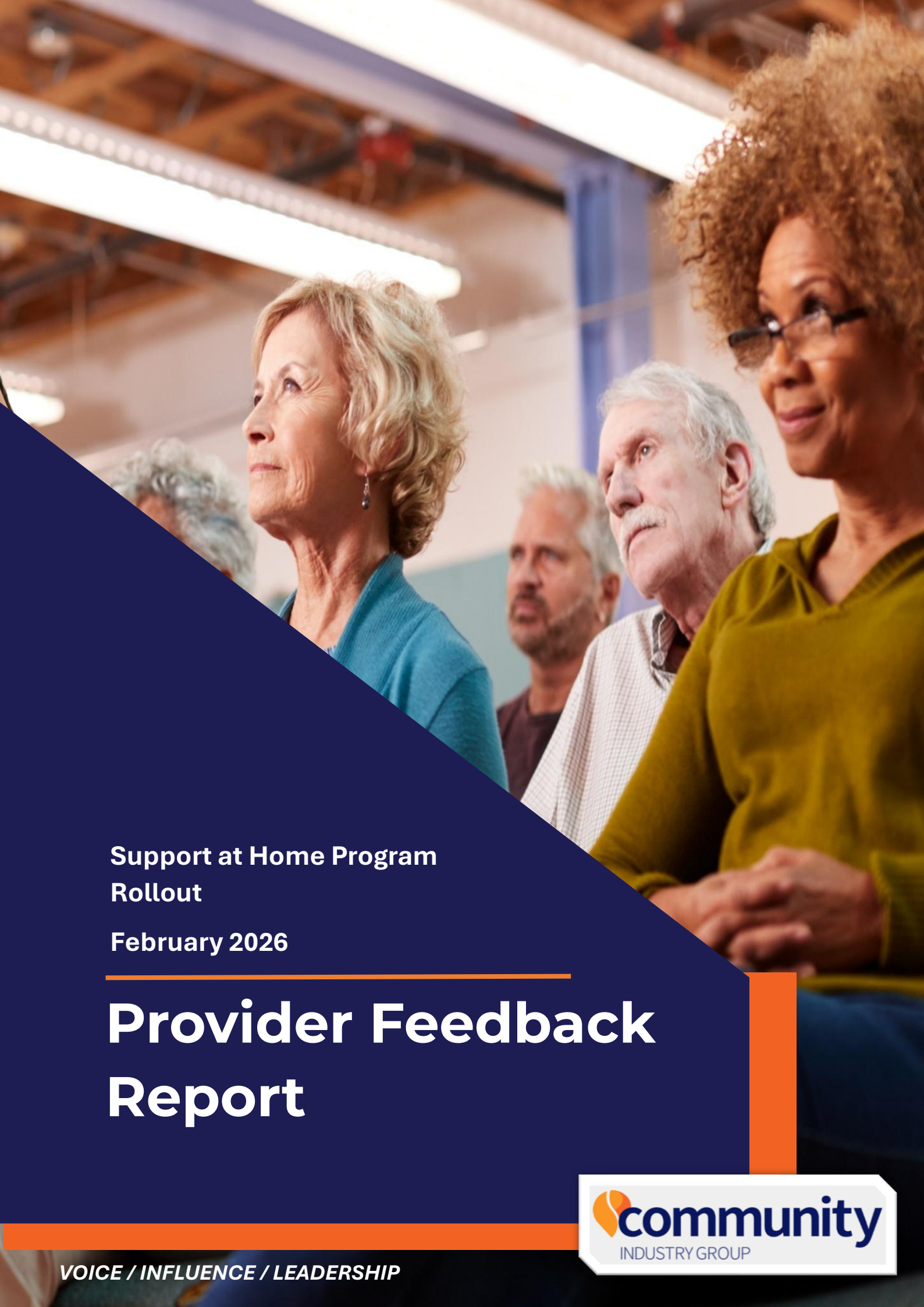


Support at Home Program Rollout

February 2026

Provider Feedback Report

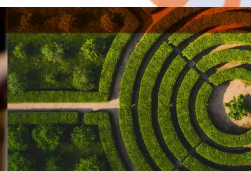
community INDUSTRY GROUP

VOICE / INFLUENCE / LEADERSHIP

ACKNOWLEDGMENT OF COUNTRY

Community Industry Group acknowledges the traditional custodians of this land, and their Elders past, present and future. We acknowledge and respect their continuing culture, the world's oldest living culture, and the contribution they make to the life of this region and our country.
We acknowledge that we live and work on Aboriginal land and recognise the strength, resilience and capacity of Aboriginal people.



