalone program, but it integrates with everything else that actually happens within somebody's community. How well do you think Support at Home has taken into account other things within someone's community, like access to housing, other services, primary care, allied health and community organisations? Do you think there are any gaps in terms of the way Support at Home fits into communities or particular types of communities?

Mr Symondson: As a national system, it is a bit one-size-fits-all from a policy perspective, and its providers often are trying to do what you're saying and align it with other programs that exist. Where you're a provider that delivers CHSP, Support at Home and residential, it's potentially easier for you. But the system as a whole does not take those things into account. It does not, for example, say that you will get more funding if you're in an area of lower levels of service, because that's not how the system operates. You do not get allocations for people with dementia. We don't prioritise people with dementia in the way that we rightly do with people with MND. We don't prioritise access to services for people based on what they've experienced in the past, only their status as it is now. The system is completely deaf, from a policy settings level, to what else is going on in that community. It has no way of responding, other than asking the provider to do so, which we try to do.

Senator RUSTON: I'm interested in your views around care management. How do you think the concept of care management, and the perception of care management as a result, can be improved or strengthened from where we are at the moment, where it constantly keeps being raised as a challenging issue?

Mr Symondson: The first thing is that we need to stop thinking of it as a place where admin tasks are done. I think it's still got this reputation of being just an admin charge. Admin charges have been banned and they now have to be part of the unit price. It's one of the reasons the unit prices went up so much. Care management is generally, not entirely, a clinical process where you are supported to understand what services you can access, what might be able to be done to improve your condition, to help monitor as your needs change and to respond to questions about your services on a clinical basis. Increasingly, care managers are now just supporting people to navigate through the system, which is not what care management was supposed to be for. It's supposed to be about managing your care with that provider, with those particular services.

The other problem we've got is that, pre 1 November the average amount taken for care management was, I think, about 17 per cent. We had to cut seven per cent of it out in order to get to 10. Because of the way that it's pooled and the way that you now have to justify, essentially, every minute of care management that you do—which you didn't used to have to do—a lot of providers aren't even able to claim the 10 per cent because we haven't caught up culturally. A lot of our care managers who are nurses and clinical staff are saying: 'Why on earth would I have to explain that? I'm trying to support this person to get a good outcome, and suddenly I'm spending X amount of my time trying to justify every moment of that.' That's a cultural change piece for us, which we haven't yet caught up on. I don't think we should have to, but that is what the system requires us to do. We're actually seeing people claim less than 10 per cent because we haven't yet been able to get our care managers to stop delivering in the way that older people want them to, and to instead deliver in the way that a lawyer does, five minutes by five minutes. Unfortunately, that's on us. We haven't been able to catch up with that, but it's hiding something, which is that 10 per cent simply isn't enough.

Senator RUSTON: It sounds like the bureaucracy's gotten in the way of the care. We've heard through this inquiry and elsewhere that there are concerns about the Assistive Technology and Home Modifications scheme and the whole process that sits behind that. Do you have a view about what changes are needed to improve access to these really important supports for people's ability to stay at home? Have you got any concerns about the way the program is currently operating?

Mr Symondson: Yes, we do have concerns. There are a whole range of issues. We should be able to, much more rapidly, provide access to urgent assistive technologies, particularly relatively cheap ones. Walking aids and those kinds of things can still take absolutely forever to get access to and cost far too much through the system. We need to make sure, if someone's being assessed and approved for assistive technologies allocation, that they've got a package as well because often you get one before you get the other. A provider will say, 'I can't deliver you services because you don't have a package yet.' The potential client will say, 'But I do have an allocation for assistive technologies.' And the provider will say, 'Yes, but until you have a package, we can't deliver that to you.' These are the kinds of artificial things that should not be in our way. We genuinely need to make it easier for people to get the assistive technologies that they need. We need to accept that sometimes they're going to need more than the cap allows them to have—maybe not by that much—to allow them to stay living at home independently. Unfortunately, the inflexible cap will mean that, for some people, they will not be able to stay at home independently because they can't find five or $10,000 that, frankly, for the taxpayer, would be a much better investment than a bed in a residential home.

Senator RUSTON: Do you have any data about the cost of some of these assistive technologies and home modifications and the cost that is being applied to them through the system, as opposed to what the market price is if you just ring up an AT supplier or home mod provider and get the services directly from them? Are you hearing stories about providers of these supports and services actually saying, 'Are you on a Home Care Package?' and where, if you're on a Home Care Package, they quote you a different amount of money than if you're not?

Mr Symondson: Only anecdotally. One of the main things for us is actually less the price of the technology; it's the price of us providing it via an OT assessment or multiple visits to the home when—

Senator RUSTON: So it's the requirements that are placed on the provider in order to be able to sign off to say the person needs that particular thing that's the cost?

Mr Symondson: Yes. OTs, in particular, are a very expensive resource. They have been forever, but the requirement for us to assess what that person needs, how to do it—and what we will often get is, 'I could have gone down to the local NDIS shop and bought that cushion or that walking stick for much, much less.' And the answer is: 'Yes. Unfortunately, we can't do that. We should be able to, but we can't.'

Senator RUSTON: Is there a sensible system whereby fully qualified, accredited healthcare workers should be able to make some determinations in relation to older people's needs without having to go through this whole gold plated process that costs a squillion dollars and takes forever? The thing that probably horrified me more than anything else during Natalie Siegel-Brown's address to the National Press Club was when she told the story about the chap who was recommended by his doctor to get a pair of crutches that would have cost him 50 bucks if he'd gone down to the local chemist shop. Eventually, three months later, he got them. They cost $1,800. Do you have a view about how we could better use existing, fully qualified, registered and accredited health services to be able to deliver this more efficiently?

Mr Symondson: I think we should just allow them to. At the moment the problem is that the requirement on us is to go through a very compliance-heavy process to ensure the good use of taxpayers' money, and it unfortunately has the opposite outcome. I have spoken to older people who have said, 'We've gone fully self-managed because it was the only way to squeeze as much as we needed out of our package. We don't want to be self-managed because it's too much work.' So, what we're potentially doing is forcing people to go into a self-managed environment when they didn't want to. If they want to, fine. But they don't want to go into it because it's a way to get things without those decisions being made for you.

Senator RUSTON: I'm sure I'm going to be told I need to wind up, but I'd be really keen to understand, even if you can't do it now, how you think an efficient system, under those sorts of circumstances, could actually operate.

Mr Symondson: That's a very large question. We can probably provide some ideas. I don't want to make them up on the spot.

Senator RUSTON: No. But that would be really useful, because it seems terribly inefficient. The other thing is around whether you think that the current model for the end-of-life pathway is adequate and whether you had a view on that.

CHAIR: You have another three minutes if you want to ask a question.

Senator RUSTON: If you could think about the last question, the—

Mr Symondson: I didn't hear all of it. What was it?

Senator RUSTON: It was following on from the conversation we were just having about actually using the existing systems—existing resources, existing professional registered accredited personnel—to actually make the system work efficiently instead of repeating everything and gold-plating everything to the highest possible standard you could imagine. Particularly in issues of assistive technology and home modifications, or some of that lower level care as opposed to higher level care, could the existing, normal systems that operate within our communities and our healthcare system be better utilised to more efficiently and effectively get cheaper and quicker access to care and bypass all of these convoluted additional systems? I'd be interested if you've given any thought as to how that might actually translate, as a system, on the ground.

Mr Symondson: Absolutely, and the answer is that, undoubtedly, we can. At the moment, one of the challenges we've got is, obviously, that we're still implementing a new system, so some of it is a little bit unknown, but we definitely have seen a drastic increase in the amount of compliance activity that takes place delivering a service post 1 November as compared to pre. We know that a lot of the professional groups are saying that they've seen their members, whether it's nurses or allied health professionals, report higher amounts of their time being used on paperwork. I have no issue with accountability mechanisms, but they have to add value to somebody, preferably the older person, and we're not seeing that translate. In the healthcare sector, there is generally an understanding that if a piece of regulation or reporting is not adding any value it is removed; having worked in that sector, it didn't happen immediately but that generally was the principle. In aged care, unfortunately, we add and add but very rarely take away, for fear of being accused of doing something terrible—but we are starting to reap what we sow with that, which is why you are seeing these outlandish examples. I think we have to have a bit of bravery and say we're willing to take a bit of risk as a system again, from government to community to providers to whoever, to remove some of this stuff that doesn't add any benefit. An $1,800 process to assess whether someone needs a $100 mobility aid is clearly not what anybody intended.

Senator RUSTON: It's hardly giving choice and control to the individual either. Do you think the end-of-life pathways, as they are currently designed in the model, are adequate or do you think more should be done to support Australians in the last weeks of their lives?

Mr Symondson: This is one of the great things about the reforms—that there is an end-of-life pathway. That is a good thing. Extending the amount of time you can access it was also a good decision. We are still seeing—and members tell us this regularly—people not being approved fast enough. If you need to be on a palliative care

pathway, you need it within hours, not days or weeks—48 hours, let's say—and that is not always happening. We also know that, whilst the amount of time you can be on that pathway has been extended, the amount of money is still a fixed amount of money—and if you need more than that, you're not adequately catered for.

Ultimately, we always say—and this is something that's causing great trauma to our staff—that if you fail someone in their last months you don't get a do-over. We're also seeing trauma in our frontline staff because, yes, it's terrible if you can't provide ongoing services to the level that person needs, but it's much worse if it's as they pass away. We're seeing a moral or ethical injury, almost, taking place because people are not able to provide those services in the way they think they should be provided to someone at end of life. The current situation is a massive improvement on what we had before, but people not getting what they need quickly enough is still happening.

Senator RUSTON: Do we have any line of sight over the length of time it is taking? I understand that it's varying lengths of time, but do we have an average time that somebody waits from when they've been determined that an end-of-life pathway is the appropriate pathway, and how quickly they are able to get access to that?

Mr Symondson: We don't, which is why we think it should be built into the program design—that it's, say, 48 hours to 72 hours. On the whole, people receive that care relatively quickly, but 'relatively quickly' is not good enough, particularly if it's a rapidly deteriorating condition that requires pain management. Often what will be said is, 'The states are responsible for that,' but not all the states have particularly strong community based palliative care services, and in some states we have waiting lists for those services. We don't have an average, but we know anecdotally that some people wait much longer than 48 to 72 hours.

Senator RUSTON: Thank you.

CHAIR: That brings us to the end of this panel. We ceded our time to Senator Ruston; she's doing such a good job asking questions for all of us. Thank you very much for your detailed submission and making time to appear before the committee again today; I know we've received several submissions from you across several inquiries, and we appreciate the evidence you bring. The committee will report to the Senate on 24 November 2026. It's agreed that responses to questions on notice—and I think you took a couple, Mr Symondson—should be provided by close of business on Tuesday 6 October 2026.

Margaret, Private capacity

Mary, Private capacity [by video link]

Philip, Private capacity [by video link]

[15:36]

CHAIR: I welcome our lived experience panel witnesses. This session is an opportunity for the committee to hear from members of the community about their lived experiences. I remind the committee that this is a listening exercise for us. I would like to remind everyone that this is a public hearing and these are formal proceedings of the Senate. So we'll be conducting it in an orderly and respectful way. I would also like to remind witnesses not to disclose any personal or private information, such as your full name, date of birth or address, because we are livestreaming and, once it's out there, we can't get it back. I now invite you to make your statements. I think there is around 10 minutes each. Philip, let's start with you.

Philip: I thank you all for the chance to talk to you and hopefully guide you in the right direction. For myself, I have been in the system since I was young. That's starting from the home community care to disability care and aged care. Under the new act, the Support at Home program has been a very big move in the right direction to allow us to live a life at home. That's improving our lives and service delivery compared with the old act.

But, in saying this, there is still plenty of room for improvement. Under the old act, money went to the service providers, who would then decide on the services that we got. It was classified then as block funding. So they would hold on to the money. My case manager from my previous service provider would say, 'We are a business to make money first; it's not about the client.' This was made very clear to me by my old service provider.

I am a forgotten Australian, but I am a strong advocate in ensuring the system works and is not ripped off. In 2019, the Department of Health and the Australian government created a book called *Caring for Forgotten Australians, Former Child Migrants and Stolen Generations*. This was for the aged-care services, but I've never seen it implemented. Even today, seven years later, they still do not know what forgotten Australians are or what childcare leavers are. The communication that is going out there is not 100 per cent. I was at a disability forum the other day, and we had your Department of Social Services there from the National Redress Scheme. I recognised them straight off, and one of them recognised me, so it was good to see them at the disability forum. I'll give you credit there.

With my current service provider, I'll give them a four out of 10 star rating. But, to my case manager, I'll give her 8.5 out of 10, because I know she's overworked and she's struggling to meet the demands required by the service provider. When I was a case manager, we had 15 to 25, maximum, people to look after. I know she's got more than 50. That's just too much, because there's no way they can do the home visits correctly, and that's something I would like to see brought back in. The golden rule, as I say, is communication, and this is not happening. From assessment to service delivery, you need to talk to the person at their level and actually listen to them. Don't presume or judge us by our looks or by our voices.

I'm still waiting for my 11 months of statements. I'm still waiting to be reassessed from the old act to the new act. Once this happens, I can claim my lifestyle. I've missed a year of meetings with my federal minister and also my state minister, because they know I keep them honest. Along with the support meetings with Open Place and the RSL, I would like the Senate to get rid of the 48 hours notice to cancel a shift. Service providers can cancel the shift in one minute, four minutes or four hours, but no-one can tell me when I am going to go into a code 1 medical emergency. If I get a flu or a cold, they want me to go to the emergency department, get admitted and then provide them with a written statement. That should apply to them if they want that. So I would really like you to take a very close look at that clause and get it taken out of the service agreement.

You can see my social life has dropped. My garden and lawns are overgrown. The service providers, the carers and support workers need to understand what's going on. So this leads me to ask that you also get rid of the 90-day rule for complaints. Wait until the service provider and our advocacy and the client agree that the complaint is closed, and do not close a complaint on an advocate from OPAN without even telling her or telling me. That's why I will not put the advocacy service in jeopardy with the department of aged care again. I would rather take them on myself, being a former public advocate officer. The stress and extra workload for OPAN and the state advocates need extra funding to help both you as the Senate and the government to help us and the department to deliver a better and higher level of service. The carers, whether paid or volunteer, are the backbone to the whole system, because without them the system breaks down. The carer is there to help us with little things and carry the heavy things, and behind each task is compassion. Every routine is patience, and every tired moment is care. This is a professional service of strength and hope for all of us.

Learn—I would like to see a lot more learning from Dementia Training Australia brought in, so they know how to communicate to people and understand the behaviours of different people, because we're all different, and we're unique. Remember these four: remember, reflect, recognise and respond. These break down the barriers for all the elderly, disabled, First Nations, forgotten Australians, healthcare leavers, the LGBTQ and anyone else who is using the aged-care service.

I know from past experience you won't get things right within the first 10 years. You take time to implement the new strategy. It's like the NDIA and the NDIS. I was working with Julia Gillard and Kevin Rudd. I just hope that the aged care learns from all of this.

Now, the pricing I am worried about, because things have gone up so much. Now, you ask the question to one of the others about the ability to buy things. I would prefer to see the small stuff—knives, forks, pick-up sticks and all that—be exempt, and we can use our funding for that, because you're only looking at around $500 for them. I agree the OT is very important, but, like my new wheelchair, which is $57,000, that's got to be justified.

On home modifications and maintenance, the price that I got given for the bathroom—that's a rip off. So there's no way I will allow my service provider to use $46,000 just to take my bath out, because I know it doesn't cost that. I designed a disability house, so I know what it takes and how much it roughly costs to build a 26-bedroom respite house.

In saying that, I'm not going to go on too much, because you've got Mary there waiting patiently. I thank you very much for your time and thank all the other senators as well, and I just hope everything goes well for you. I'll sign off now.

CHAIR: Thank you very much, Philip. I'm now going to go to Mary.

Mary: Good afternoon, everyone. Thank you, senators, for the opportunity to provide lived-experience evidence today, I'll be reading, I hope you don't mind, but it's a better use of the time.

CHAIR: That's fine.

Mary: In my brief statement, I'll open with an introduction. Then I'm going to refer specifically to two of your terms of reference and conclude with some recommendations that I hope you will consider. My name is Mary, as we've said, and I'm speaking to you from Brisbane, Queensland. I'm a systemic advocate for rights based care. I'm also carer and attorney, under enduring power of attorney, for my brother David, who's 65.

David is a neurodiverse disability pensioner living in public housing on the Sunshine Coast in Queensland. David has been transitioning since 1 November 2025 from 10 years on a home care package at level 4 to Support at Home. Two months ago, a local ACAT team member called me to say David's Support at Home reassessment was pending, telling me that the IAT would be used. That was it, and so far I've heard nothing more. Based on what I've heard and the conflicting information available to us, I'm considering refusing the assessment—should it finally arrive—as we think it may not result in an accurate measure of David's increasing care needs.

I hope you're able to see the two photos that I've tabled for today's hearing—I did provide them to the secretariat—and a number of documents which perhaps provide context for today's meeting. The first shows me with David last year in the ICU, in November, and I'll talk about that later. And the other shows him at home with his wonderful nurse navigator, whose service is provided through local community and preventative health.

My mother, Patricia, who died at 96 from advanced Alzheimer's, was cared for entirely at home by family and teams of carers. The dignity and safety provided to her by in-home support in those pre-Home Care Package days is what drives my advocacy for it today. As a JP also serving at a major Brisbane hospital, I often witness enduring powers of attorney where older people invariably express a wish to remain at home over being discharged to aged care. That's on page 2 of the Queensland enduring power of attorney form.

Let me add here that, as attorney, with my sister, for David, under an enduring power of attorney, I'm also doubly challenged by what seems to be a flawed system that prioritises financial entitlement and algorithmic assessment over clinical judgement. My sister and I—both of us are over 75, by the way—have the ongoing responsibility of ensuring that Support at Home services meet David's current and future needs. But we also have our own aged-care requirements to plan for. As former directors in the Australian public and private sectors with some critical insight and judgement, we hope, not to mention years of experience in caring for David, we're worried. It looks like the clinical judgement used previously in ACAT's assessments for home-care packages has been replaced by an algorithmic tool that cannot possibly capture the nuances and changing care and psychosocial needs of older people like us.