Contents

Executive Summary **3**

Introduction **5**

Recommendations **6**

Fix the Assessment System 6

Reduce Administrative Burden 6

Provide Transparent, Consistent Communication 6

Address Financial Sustainability Concerns 6

Support the Workforce 6

What Is Working: Local Provider Feedback **7**

1. Provider Organisational Readiness and Flexibility 7

2. Software and IT Integration Improvements 7

3. Internal Support Networks 8

4. Contribution Costs for Former Income-Tested Fee (ITF) Clients 8

Key Observation: 9

What Is Going Wrong: Critical Issues **10**

1. Assessment Delays and Referral Pathway Dysfunction 10

2. Administrative Burden Overwhelming Capacity 14

3. Inconsistent, Late, and Inadequate Government Guidance 17

4. Pricing, Funding Arrangements, and Financial Sustainability 20

5. Workforce and Morale Crisis 24

6. “No Worse Off” Promise Breaking Down 26

Implications and Risks – Next 6 Months **27**

Conclusion **29**

Appendix **31**

References **31**

Executive Summary

Community Industry Group consulted with members and other Support at Home providers across the Illawarra and Shoalhaven regarding the rollout of the Support at Home Program.

While providers strongly support the intent of the reform, the findings reveal serious implementation failures that are placing unsustainable pressure on service providers and putting client care at risk.

Key Findings[1]:

- **75%** of providers found government guidance "unclear''
- **100%** identified assessment delays as a critical risk
- **88%** of providers are overwhelmed by the increased administrative workload, with **100%** reporting operational disruption to their services
- **88%** cited referral and assessment pathways as most challenging
- **50%** are concerned about the ongoing financial viability of their services
- Only **13%** rated their overall experience with the rollout as positive

What is Working:

- Providers' organisational readiness and flexibility
- Software and IT integration and improvements
- Strong internal support networks within organisations
- Contribution costs for former Income-Tested Fee Clients

Critical Issues:

- Assessment delays creating gaps in care and hospital discharge bottlenecks
- Administrative burden overwhelming provider capacity
- Inconsistent, late, and contradictory guidance from government
- Financial sustainability concerns, particularly for regional, rural, and remote providers
- Client confusion, hardship, and service disruption

[1] CI Group. (2025, December) *Support at Home Transition: Provider Feedback Survey.* Illawarra and Shoalhaven Region

National Alignment

These local findings mirror national reporting. A national provider consultation conducted by Invox identified similar systemic failures, including algorithm-based assessment concerns, rural service gaps, and unsustainable cost-shifting to providers.[2] ABC reporting confirms thousands of older Australians waiting months for reassessment, with some described as “worse off” despite reform promises.[3]

Urgent Action Required:

Without immediate intervention, providers face escalating financial strain, workforce burnout, service reduction, and potential market exit. In regional communities, even small reductions in service availability have significant consequences for vulnerable older Australians.

This report outlines the implementation failures, the limited elements that are functioning, and the urgent corrective actions required to stabilise the reform and restore confidence in its delivery.

[2] Naufal, R. (2025, December 11). *A Letter to the Minister: Provider Feedback on the Support at Home Reform*. Invox.
[3] ABC News. (2025, December 13). *Aged care package reform: Clients worse off amid confusion, despair and lengthy waitlists*. Australian Broadcasting Corporation.

Introduction

The Support at Home Program began on 1 November 2025, fundamentally changing how home care is funded and delivered across Australia. In the months since, Community Industry Group has been talking with aged care providers across the Illawarra and Shoalhaven to understand how the rollout is actually working on the ground.

What we have heard is concerning. While the Aged Care Reforms were designed with good intentions to improve choice, flexibility, and outcomes for older Australians, there has been a significant gap between what was promised and what is happening in practice. This report brings together what local providers are experiencing and compares it with what is being reported nationally. The evidence shows these are not just isolated teething problems or local issues. They are systemic implementation failures that need urgent attention.

Our purpose in preparing this report is straightforward: to give local MPs a clear picture of what is happening in our region and what needs to be raised with the Minister for Aged Care as a matter of urgency. Providers want these reforms to succeed, but right now, the implementation is creating serious risks for both the organisations delivering care and the older Australians who rely on them.