Now to the terms of reference—I refer to (a) and (f), where (a) is 'the ability for older Australians to access services to live safely and with dignity at home'. I refer you to the letters that you have in front of you—in

particular, the one from David's GP, which gives in detail, I think, a clinical approach to what we're dealing with here. The other is a letter from Services Australia basically saying that David, as a full pensioner, will not be required to make a co-payment.

My brother David is a survivor, with his complex medical and mental health history. In the 1960s, the term 'neurodiverse' didn't exist. He is lucky to be alive, and for that we're thankful for the Medicare services and the other Australian and Queensland state government funded services that have supported him—and us, in our care of him. He currently receives funding under the transition program for 16 hours of care a week. However, his days are spent primarily sitting watching anime on TV—that's his favourite. Because he lives in public housing in regional Queensland, my sister, from Sydney, and I, from Brisbane, regularly use telehealth with his GP and other medical, community-health and hospital-outpatients teams. This is setting the scene for you.

David is an insulin-dependent type 2 diabetic. We've just found out he has a 99 per cent potential risk for glaucoma, which is in the family, although his eye health is good at this point. With chronic leg ulcers, amputated toes and limited mobility, not to mention poorly managed blood-sugar levels and recurring bouts of diarrhoea, David is a clear example of why the many older people like him need to access increased services to live safely and with dignity at home. The care David needs as a full pensioner would cost the taxpayer a lot more in residential care.

I refer you to the ABC's *Four Corners* investigation 'The Waiting Game', aired on 17 August 2026, which exposed serious flaws, I think, in the Aged Care Act reform and the software deciding the support levels. Professor Kathy Eagar, who, as you may know, is an algorithm specialist and a clinician, said, 'The model is statistically flawed and systematically underassesses people with frailty, cognitive issues and mental health conditions.' I would put my brother squarely in that category.

The second term of reference is:

(f) the impact on older Australians transitioning from the Home Care Packages Program …

In the documents provided in support of this, in addition to that GP's letter, I have also included the very brief and spare email from David's care provider as an example of the kind of communication that he and we are supposed to interpret. This is one of hundreds, but it's the one that I have chosen.

Let me now move to describe the stressful impact on myself and my sister as David's responsible persons and advocates for his future care as he transitions. David knows that sitting in a chair watching TV for seven to eight hours a day is not good—he often tells us he's bored—but there's little funding available currently for psychosocial support. These are some of the lived experience scenarios we have experienced recently with David, that the current assessment tool, even with a cognition score component, which I understand it has, will most likely not consider.

David can read but not write to any degree. He can use speech recognition apps to send a short message. Given that only 40 per cent of adult Australians are literate to a functional level, for example in a health context, how would David or any of the 60 per cent understand the implications of the term 'grandfathered' in letter 2. Indeed, how am I to understand the term and its implications? I have a Greek background, by the way. Does it mean he keeps the funds that he has accrued as he now transitions, or does it mean he is guaranteed not to be reassessed at a lower Support at Home level?

In November 2025, the family and David decided to fund implants because he had lost five dentures in five years. Unfortunately, David had an anaphylactic reaction to the muscle relaxant used in anaesthesia for the implant surgery, which was supposed to be 20 minutes. He went into cardiac arrest but, fortunately, was resuscitated. The photo that you have shows David and I in the ICU, where he was transported by ambulance just in time. A month later, David had to have a third toe that was infected amputated from his right foot. Preparation for surgery obviously required consultation with an anaesthetic allergy specialist to prevent a re-occurrence of anaphylaxis. Intense post-operative care at home was required for the recovery period.

I cite these examples not to elicit sympathy but to demonstrate the complexity of the changing care needs of older people under the Support at Home program. You will note from the GP's letter that, in his opinion, David's understanding of his diabetes and health condition has deteriorated and is likely to deteriorate further. He has high levels of anxiety related to past trauma, which can only increase if the assessment tool for his ongoing package does not take this vulnerability into account.

My question is this: why should we, as his carers, be required to challenge algorithmic decisions that may not reflect his increasing needs. If I am concerned about the shortcomings of the transition process, why do I have to wait to complain after the problems occur? A rights-based person-centred system should not rely on older people having to complain in retrospect.

Finally, if I have the time, I would like to make six recommendations very quickly. No. 1 is that the IAT, or the algorithm, currently being used to determine Support at Home levels be abolished. No. 2 is that a new assessment process involving clinicians be co-designed and tested with older consumers, independently validated and put into practice as soon as possible. No. 3 is that particular sensitivity to the care needs of older people with cognitive or mental health issues be embedded in the new process. No. 4 is that providers be required to give accurate information about assessment to clients in a language and manner they understand. No. 5 is that the misleading rhetoric about assessment on the My Aged Care website—I don't know if you've seen it—be rewritten. Currently, it describes assessment as a simple process, reassuring anxious applicants that they will feel comfortable and safe when the assessor visits and asks them about their situation and needs. Finally, No. 6 is that, overall, the Support at Home program and its mechanisms be redesigned not as a crude way to manage government funding priorities but as a visionary approach and a preventive investment in aged-care support to a rapidly increasing section of the population.

Thank you very much, senators.

CHAIR: Thank you very much, Mary. I'm now going to come to Margaret.

Margaret: I've got to thank you for the opportunity to present to this committee. As an over-80-year-old retired nurse educator, I come to this from a very different perspective. I have spent over 20 years in the latter part of my working life specialising in residential aged care, and I was an educator within that facility, assisting through—I don't know how many changes of accreditation we had or the past history of it all, but it was all residential.

I'm a recipient of a Support at Home package, although I am in transition through to it, and I have received some form of package for over eight years due to a genetic condition, through all the different systems. Prior to last November, it gave me a fairly stress-free life with assistance. In my area where I used to live, my provider was unable to facilitate house cleaning—I'm sure that happens in other areas still—or garden and yard assistants. These had to be paid for privately out of what pension I had. Once I was given a Support at Home package, I chose to become self-managed, and then for a short time life was quite good. Then we had the changes that occurred after the new Aged Care Act, but getting assistance was still manageable until last November. What a massive change that made to my life—and not for the better.

First came a 64-page contract that had to be read, comprehended and signed. I still don't understand half of it. Then there was the contribution system, which had previously meant a simple one month contribution. I'd always paid a contribution because I have a small pension on top of my age pension. Once a month, I made the payment, which was fine—just a total amount. That was it. It was set by Services Australia as to how much I paid. I had a provider and a care coordinator that produced a care plan which matched my condition, ability and needs.

Since November, I am classed as grandfathered—and I note that suddenly I've changed sex, but apart from that—on an interim package which is at level 3 on the old categories. I still have a provider and a co-coordinator but have to be much more in contact with them, because the system is just confusing. I have monthly phone calls to update my care plan, which causes its own problems, as these coordinators do not stay in their jobs for very long and I'm about to have the third person since November. These monthly interviews can be quite farcical, as the person frequently has no prior health, nursing or medical background. They ask questions from forms and, having given the answers, I find myself explaining the answer, spelling the words out so that they can write them down—both health conditions and medications. After that's all been written, I get sent a copy. If it were not serious, it would be funny. I have received care plans that I don't even recognise myself in. I have been given diseases that I had to look up—I had never heard of them. My needs have to fit into a box that has certainly not been formulated by anyone concerned with health care.

Then came all the digital paperwork. Invoices are sent by my workers from higher up, who then send them on to my provider after I've approved them. From there they get sent to Services Australia and are then sent back to my provider, who adds their portion to it. Someone then approves there is sufficient money in my package to make the payment and that it's an appropriate claim. All of this takes time, and I don't get to see the balances when all of this is done. The problem with not seeing the balance is, if I have a bad session—and I can go up and down in my health requirements or my ability—in the old system, I could quickly go onto the webpage, see what my totals were and think, great, I can get some extra help for a couple of weeks. The money is there. Now, by the time I know the money is there, I've got over it without the help.

Producing reams of computer data of which we never see and is sometimes incomprehensible to someone who's not a bean counter—then, quite erratically, I'm sent a contribution invoice, with very little detail on it. I have opened a separate bank account which gives access to my provider to direct debit. They put the money in—the same amount as I used to pay. The most they've ever taken out is only about half that amount. Why? I used to

pay that amount. Now I pay half of it. Some of the calculations have gone wrong somewhere, but you get no input to it. I wouldn't object if it were still at the same level it was at.

I worry that, at some time, Services Australia will suddenly send me a bulk-bill that says I haven't paid enough money over the months, so I keep on leaving it in that account in case it suddenly gets called on, but any minute now they're going to cut my pension down because I own too much money. There's no win. There's absolutely no win to that situation. I have a graduate and postgraduate education, but many of the recipients of packages have not had that opportunity in life, and they would find it all more top heavy with bureaucracy than I do and extremely time consuming. I should be able to reasonably choose my activities for my life now. Sometimes I feel I'm back at work and trying to juggle some sort of social life around the bureaucracy.

As for the system having clients at its centre, that just doesn't happen. We have an assessment when we first apply for a package. Our needs are identified. No-one ever sees us again, or usually not, and everything is done via internet and phone. We're answering subjective questions. How clients who have had no history of working in health fields manage to give clarity to the answers I don't know. In my case, it has been over six years since my original assessment. I have seen one other person. Two years ago, when I was about to go in for eye surgery and I was on the old, old system, they had to come and see me because I was allowed respite. I didn't use it, but I was allowed it. That was the only reason they came.

Back to having choices, I'm finding my choice of allied health persons, like acupuncture and exercise physiotherapy, is decreasing. Those are the sorts of needs I have rather than acute needs. When phoning to find a practitioner, I'm asked, 'How are you going to pay for it?' If I say, 'By my package,' very often, the answer is: 'I'm sorry. We can't take you as a client. We don't deal with the aged-care packages.' I ask why. I'm told that the paperwork now takes so much of their time that they are choosing not to deal with us as their clients. That is an appalling situation.

Due to the now quarterly budget, it's impossible for me to have more care in the winter than the summer, which are my needs. I have to have the same amount of need regardless of the season. In the summer months I didn't use all my package—I'm sure they took some of it back, but I can't see that on the paperwork—but for the last two months I've had to pay for extra care because there wasn't enough on my package. When the budget was annual, I could balance the different needs across the seasons. The quarterly $1,000 carryover they're giving us is definitely insufficient. It works out at approximately $350 a month—and we won't divide it down to weeks; it's not much at all, less than $100 a week. If this was made a $3,000 or $4,000 fluctuation, it would be manageable. We could manage. We could equal it out over the time. That, by allowing a figure buffer, would not cost the government one cent more because it's all coming out of our annual money. That would take a lot of stress away from a lot of people, if that could be done.

The system is just not flexible enough. I've been monitored, that's me and don't you dare change—which is the feeling we get. Money granted for house additions like grab handles and equipment is so delayed, from what I am hearing—I must admit, I put mine in before I moved—that we are diminished in our ability by the time it becomes available. I tried to get a hoist for my car because my arms were getting too weak; I had been lifting a 23-kilo wheelchair into the car. After three months of trying to get an OT to even come out and do an assessment, I was told he could not approve equipment that he had not seen me demonstrating the use of. There was only one hoist available on the market; it came from England. It had to be purchased before they sent it to us—quite reasonable, since it was $6,000. The engineer and the garage that I was dealing with in the area were approved people recommended by the NDIS, and I felt I had received the correct advice from an experienced engineer. This all became a ridiculous situation, and in the meantime I had not been able to go out to activities unless there was parking within 20 metres, which was as far as I could walk with a walker frame. My life just kept shrinking and shrinking. I gave up, drew an advance on the pension I have and bought my own. It is great, and I'm here today because I have that piece of equipment—and I haven't stopped using it; my life definitely increased because I got one bit of equipment.

In conclusion, I find that the Support at Home system is complicated and does little to prevent deterioration of my health. Due to my prior knowledge and education, I can get assistance to create enablement, but my knowledge and education is not available to most recipients, and you're not obliged to be a degreed nurse with postgraduate qualifications in order to use a package. The new system creates stress and is depressive, limiting my choices, and does not make me feel that my needs or choices are being considered. I sincerely hope the implementation of this system can be effectively and sensibly changed.

CHAIR: Thanks, Philip, Mary and Margaret. Thank you so much for taking the time to submit to the inquiry and to appear before us and give your lived-experience evidence. This is the most important evidence that we get in this inquiry. Hearing from you gives practical effect to what we hear from the advocacy organisations and

others—who are saying similar things, but it makes so much more sense in terms of how it's playing out on the ground when we hear it directly from you. The committee appreciates your evidence. The committee will report to the Senate on 24 November 2026.

BARNETT, Ms Erika, Acting Assistant Secretary, Department of Health, Disability and Ageing

BLACKWOOD, Ms Rachel, Assistant Secretary, Department of Health, Disability and Ageing

CREELMAN, Mr David, Acting Assistant Secretary, Department of Health, Disability and Ageing

LAVITHIS, Ms Naomi, Acting Assistant Secretary, Department of Health, Disability and Ageing

MALDON, Mr Joshua, Acting First Assistant Secretary, Department of Health, Disability and Ageing

PUGH, Mr Greg, First Assistant Secretary, Department of Health, Disability and Ageing

STEWART, Ms Sonja, Deputy Secretary, Department of Health, Disability and Ageing

[16:23]

CHAIR: Thanks, everyone, for appearing before the committee this afternoon. The Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution doesn't preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Commonwealth officers appearing today are also reminded of the Senate order specifying the process by which a claim of public interest immunity should be raised. A copy of the order is available from the secretariat.

The extract read as follows—

Public interest immunity claims

That the Senate—

(a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;

(b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;

(c) orders that the following operate as an order of continuing effect:

(1) If:

(a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

(4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee could result only from the publication of the information or document by the committee, or could result, equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

(5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.

(6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.

(7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (1) or (4).

(8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the

committee of that conclusion and the reason for that conclusion, and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

(d) requires the Procedure Committee to review the operation of this order and report to the Senate by 20 August 2009.

(13 May 2009 J.1941)

(Extract, Senate Standing Orders)

CHAIR: I understand that information on parliamentary privilege and the protection and obligations of witnesses giving evidence to Senate committees has been provided to you. Is there an opening statement from the department this afternoon?

Ms Stewart: No, there isn't.

CHAIR: Okay, we'll go straight to questions. Senator Whiteaker, would you like to kick us off.

Senator WHITEAKER: Thanks to all of the officials for their time today. I want to start on wait times. We've heard lots of concerns today, and over the course of this inquiry, about wait times. Can you talk to the work that's underway on bringing down those wait times. Specifically, I'm interested in the end-of-life pathway—I understand the government made a commitment to this in the budget, so I'm interested in that specific pathway—but also the broader work that's being done on wait times and what we're seeing in terms of the numbers on waitlists.

Mr Pugh: The government has made a commitment for there to be, by the end of the second year of the Support at Home program—by 1 November 2027—an average wait time to some funding of three months for all participants. This approach has been helped by the release of the additional 83,000 places that happened during the deferral period and through to the end of the financial year. We had around 390,000 people in the Support at Home program by 30 June 2026. We have a forecast of needing to have an additional 300,000 places in the system by 2035, and that's the approach that we are taking. That includes an additional 32,000 places that are being released this financial year, which should bring the total number of people in places to 420,000 by 30 June 2027.

There's a lot more detail I could go into on that, but, just to cut to the record number of people that we have in Support at Home places at the moment and what that means for wait times, since the Support at Home program began on 1 November 2025 those estimated wait times for an ongoing place have fallen across each of the priority categories. As of 30 June 2026, every person who is classified as urgent priority continues to get their funding within one month. Those who are on high priority are now roughly one month to access. That's down from between 1½ and 2½ months previously. Medium priority is now between five and six months, which is down from eight to nine months previously. The standard priority is now seven to eight months, down from 10 to 11 months previously. So, with about 12 months to go, we are seeing some very positive signs towards meeting that three-month average wait time commitment, but, of course, there's more to do.

Ms Stewart: In terms of the answer to your question about the end-of-life pathway, there was a commitment from government and extra funding provided for that end-of-life pathway. It's a 12-week period that is provided. From March next year, that will be extended for a further 12 weeks. That recognises that, for some people on their end-of-life pathway, that pathway might be a little bit longer—just to give that recognition. In answer to your question, government has also extended that optionality for some older people that might require that.

Senator WHITEAKER: We've heard lots of support for making financial hardship assistance simpler to access. Can you talk to the work that's underway to simplify the hardship process and give us a sense of how many hardship applications you've currently got and what the average processing time is. One of the other things we've heard a lot from providers and advocates is their sense that people aren't being approved for them very often. Do you have some information you can give us on how many of those applications are successful?

Ms Stewart: Yes. I'll ask one of the team to do that. I think it's important to recognise at the outset that the co-contributions are set at a rate for older people in terms of their capacity to pay. In terms of the information about hardship applications, Services Australia is our delivery agency that receives and processes those claims, but we can speak to you about that process and making that more efficient, which was, again, a commitment of government in terms of providing that.

Mr Pugh: In terms of the additional information—carrying on from Ms Stewart—there was a budget measure announced in the 2026-27 budget just gone, and the department is working closely with Services Australia to progress that measure. That's largely focused on the digitisation of the hardship application process. That's in response to longstanding concerns that we've heard around the timeliness of those hardship determinations. The project will deliver that more streamlined, accessible and efficient application process. It means that customers will be able to lodge, save, complete and submit applications online through their Centrelink account. Then

there'll be some dynamic questioning attached to it that will help guide applicants and ensure that only relevant information is collected.

So, rather than having to go through a long form, it's just giving the information that you absolutely need to provide in order to have that process progressed. It will improve the customer experience. It will reduce administrative burden. It will minimise those requests for additional information. It will also support the upload of required documentation and decrease the processing delays that we've seen.

In terms of some of those statistics, as Ms Stewart said, this does fall within the remit of Services Australia. However, I understand that, as at 30 June 2026, there were 470 hardship applications on hand, with them across all aged-care programs. That was a decrease of 1,115 from 31 March, the quarter previous. Those processing times have also, I believe, halved from about 28 days to about 14 days.

Senator WHITEAKER: That's useful information. Thank you. The Commonwealth Home Support Program has, of course, been the subject of much discussion. The government announced partway through this inquiry that that program would be extended and has signalled an intent to consider how it can be kept as a standalone program, separate to Support at Home. Can you talk through this decision and how it's going to work?

Mr Pugh: You're right: on 20 August this year, the Australian government announced that the Commonwealth Home Support Program grant funding would be extended for another two years, to 30 June 2029. I know that this has been of significant interest to this inquiry, and to other forums as well. I'm really happy that that announcement has been able to be made. It provides that certainty for providers for older people who access those services.