Recommendations

Based on provider feedback and national evidence, the following actions require immediate ministerial attention:

Fix the Assessment System

- Implement clinical override pathways so assessors can correct inappropriate algorithm outcomes
- Increase assessment workforce capacity immediately
- Allow providers to adjust services for changed client needs while awaiting reassessment
- Monitor and publish transparent assessment wait times weekly

Reduce Administrative Burden

- Conduct immediate administrative burden audit with provider input
- Remove duplicative reporting requirements
- Provide testing environments for IT systems before going live

Provide Transparent, Consistent Communication

- Create a direct provider hotline with guaranteed response times
- Stop mid-implementation changes to invoicing and claiming requirements

Address Financial Sustainability Concerns

- Clarify funding caps and long-term arrangements immediately
- Strengthen thin-market grants for rural/remote sustainability with realistic funding levels and provide block funding guarantees for rural/remote services
- Provide transition funding covering actual implementation costs
- Waive co-contributions for people in end-of-life care and genuine financial hardship
- Monitor and publish service availability data by region

Support the Workforce

- Adequate workforce funding for fair wages to retain experienced staff
- Allow a grace period for compliance during transition

What Is Working: Local Provider Feedback

Despite the systemic challenges, providers have identified some elements that are helping them navigate the transition. These positive aspects demonstrate both what is possible when the right supports are in place and the resilience and commitment of the not-for-profit in-home aged care sector.

1. Provider Organisational Readiness and Flexibility

Many providers mobilised internal resources effectively in the lead-up to the rollout, using the extra four months to refine processes, train staff, and prepare systems. Organisations with flexible, experienced teams have been better able to absorb the changes and adjust workloads to maintain service delivery during the transition.

"Having an amazing, flexible team, and a good software provider."

"Our organisation was aiming for the July 1 date. The extra 4 months has given the organisation more time to refine processes."

"Have been well informed with plenty of [internal] meetings, we felt like we were ready for the rollout."

These providers demonstrate what is achievable when organisations have strong internal capacity, committed staff, and adequate preparation time. However, it is worth noting that this level of readiness required significant investment of resources and staff time that was not funded by the transition grant. Providers absorbed these costs because they were committed to making the reforms work. The question is how long providers can sustain this level of effort without additional support.

2. Software and IT Integration Improvements

For some providers, improvements in system integration have made some processes smoother. When IT systems work as intended, they can reduce administrative burden and create efficiencies that benefit both providers and clients.

> *"PRODA now speaks directly with software, and the claim can be completed there. This leaves less room for discrepancies."*

This is encouraging and shows what is possible when systems are properly integrated and tested. The challenge is that this experience is not universal.

- **50%** of providers still reported IT and system issues as a major risk.

The providers who have had positive experiences typically have good software providers and adequate IT support, which again points to the importance of adequate resourcing.

3. Internal Support Networks

Providers who are part of larger organisations or networks have been better positioned to weather the transition pressures. Having access to shared resources, centralised support functions, and organisational expertise has made a real difference in managing the rollout.

> *"From an organisational perspective, [we] are not currently concerned that payroll won't go through, being the size [we] are, [we] have strength in numbers."*

However, this also reveals a significant equity issue. Smaller, independent providers and those in rural and remote areas do not have these safety nets. They are managing the same complex requirements with far fewer resources. The rollout is essentially creating a two-tier system where larger providers can cope (albeit with difficulty) while smaller providers are at serious risk of not surviving the transition.

4. Contribution Costs for Former Income-Tested Fee (ITF) Clients

Providers have reported that changes to contribution arrangements have delivered tangible benefits for some clients previously subject to the Income Tested Fee (ITF).

Under the former system, clients assessed as having income above the threshold were required to pay a fixed monthly Income-Tested Fee. The transition to a percentage-based contribution model, alongside the retention of a 0% contribution for clinical care, has reduced costs for some income-tested clients and improved transparency around how contributions are applied.

Several providers noted that former ITF clients are now paying significantly less overall for their care. The removal of a mandatory monthly fee has alleviated financial pressure for some households and improved access to services.

The decision to maintain a 0% contribution rate for clinical care is particularly welcome. This ensures that essential nursing and health-related supports remain accessible without financial barriers and reinforces the principle that necessary clinical care should not depend on the ability to contribute.

These examples show that when policy settings align with service realities and client needs, positive outcomes are achievable.

Key Observation:

The elements that are ‘working’ share a common thread: they are almost entirely provider driven.

The improvements to contribution settings for some former ITF clients reflect policy design that has delivered tangible client benefits. However, most other elements that are “working” are the result of provider-driven adaptation rather than systemic support.

Flexible teams, good software, organisational strength, and sector commitment are all assets that providers brought to the table. They are not outcomes of the transition support provided by the government. Extra preparation time helped, but providers absorbed the costs of that preparation. IT integration is working for some because they invested in good software providers.

This reveals both the sector's strength and a critical equity issue: smaller, independent, and rural providers lack many of these safety nets. They do not have the same access to IT support, shared services, or organisational backing. They are facing the same complex requirements with significantly fewer resources. The providers who are managing are doing so because of their own capacity and investment, but that is not sustainable long-term, and it is not fair to expect the sector to continue carrying out implementation on their own resources.