We've heard a lot through this inquiry, but also through all of our other regular engagement forums, around the importance of the CHSP, in particular, as an entry-level program to support people and help people with their cleaning, their shopping, their transport and their home maintenance. The extension of it helps not only those older people have certainty around those ongoing services but the approximately 1,300 CHSP providers, including local governments, continue to deliver those essential services.

We have some final formalities to go through before we officially launch our consultation process. We expect to do that in the coming weeks. The consultation will go to what CHSP could look like beyond 2029, noting that the government's announcement indicated a preference for CHSP to remain a standalone program. But we've got to work through exactly what that would look like to make sure that that program is fit for purpose and is operating for all.

We'll be focusing on things like how we maintain a sustainable entry-level in-home aged-care program, how we can ensure that there are fair and equitable contributions to the costs of home care—we've heard a lot about that today and in previous inquiries as well—how those early intervention approaches can reduce pressure across the system and then also, if the two programs are to remain separate, how we can provide that better continuum of care so you don't have to hop from one program to the other and it's a seamless or more seamless experience for the older person. We will be consulting on all of those elements.

Ms Stewart: Further to that, in making the announcement, the minister, I think, set a direction in that there are going to be a number of service categories that are better off block funded. I think, in the minister and government making that announcement, we're delineating that there is some alignment of services with the current Support at Home service list but there is also a level of services which are block funded to organisations that deliver that to older people across Australia.

Senator WHITEAKER: We've heard from local governments, in particular in regional parts of the country where they're the only provider of some of these aged-care services. Have you been consulting with local governments? How do you think the continuity of this program will assist those providers operating in challenging markets?

Ms Stewart: One of the aspects of the group that I lead is a very strong local network in terms of state and territory and also some very big regional centres. Part of the consultation process will be engaging with those local government providers, and that has occurred in some form already. We do see local government as a really key part of the community home support program. I'm not sure if one of my team wants to make any further comment about that.

Mr Pugh: One additional point to what Ms Stewart has raised is that we appeared at the inquiry into local government service delivery, where CHSP did come up. Note that, of the approximately $3½ billion in annual CHSP grant funding, around six per cent goes to those councils. As at the end of July, we've got grant agreements in place with over 130 local councils, and there are over a thousand grant agreements in place to support that provision of service. They are a very important part of CHSP service delivery.

Senator WHITEAKER: The government has made a decision that, from 1 October, a range of personal care services will be fully funded. Can you talk through that decision and how you came to that and why you think it's an important change.

Mr Maldon: The Australian government has agreed to fully fund personal care services under the Support at Home care program. The types of personal care services that are included are things like assistance with showering and non-clinical continence management. It's going to be implemented by moving that category from the independent service category across to clinical supports. What it will mean for people is that they'll no longer be out of pocket for the approved personal care, where they have funding available. The intent of the change is to support dignity, hygiene and access to essential daily care for all participants. It will benefit all those participants who were approved for Support at Home after September 2024. Government took this decision because it has been continuing to listen to the sector and respond to the sector as issues have been raised, so that's a decision that it has made.

Senator WHITEAKER: Thank you.

CHAIR: My questions go to the IAT. I note that, in reporting in the *Guardian* on 17 September by Melissa Davey, she noted that FOI documents appear to show that Ms Blackwood emailed Mr Pugh on 24 October raising the issue of the rules not allowing or not giving assessors a legal discretion to override the algorithm. Can I check that that reporting is correct.

Ms Blackwood: That's correct, yes.

CHAIR: Ms Blackwood, are you able to tell us how it came to your attention that the algorithm couldn't be overridden or there was no legal discretion?

Ms Stewart: I might start by making some comments—

CHAIR: No. I've asked a question to Ms Blackwood, and I'd appreciate it if I could continue my line of questioning.

Ms Stewart: Sure.

Ms Blackwood: I think we've given evidence in previous forums that, in the course of preparing for the commencement of the 1 November aged-care reforms, we undertook some final checking processes to make sure that we were giving guidance to the assessment workforce that fully aligned with the policy decisions of government and the legal framework that had been determined by government. So, in the course of undertaking those processes and seeking various pieces of internal legal advice, we reached the conclusion that there was no discretion under the rules as they'd been agreed.

Mr Pugh: We would have done that sort of implementation-readiness checking across the whole suite of reforms that were scheduled to come online. It's not unusual to go through and make sure that what we've got is a clear link between a government decision, what the legislation says, what the rules say and then what our policy guidance says.

Senator ALLMAN-PAYNE: I guess what I'm trying to understand is something which I'm not sure that we've understood in the past. You've certainly told us before that, through a process of checking, that was the position. I guess what I would like to try and understand a bit better today is this. The department had repeatedly assured assessors that they would retain that power. You then got legal advice, if I understand it correctly, to say what the rules actually allowed. Ms Blackwood, you then emailed Mr Pugh to say, I presume, that the legal advice had told you that the rules don't provide that discretion.

I guess what I would like to understand today is: how was it that there was a difference between what the department had been telling assessors and what the rules actually gave effect to? Was it the case that the minister, for example—someone must have. Was it the case that a direction was given to say that the rules had to give effect to no discretion, or was it the case that the rules were done, were written; then they were looked at; it became apparent that, in the way they were written, there was no discretion; and then everything went from there? Which was it? Did someone give a direction to the drafters for there not to be discretion in the rules, or were the rules written and the department was assuming, given the advice you were giving assessors, that there would be a discretion, but then it turned out that they hadn't been written that way?

Ms Stewart: I would like to begin by explaining, because I think it's a really important point, how the actual system works. There is an override functionality.

CHAIR: I'm just—

Ms Stewart: Could I please finish. I think that's really important about the discretion, if I may continue. There is an override functionality. There is a functionality that exists right now. The reason that there is an override

functionality is that, when an assessor is looking at an older person's needs, they might need to put in the system that they're having restorative care or, as we talked about before, there might be an end-of-life pathway or they put in the system an override so they go to the residential aged-care stream. I think it's important to note that the system exists with an override and then the older person gets tracked to the services that they need. I just want to say, in terms of that discretion, that there is an override functionality. The system is built with an override, so the older person gets referred to the service line that they need.

In terms of your question, the rules were written in a way which did not—what we're talking about here is the Support at Home program. We talked about that override with the others. The rules were drafted in a way that provided Support at Home to not have that override. What happened in the guidelines was there was a mismatch between the guidelines. It should also be said that the guidelines, in signalling that to the assessors, did say that from time to time we will be changing those guidelines. It happens in big systems. You get the legal advice about whether you have alignment between the legislation and the rules and the system that was built and the guidance materials and the policy. There was a misalignment in this stage. Unfortunately, that misalignment was considered and found late in the piece. That's an important point to make—that there is an override functionality, and it exists right now. It's a fundamental part of the system, to direct people to where they need to go in the service system. Maybe somebody could say it more eloquently—

CHAIR: With respect, I appreciate you wanting to give me more context, but we have limited time and I have a series of questions I want to ask. To be frank with you, what you've just said makes it no clearer; in fact, it's more confusing. You literally just said to me there is an override and then said it was drafted with a mismatch, so there's no override. If I could ask my questions one by one and get an answer to them, I think that would help us understand what's going on.

I want to come back to my original question. There was information going from the department to assessors, telling them that there would be an override function in the Support at Home assessment tool. We then have a situation where advice is given to draft the rules, the rules are drafted and Ms Blackwood then emails Mr Pugh to say, 'You've received legal advice that there is no discretion to override in the tool under the rules.' I want to understand: was a direction given to the drafters not to include a discretion to override, or was it the case that the rules were drafted and you then found out afterwards that, with the way they were drafted, there was no rule to override? That's a simple question that I think should be able to be answered.

Mr Pugh: I might take us back to the rules. The consultation draft of the rules was first published on 15 April. There were several parallel processes underway, including finalising the implementation of the approach that will be taken on 1 November—so we had system, legislation, rules and policy design happening in parallel. When we got to the final point of checking, to make sure everything was lined up, that was when the misalignment was identified and that was when the advice came to me that said: 'There is a mismatch here. What do we do?' In terms of whether there was a direction to the drafters, I would have to take that on notice for no other reason than I don't believe I was around in this particular role at the time, so I'm not 100 per cent sure. Let me find out for you and come back.

CHAIR: Yes, if you could take that on notice, that would be helpful. I want to understand, then—if you're saying there was a whole bunch of things going on in parallel, is it your evidence that a policy decision was made at some point, which then changed what it was that the drafters had given effect to, and that's why there was a mismatch? I'm trying to understand why there was a mismatch. Was there an error in the drafting instructions or was there a policy decision made subsequent to the initial drafting instructions—and, if so, who made that decision? I'm trying to understand the sequence.

Mr Pugh: I'll take that specific set of questions on notice because I don't want to mislead and I don't want to provide incorrect evidence.

CHAIR: After Ms Blackwood emailed you, Mr Pugh, to say that the rules didn't give assessors any legal discretion, what briefing, if any, was provided to Minister Rae and Minister Butler between then and 1 November?

Ms Stewart: There was a misalignment. There was advice provided about the misalignment, between what was drafted and what was consulted on, and the guidelines.

CHAIR: So the minister was briefed on the misalignment. Who was briefed—Minister Rae or Minister Butler, or both?