What is working is provider resilience and commitment. What is concerning is how much the rollout depends on that resilience without adequately supporting it.

What Is Going Wrong: Critical Issues

1. Assessment Delays and Referral Pathway Dysfunction

Local Evidence:

- **100%** identified assessment delays as a critical risk over the next 6 months
- **88%** cited referral/assessment pathways as most challenging

The assessment system is creating significant bottlenecks that delay or prevent clients from accessing care. Local providers report that the current structure lacks flexibility, meaning clients experiencing changed circumstances cannot receive timely adjustments to support. Instead, they enter a reassessment queue, creating gaps in care at vulnerable moments.

"People in the new assessment structure do not have the flexibility to meet their changing needs. They must be sent back for reassessment - creating delays in the system."

Integrated Assessment Tool (IAT) and Loss of Clinical Oversight

Providers have also raised serious concerns about the operation of the Integrated Assessment Tool (IAT) under the Single Assessment System. The IAT is intended to standardise assessments. However, local feedback indicates that the tool's structured outputs frequently determine care levels that do not align with clinical observations.

A key concern is that assessors appear unable to exercise meaningful clinical override when the algorithm produces an outcome inconsistent with professional judgement. This has resulted in clients not being approved for the level of care that providers believe is clinically appropriate.

Providers report that when inappropriate care levels are assigned:

- Clients must enter an appeals/reassessment process
- Access to services is delayed
- Care gaps widen while waiting for review
- Client trust in the system erodes

The removal of practical clinical discretion at the assessment stage is seen as a significant shift away from person-centred decision-making. Providers are concerned that an

automated tool is effectively determining access to care, without sufficient human oversight or flexibility.

Restorative Care Program (RCP) Referral Barrier

Providers have also raised serious concerns about unintended consequences within the assessment framework relating to the Restorative Care Program (RCP).

Feedback from local services indicates that assessors have been advised they cannot approve both an RCP referral and an ongoing Support at Home (SaH) package at the same assessment. As a result, clients are reportedly being asked to choose between short-term restorative funding and ongoing package funding.

One provider stated:

> *"We have been told by age care assessors that they cannot choose both RCP and SaH packages at the same assessment, so are giving clients the choice. Clients are choosing the package as this funding is ongoing not short-term. We have only received 2 referrals [for RCP] since the 1st November. This program has had amazing outcomes for clients in preventing functional decline and my main concern is that the program will disappear."*

This dynamic is producing a difficult outcome. Clients understandably select the ongoing Support at Home package, as it appears to offer long-term security. However, because package funding is subject to significant wait times, clients are then left without immediate support, even though RCP funding could commence quickly and provide restorative intervention while they await ongoing allocation.

Instead of using RCP as a bridge to prevent deterioration and hospitalisation, the system is effectively bypassing it. This risks:

- Increased functional decline
- Delayed hospital discharge
- Preventable re-admissions
- Loss of a clinically effective early-intervention program

Local providers report that referrals into RCP have dropped sharply since the change, despite continued clinical need in the community. If this trend continues, a program with strong evidence of preventing decline may become unsustainable due to referral suppression created by system design rather than lack of need.

National Evidence Confirms This Pattern:

Invox reports assessors working with an algorithm that delivers *"outcomes they can't easily explain and in many cases, can't adjust even when their clinical judgement points in a different direction."*[4] There are reports of comprehensive assessments resulting in CHSP-only or ineligible determinations *"very out of step with what was observed in the home."*[5]

A recent *ABC* investigation confirms clients are waiting 12+ weeks for reassessment while losing essential services, with one client stating*: "I feel like I've been tossed on the scrap heap."*[6]

Similarly, sector commentary in the *Australian Ageing Agenda* indicates that a significant proportion of clients assessed under the new system are not receiving packages aligned with their observed needs, with some providers reporting rejection rates as high as 37%.[7]

The Impact:

This is not just an administrative delay. This is leaving vulnerable older people without proper care while their condition deteriorates. During these waiting periods:

- **Care needs go unmet:** Falls risk increases, medication management suffers, nutrition declines, and social isolation increases
- **Hospital presentations rise:** Without adequate home support, people end up in emergency departments, the exact outcome the program was meant to prevent
- **Family caregivers burn out:** Unpaid family members fill the gap, often at the expense of their own health and employment
- **Providers face impossible choices:** Continue delivering unfunded care (risking financial sustainability) or reduce services (risking client safety)

The algorithm's rigidity means that assessors, despite being trained clinical professionals, cannot override outcomes, even when their expertise suggests the classification is incorrect. This removes clinical judgment from care planning, replacing it with an automated system that providers and families cannot effectively understand or challenge.