Ms Stewart: I'll have to take that on notice, in terms of who was in the actual brief. We have to follow the legislation; I think that's important, in terms of being lawful. I can take it on notice in terms of who was being briefed.

CHAIR: With respect, I guess, the reason it's important is that, once the misalignment was identified, it was before the legislation took effect, which means it was open to the government to determine that they needed to change the rules. I guess this is the key point: if it was the case that there had been an intention for there to be a human override and that mistake—or that misalignment, as you're characterising it—then became apparent, there are a series of decisions that the minister needed to make, such as, 'Do we need to fix the rules, because this is significant?' Someone then obviously made the decision to simply change the guidelines or update the assessor instruction manual. So who made the decision once that misalignment was brought to the minister's attention that the to way deal with this was to simply update the assessor manual?

Mr Pugh: We'll have to take that one on notice, again, because we don't want to mislead the committee and provide incorrect evidence.

CHAIR: Between when the department first told assessors about an override function and 24 October 2025, when it became apparent that there was a misalignment, how many internal or external communications stated that assessors would retain override?

Ms Blackwood: I'd need to take the specifics of that on notice. There were certainly a number of documents that stated that there would be an override and that we would provide additional information before 1 November around the circumstance—

CHAIR: Could you take that on notice, and could you provide copies of the documents that indicate that there was or wasn't going to be an override? I think my next question will have to wait because we need to wait to find out who made the decision. If I understand correctly, Ms Blackwood, your evidence resulted from the obtaining of legal advice. Is that right?

Ms Blackwood: Yes.

CHAIR: What date was that legal advice obtained?

Mr Pugh: We'll take that on notice too.

CHAIR: Was any legal advice obtained subsequent to the legal advice being given that there was a misalignment? Was any further legal advice sought then as to what could be done to align those things?

Ms Blackwood: It is probably best for us to take that one on notice as well just to make sure we give correct evidence.

CHAIR: You may or may not be able to answer this. If not, I'm happy for you to take it on notice. Was amending the rules before 1 November considered and rejected or not considered at all?

Mr Pugh: We'll take that one on notice too. It falls into the same line of questioning that you previously asked, just with one qualifying statement. During the deferral period and prior to the decision to defer the implementation by four months, we heard a lot of feedback from older people from the sector around the need to finalise settings so that people could be in a position to actually enact the rules or the legislation and the policy guidance. That is just a broader contextual piece about trying to have these things bedded down and give the certainty that people were so keen for at that time.

CHAIR: I certainly understand that context, although I think, if you'd told older people that human override was being removed—and I'm still not clear, I have to say, on how you use the term 'misalignment'. Does that mean there was a mistake? Was there an intention to include override and it was missed, or not? I really would like to get clarity in those answers to questions on notice around that.

Here is one last question from me on this topic, and then I'll hand over to Senator Ruston. I understand that the Ombudsman is looking into the IAT. Has the department made any submission to the Ombudsman's investigation?

Ms Stewart: We engaged with the Ombudsman on that process, but I'm not quite sure of the extent to which we would be discussing that at this committee. It would be a usual part of the department to—

CHAIR: Has the department made a written submission to the ombudsman's investigation?

Ms Stewart: I don't know we'd call it a written submission. No, I wouldn't.

Mr Pugh: The ombudsman has got an established process of going through requests for information, and so we have engaged fully and completely with that process.

CHAIR: Thank you. Senator Ruston.

Senator RUSTON: I'm just keen to understand: do you know how many people died while waiting for an aged-care package in 2025-26?

Mr Maldon: The mortality data for 2025-26 is not yet available. We're still validating the methodology to reliably identify deaths and determine the mortality rate under the Support at Home care program. We hope to have this available shortly and in line with the next quarterly release of data.

Senator RUSTON: You said that you were undertaking validation of the methodology.

Mr Maldon: Yes.

Senator RUSTON: So it's not a consistent methodology that you've used in previous years.

Mr Maldon: This is the first year that we've collected that data under the new program. That data comes across multiple source systems. For example, there's linking of data from the Support at Home priority system with the allocation data and reconcile that with deceased event notifications, which are recorded in the aged-care gateway system, and also the relevant data in Services Australia.

Senator RUSTON: To that end, how is data comparable from one year to the next if you've changed the system? Is there going to be transparency about how you've changed the systems in terms of your methodology for data collection? Obviously data has been collected in relation to people who've died waiting for a home-care package prior to the new Support at Home system. Where is going to be the comparability between the data that we've seen for the last however many years and the data that you're going to provide this year? Will you provide transparency around that methodology?

Mr Maldon: There'll be explanations provided. It's to be expected, given that they are new programs, that there will be a difference, and we'll explain that away as best we can.

Senator RUSTON: You'll 'explain it away'.

Ms Stewart: Sorry—I think that was just a turn of phrase. We're committed to transparency. We want to make that very clear, where we do need to make any references, to make sure it's comparable. What we're talking about is a new system that came in from 1 November 2025.

Senator RUSTON: When you said it will be available in the next tranche—I'm not quite sure what words you used, but it was the next reporting period—what do you mean by the next reporting period? When is the next reporting period?

Mr Maldon: My understanding is that's on track for October, so that's what we're currently aiming for.

Senator RUSTON: What date in October?

Mr Maldon: I wouldn't be able to commit to a date at this particular point.

Senator RUSTON: Will you commit to a date before estimates?

Mr Maldon: Estimates is at the end of October, isn't it?

Senator RUSTON: Yes. It probably would be the last week, almost.

Mr Pugh: Maybe just to build on Mr Maldon's point, we've heard a lot of criticisms and comments today and previously around the availability of data—

Senator RUSTON: That's very nice. I don't know that I'm asking that question. I just asked you if you were able to provide the data before the estimates in October. I don't need an explanation of other things. You're more than welcome to put that on the record if you want to, but I'm asking a question about this information that, quite frankly, was provided to us in August last year by the secretary of the department. Why are we now talking about it some 10 weeks later, and you can't give me a guarantee? I'm keen to understand if you can guarantee that I will have the validated data prior to coming to estimates.

CHAIR: Just if it assists, estimates will be the week starting Monday 26 October.

Senator RUSTON: It's very late in October. Will you give me a commitment that you will be able to provide it?

Ms Stewart: We understand that there's an interest, as there should be, in this data. There is a lot of interest in it. What we are saying is that we want to make sure it's accurate. We want to make sure that we can compare it. And we are going to be transparent. With all those factors in mind, we want it also to be relevant in terms of the time period. We would—

Senator RUSTON: You do realise that, during COVID, there was an expectation for the minister for aged care to know on a day-by-day basis how many older Australians had died in residential aged care. We are now talking about providing data four months after, potentially, the last person has passed away. You'll excuse me for being a little bit sceptical about this obfuscation that we are getting at the moment in terms of answering this particular question. But I am happy to move on. The department made some comments, which we've heard before

and which I think you made earlier in the contribution, about bringing wait times down to three months by November next year. I'm keen to understand, apart from the 32,000 additional packages that you referred to, Mr Pugh—you gave quite a number of stats—what your actual plan is, given increased demand. Where would I find out about how you're intending to get waiting times down to three months when they're currently, on average, at seven or eight months?

Ms Stewart: Before Mr Pugh answers your question, I think it's important that it's an average over the—

Senator RUSTON: Yes, I understand that—I totally understand that. I just want to understand: is there a plan that I can go and have a look at that tells me what measures you're going to put in place? You've said 32,000 packages. That is not going to get it down, so there must be other things that you have in your work plan that will enable you to say that you can get it down to three months by 1 November 2027. Is there somewhere you can point me to where that plan exists so I can look at what your measures are?

Mr Pugh: Define 'plan'. What we have got, and it's the evidence that I've provided to this committee before, is the way that the Support at Home appropriation works. When the budget allocation for Support at Home was agreed, which I believe was in the 2024-25 MYEFO process, the way that that appropriation was provided was on the basis that, by the end of the second year of the program, we would be down to an average of three months waiting time for some funding. So the levers that have been at government's and the department's disposal have been forecasting what the demand profile looks like, making sure that everyone who was in the Home Care Packages Program transitioned to Support at Home, making public commitments around having the additional 83,000 places within the Support at Home program by 30 June 2026 and then also continuing to grow the program relative to what our forecast demand was, which was about 300,000 places over the 10-year period.

There is a determination that the minister makes—I think I've given this evidence previously as well—where the minister prescribes a method for determining how many places will be allocated in Support at Home for the financial year. That's not the number of places to be allocated but the method for determining that number of places. I think the legislation is section 92(4), but I'll have to triple-check that.

Senator RUSTON: That's fine. Really, what you're telling me is that nothing beyond the appropriation is actually any proactive action on the part of the department to get the waiting times down. So let me ask you another question. It's some time since the minister made that commitment that we were going to have the waiting times down to three months by November 2027. Are you on track, in terms of how far you've got in the process, to believe that you are still going to be able to achieve that when we're only, what, 14 months away from that time? Do you still believe that you're going to make that?

Mr Pugh: Yes. I have previously given evidence to this committee as well that has been very clear around saying that this is not a set-and-forget.

Senator RUSTON: Yes. Okay. Thank you. You've made your commitment.

Mr Pugh: There are two opportunities every year, at budget and MYEFO, and the government will obviously look at all of its pressures and how all those things are tracking. At the moment, yes, but that's not to say that government won't revisit it along the way.

Senator RUSTON: Okay. But you're on track as we're sitting here today, so that's fine. How many new packages have been released this financial year to date, from 1 July to today?

Mr Creelman: That's something that we'll be looking to release in the updated quarterly report, when that's released. We're still within the current first quarter of the financial year.

Senator RUSTON: So how many packages were released from 1 January to 30 June?

Mr Pugh: Additional packages?

Senator RUSTON: Yes.

Mr Pugh: That was where there was the 83,000 commitment. So 20,000 of those were in the deferral period, 20,000 of those were between 1 November and 31 December, and 43,000 were between 1 January and 30 June 2026—

Senator RUSTON: So 43,000.

Mr Pugh: My maths could be wrong here, but it's around 1,600 new places per week.

Senator RUSTON: Of those 43,000 packages, how many were released as full packages?

Mr Pugh: I think we've given that answer before. I don't have that immediately in front of me, sorry.

Senator RUSTON: If I want to look at how many new and rolled-over packages—I'm not sure what term you use for packages that become available again—have been released in the same timeframe, you wouldn't be able to

give me any further data? What's the term you use for packages that have previously been used that come back into the system?

Mr Pugh: Under the home-care packages program, we had the concept of recycled packages, and that was when a person exited the program, and that place effectively became available for someone else.

Senator RUSTON: I'm just understanding: what is the correct terminology for me to refer to them as?

Mr Pugh: We don't have—

Senator RUSTON: At the top of the list of the packages that are released in a period of time, you've obviously got newly released packages, and there's another lot of packages. What are they called?

Mr Creelman: There's a different construct for how the places are released in the new program—the knowledge that the old program had and the concept of a defined sort of set of packages. When one came in, it could then go out. But the new program operates under a different model.

Senator RUSTON: The minister constantly refers to packages being released, and when there are no new packages released, what are the other packages called? I would have thought you'd know what a package that isn't a new package is called. I'm finding this a little strange.

Mr Creelman: We typically refer to a place—

Senator RUSTON: Oh, a place, okay. You call it a place.

Mr Creelman: That's how it's used in the legislation, where places—

Senator RUSTON: The newer are packages and the older are places.

Mr Pugh: No. The legislative term for a Support at Home place applies to all places, be they new or be they old. We don't distinguish between what's recycled and what's—

Senator RUSTON: Mr Pugh, you know what I'm asking. It's a really simple question. I'm sure you all know what I'm asking. It's a very simple question. When you release a new package into the marketplace, it's a new package that's got new funding in that period, and that goes in. And then there are other packages that are in the market that have previously been used by somebody else. But, when they go into residential care or they die, those packages become available for reallocation to somebody else. I'm simply asking, what is the term that the department uses for those packages? When you put them on a list, what's the heading on the list? I don't need an explanation of what they are. What are you call them?

Mr Pugh: We don't call them anything, Senator, because they are not recycled.

Senator RUSTON: Let's move on. How many people are currently approved but are waiting for their full package?

Mr Creelman: We can provide data as at 31 March.

Senator RUSTON: 31 March?

Mr Creelman: That's correct.

Senator RUSTON: Are you deadly serious?

Mr Pugh: This comes back to the next tranche of the next quarterly report for Support at Home. So Q4 2025-26 will be available at the start of October. That's because there's slightly additional time taken to prepare that report because it's end of financial year.

Senator RUSTON: So you don't know how many people are on the national priority waiting list, as we stand here today?

Mr Pugh: We've got the 30 June figure, because we were in a position to be able to release a limited set of data on My Aged Care. I think that was released on 10 August. The number, which I will find for you, is around the 107,000 mark.

Mr Creelman: Yes, it's 106,977.

Senator RUSTON: That data would also pick up anybody who was on a minimum-service offering too, wouldn't it?

Mr Creelman: It's the number of people waiting for their ongoing Support at Home place as at 30 June.

Mr Pugh: So, no, it doesn't pick up MSOs.

Senator RUSTON: It doesn't count MSOs?

Mr Pugh: No.

Senator RUSTON: On my question of how many people are currently approved but are still waiting for their full package, that is not that number from 30 June, because you'd have the MSOs in there as well, because they're obviously not on their full package.

Mr Pugh: We'd take that on notice and give you a definitive answer, but my understanding is the 107,000 or the 106,000 is people who are on the Support at Home priority system who have access to no Support at Home funding, be that the minimum-service offer or be that their full funding allocation, and there's a different dataset for that cohort. We just report them separately. We don't hide it; we just report them separately.

Senator RUSTON: So it's 107,000 or 106,000 people, to be exact, et cetera, et cetera. There are 107,000 people on the NPS. How many people on 30 June—or make it 29 June—didn't have their full package but were on an MSO or an interim package?

Mr Creelman: We'd need to take that one on notice.

Mr Pugh: The published figure for 31 March—and this will be updated in the next Support at Home quarterly report, which is not too far away—was that we had 100,191 people on the priority system who were waiting for any Support at Home funding, be that interim or full. We also had 53,718 people who were on an interim funding arrangement who would be graduating to their full service offer.

Senator RUSTON: What did you just say to me? I just asked you how many people were on an MSO, so what did you just tell me then? Do you actually know how many?

Mr Pugh: At 31 March—

Senator RUSTON: No, sorry. That was in March—53,000.

Mr Pugh: This was the latest data that we have available. At 31 March 2026, 53,718 people were on an interim funding arrangement or had a minimum service offer.

Senator RUSTON: So that, in conjunction or combined with the 107,000 or a similar sort of number, means we're talking 160,000 people who weren't actually on their full package. So—

Mr Pugh: If you go like for like, Senator—I don't mean to interrupt; sorry—100,191 had no funding and 53,718 had MSO, so that's more around the 154,000 mark, or just shy thereof.

Senator RUSTON: Yes, okay. This is all publicly available data anyway, though, isn't it?

Mr Pugh: Yes.

Senator RUSTON: Previously, you used to record, in the number of people on the NPS, people who were waiting for a package or people who had a package that was at a lower level of care than they were assessed as needing, and that led into 1 November. Subsequent to 1 November, you actually no longer record people who are on a minimum service offering or an interim package, which is the same as being on a package that was at a lower level than previously. So you've actually changed how you report your waitlists and wait times going through 1 November. Is that correct?

Mr Pugh: No, I don't think so, because just the fact that I gave you the 53,718 number suggests we do record it. It's just—

Senator RUSTON: Sorry, what did you say at the end of that? I didn't hear you.

Mr Pugh: You said we don't record who's on the interim versus in full.

Senator RUSTON: No, I said that, prior to 1 November 2025, you used to record the number of people on the national priority system, including those people that were receiving a package that was at a lower level than the package they were assessed as needing, so you had people who received nothing and people who were receiving a lower-than-assessed package. Subsequent to 1 November, the people on the NPS are only those people who are not receiving any package at all. You have taken the people who previously remained on the NPS, and you've taken them off—anybody on a minimum service offering. So are they recorded in the NPS or aren't they recorded in the NPS?

Mr Pugh: All we've done is split the two line items.

Senator RUSTON: No, I understand the recording—

Mr Pugh: That's all we've done.

Senator RUSTON: Are the NPS prior to November 2025 and the NPS after November 2025 recording the same thing?

Mr Pugh: They are recording at the same thing, but all we have done is split out the two figures, so you've got, 'Here's who's on the system with no funding, and here's who is on the system with interim funding.' So it's been able to clarify clearly the distinction between the two.

Senator RUSTON: Okay. So, when you publish the NPS, is the NPS made up of two components now?

Mr Pugh: I think we just literally say it the way that I've said it: 'Here are the people on the Support at Home priority system; here are the people who have an interim funding arrangement waiting for funding allocation.'

Senator RUSTON: Let's be clear. If I asked you in October 2025 for a figure on the NPS, you would have given me a figure. If I asked you to give me a figure of the number of people—the 107,000-plus or 106,000-plus—post 1 November 2025, does that figure include all of the people in the figure that you would previously have given me?

Mr Pugh: The total remains the same.

Senator RUSTON: So the total on the NPS remains the same.

Mr Pugh: Rather than saying 154,000 people are on the Support at Home priority system, we say 100,000 are on the Support at Home priority system and an additional 53,000 or 54,000 people are on interim funding. So I think it's very clear. We've just made those two things distinct from the other.

Senator RUSTON: In recording, when you provide your waitlist numbers and your wait-time numbers, do your wait-time numbers include people who are on a minimum service offering? You said you've dropped the wait times for a standard package to seven or eight months from 10 or 11 months. Does that seven or eight months include people that are on a minimum service offering?

Mr Creelman: The wait times which are reported on the My Aged Care website will be the time for any funding. For some individuals, that's immediate funding. For some individuals—

Senator RUSTON: So it's any funding. Previous to that, in the nine or 10 months that were recorded last year, prior to this, did they include the wait times for any funding, or did they also include people that were on packages that were lower?

Mr Pugh: I'll have to double-check. I believe that when interim was used as a construct under home-care packages that that did include that cohort of people. But I'll have to take that on notice and triple check.

Senator RUSTON: What I would say is that from that point, from 1 November last year, you have not been recording the same things. And the figures that you have been publishing and claiming as some great success, in terms of getting wait times down, are distorted by the fact that you have removed what you yourself admit is somewhere around 53½ thousand older Australians who previously would have been collected in that cohort. You've removed them. So, therefore, there is no way that you can actually make the claim that the wait times have dropped, because the data you're using to make that assessment has changed in that period of time.

Ms Stewart: I don't think that's an accurate description.

Senator RUSTON: Well, you can provide me evidence to counteract that, but that's the evidence Mr Pugh has just given me.

Mr Pugh: Sorry, Senator, I don't believe that it is. What I clearly said was here's who we count on the Support at Home priority system, and, in addition, here's the number of people who are on a minimum service offering waiting for their full service offer.

Senator RUSTON: I know exactly what you've just said. You've basically told me prior to November they were included in the NPS. Post November, they were no longer collected in the NPS data. So unless you're telling me that that's wrong—that they still are collected in the NPS data.

Mr Pugh: The difference is literally—if you had asked me before 1 November, I would have said it's 150 000, of which 50,000 people are—

Senator RUSTON: Oh, no, no, no. That was not your answer. If you can find anywhere where I've asked this question and that's the answer you've given me, that'd be great—because I can tell you you have never given me that answer. And I ask it ad nauseam. You have never given me that answer. But, if you can find that answer that you've given me and contradict me, I'm more than happy to apologise.

CHAIR: I just want to clarify because I think there were two separate questions asked, and I want to check that I've understood. The second question was actually about the average wait times. If I understood you correctly, Mr Creelman, you said that when you were working out average wait times in the old system, it was the wait time for people to get a package. And it also included those people who were on a lower package waiting for a higher one. Then I think what you said was that under the new system, when you're working out average wait times,

what's being calculated is people who are getting any package, which means that people who are getting an MSO are now included in that average, whereas they wouldn't have been included under the old average time calculation. So, when calculating wait times, you were including people who were, effectively, on the equivalent of an MSO before, but you're not now. Is that correct?

Mr Creelman: I don't believe I spoke to the methodology or calculations for the previous system. For the current system, the information that's published on the My Aged Care website represents wait times across all participants. As I mentioned, some participants receive funding within one month—or even quicker than that in some situations—and some participants receive an interim level of funding initially. So it's across both.

CHAIR: The average wait-time measure now is to when you first get funding, whether that be your assigned package in full or your 60 per cent package. Is that correct?

Mr Creelman: I want to be specific. The numbers I'm referring to are where information is published across different priority categories, and I'm not referring to a specific average figure that might be published.

CHAIR: When wait times are published for each category, they now include everyone who either got their package at that level or the 60 per cent?

Mr Creelman: Yes. It would include people with a funded place, and some of those are funded at a 60 per cent level.

CHAIR: But, under the old system, when you were looking at average wait times for particular package levels, it was only the wait time for people who got their package and it didn't include people who got a lower one. Is that right?

Mr Pugh: I think that's the one that Mr Creelman took on notice because we want to go back and double check that that's the same.

CHAIR: If we could get clarity on that, I think that'd be helpful.

Ms Stewart: I would like to say—and I understand the interest in the wait list—that there's a record number of older people receiving these services. We understand the importance around transparency of the wait list, and we are trying to be as accurate as we can. The government's committed to the publication of those if there's feedback about improving that so that it's clearer, but this isn't an accounting trick; this is us trying to be transparent about the wait times. We know there's a lot of interest in it and also recognise that this is a brand new program. We take on board the feedback if it can be clearer, but we are trying to be accurate. More people than ever are receiving it, and we're working on track to deliver that timeframe.

CHAIR: I think what we're simply trying to do, Ms Stewart, is understand what we're comparing and whether we're comparing like for like.

Senator RUSTON: As a point of clarification, is the three-month average wait time in November 2027 for MSO or the full package?

Mr Pugh: In the statements that I provided in this hearing previously, it's an average three-month wait time to some funding or any funding. It includes the interim service arrangements.

Senator RUSTON: The Health Ministers' Meeting communique from 4 September 2026 stated:

Health Ministers agreed to a revised national definition for Delayed Discharge of an Older Person.

Do you have that definition?

Ms Stewart: I'm not sure if I've got the—

Senator RUSTON: I have the communique, but it didn't really say.

Ms Stewart: Yes, you're right. A definition of delayed discharge was agreed to by all the state and territory ministers.

Senator RUSTON: I'm asking: what was the definition?

Ms Stewart: I can take that on notice. I don't actually have it in front of me. Sorry. But I know it's clinically ready for discharge, and it effects the—

Senator RUSTON: If you don't have it, don't make it up. Maybe you could just table it. I'm keen to understand. Could you table that and subsequently how many people are now stranded in hospital by the definition that was agreed to at that meeting. I'm also keen to understand how many hospital assessments were conducted in the April to June quarter.

Ms Stewart: There were 13,900.

Senator RUSTON: Is a hospitalisation at assessment considered as part of the prioritisation process?

Ms Blackwood: The prioritisation for Support at Home places?

Senator RUSTON: Yes.

Ms Blackwood: No, not at present.

Mr Pugh: Did you want to speed through the six or seven supplements?

Mr Creelman: It's not a factor considered in the Support at Home priority system when determining the priority for a funded place.

Senator RUSTON: How many reviews have been submitted for inaccurate results produced from the IAT, and how many of those have been resolved?

Ms Lavithis: There have been 2,208 review-of-decision requests in relation to the IAT. Of those, 644 are in progress and 1,564 have been finalised.

Senator RUSTON: Could you please provide on notice, of the 1,564 that have been finalised, what the categories of finalisation were in terms of the outcomes of those findings. Were they found in favour of the person? Were they found not to have—

Ms Lavithis: We can take that on notice.

Ms Stewart: It's important for the committee to note—I'm not sure if you've got the percentage figure there—that there was a record number of assessments done. That's around the 500,000—

Senator RUSTON: That's fine. You don't have to contextualise everything. I just asked a question, and I'm happy just to get the answer. I'd be keen in the process of that—

Ms Stewart: Sorry. I just thought proportionality is quite important. I think it's—

Senator RUSTON: Proportionality is fine, apart from when you're one of those people that's had an assessment that has appeared to be clinically wrong.

Ms Stewart: It's an important mechanism.

Senator RUSTON: Everybody's a person; they're not a statistic or a number. I really think maybe the department would be well advised to stop talking about things being statistically relevant, or otherwise to actually think about the people that are being impacted by those decisions. I'd also be keen to understand what the average time was for the assessment of those particular reviews.

Ms Stewart: Sure.

CHAIR: Thanks, Senator Ruston. I'm going to quickly put three or four questions on notice. Then I want to give Senator Ananda-Rajah time; she said she has one question. My questions are: What measure, if any, does the department use to determine the proportion of Support at Home participants whose assessed needs are actually being met in full? What data, if any, does the department collect on services that are declined, reduced, or discontinued because a participant cannot or does not agree to pay the required contribution? What analysis, if any, has the department undertaken of whether the transition to Support at Home has increased the number of hours of unpaid care being provided by family members and carers? Finally, what indicators, if any, are the department using to determine whether the program is actually maintaining or improving people's independence, rather than allowing preventable deterioration? I'll go to Senator Ananda-Rajah for our last question.

Senator ANANDA-RAJAH: I want to turn to regional providers. We've heard a lot about how difficult it is for them to provide care. Can you please explain the Regional, Rural and Remote Home Care Workforce Support Program and the additional workers it is delivering for regional communities?

Mr Pugh: The Regional, Rural and Remote Home Care Workforce Support Program funds three organisations to support home care providers in eligible locations to attract, recruit and retain personal care workers. Some of the activities that they undertake include promotion and raising awareness of aged-care career opportunities; assisting home care providers with HR activities, including screening potential workers for the right skills and attributes; supporting personal care workers to develop the skills and undertake training to deliver high quality aged-care services; and enhancing the mentoring and leadership skills of the existing workforce to better support career pathways and retention of new personal care workers. The program is focused specifically, as the name would suggest, on regional, rural and remote areas, where those workforce shortages are most acute. The aim of the program is to add an additional 4,000 home care workers over the three years that the program is in existence, and it's funded $20.5 million over that three-year period. It commenced in 2024-25.

Senator ANANDA-RAJAH: Maybe on notice, if we could get a bit of a breakdown of progress so far, in terms of the number of people who've been recruited or attracted into the sector, that would be helpful.

Mr Pugh: Shall do.

Senator ANANDA-RAJAH: Thank you.

Senator RUSTON: Can I ask one quick question?

CHAIR: It'll have to be quick, because my flight's earlier than yours.

Senator RUSTON: Yes. I'm super keen to understand—I'd like some clarification, following on from Senator Allman-Payne. Mr Pugh, in Senate estimates in March this year, you told us that the decision to proceed with the IAT algorithm was made as part of the 2024-25 budget process, which was obviously finalised in May 2024. Was the absence of the assessor override discretion in the aged care rules known by you from that point?

Mr Pugh: I'll take that on notice.

Senator RUSTON: Thank you.

CHAIR: Thanks very much, everyone. I appreciate your evidence today. The committee will report to the Senate on 24 November 2026, and it's been agreed that responses to questions on notice should be provided by close of business on Tuesday 6 October 2026. That concludes today's hearing. Thanks very much to all the witnesses who appeared before the committee today, to Hansard and Broadcasting for their assistance, and also to the secretariat.

Committee adjourned at 17:29