As Invox warns, Support Plan Reviews *"will rapidly become a second queue, drawing assessor time away from clinical work, clogging the system, and delaying services further."*[8]

---

[4] Naufal, R. (2025, December 11). *A Letter to the Minister: Provider Feedback on the Support at Home Reform*. Invox.

[5] [as above]

[6] ABC News. (2025, December 13). *Aged care package reform: Clients worse off amid confusion, despair, and lengthy waitlists*. Australian Broadcasting Corporation.

[7] Jones, K. (2026, February 11). *Calls for assessors to be able to 'override the algorithmic decision'.* Australian Ageing Agenda

[8] Naufal, R. (2025, December 11). *A Letter to the Minister: Provider Feedback on the Support at Home Reform*. Invox.

Providers expect to ‘be flooded’ with these reviews by early 2026, which will further compound delays rather than resolve them. The system is creating its own crisis.

Actions Required:

- Implement clinical override pathways so assessors can correct inappropriate algorithm outcomes
- Increase assessment workforce capacity immediately
- Allow providers to adjust services for changed client needs while awaiting reassessment
- Monitor and publish transparent assessment wait times weekly

2. Administrative Burden Overwhelming Capacity

Local Evidence:

- **88%** of providers identified increased administrative workload as a major risk. The volume and complexity of new requirements are pulling resources away from direct client care.

Providers report that administrative staff are burnt out and care coordinators are overwhelmed:

"Teams are burnt out. Coordinators have borne the brunt of conversations, information, budgets, and managing caseloads."

"Administration burden - pricing had been entered but was not showing correctly on MAC, so emails from the department flagged non-compliance. When providers were transitioned across, there was incorrect information about services they never provided."

The burden is not limited to increased reporting. It reflects structural design issues within the rollout that require repeated corrections, rework, and client renegotiation.

Minimum Service Offer (MSO) Packages

One of the most significant contributors to the administrative burden complexity is the approval of Minimum Service Offer (MSO) packages, effectively interim packages that provide only 60% of the approved Support at Home funding level.

Providers report that:

- Clients are often not clearly informed or are unaware that they have been approved for an MSO rather than a full funding allocation.
- Systems and provider software were not originally configured to accommodate 60% funding levels.
- Care plans, budgets, and service agreements frequently need to be redone once the MSO status is identified.

One local provider shared the following case study:

"We signed up a new client's Support at Home funding, had a Care Partner go out and do their budget and advise them on their weekly service amount. After accepting the client's code, it was noticed by one of our staff that they were only approved for an MSO. Not only was our IT system not set up to provide a 60% funding package level, but then our Care Partner had to go out and redo the service agreement and budget with the client."

This creates:

- Duplicate administrative work
- Client confusion and loss of confidence
- Increased pressure on care coordinators
- Delays in service commencement

There is also a significant equity concern. Clients transitioning from a lower-level Home Care Package to a higher Support at Home classification may, under an MSO arrangement, receive less effective funding than they previously had, despite being assessed as needing a higher level of care. This is both administratively inefficient and clinically counterproductive.

Assistive Technology and Home Modifications (ATHM) Funding

Providers have also reported administrative complications arising from the allocation of Assistive Technology and Home Modifications (ATHM) funding without concurrent allocation of Support at Home package funding. Often these are small amounts ($500 - $2,000) which are inviable for a provider to initiate without the full care package in place.

When ATHM approvals are provided in isolation:

- Clients may have equipment or modification funding approved but lack ongoing package funding to support implementation, coordination, or complementary care services
- Providers are required to manage fragmented funding streams with separate compliance and reporting pathways

This separation creates further administrative complexity and delays, particularly when modifications are required urgently to enable safe discharge from hospital or prevent falls.

Rather than streamlining access to assistive supports, the current structure is adding additional coordination layers for providers already under strain.

The Impact:

The administrative load is not just inconvenient; it is redirecting resources from care delivery to compliance management. Providers report that time and staff capacity are increasingly absorbed by navigating changing requirements, system issues, and late or fragmented guidance, rather than supporting older people. Care coordinators are under pressure, managing complex client conversations, budgets, and caseloads while also responding to compliance concerns. The cumulative effect is that workforce strain and burnout are at a critical point in the transition, with real implications for service continuity and quality of care.

Actions Required:

- Conduct immediate administrative burden audit with provider input
- Remove duplicative reporting requirements

3. Inconsistent, Late, and Inadequate Government Guidance

Local Providers:

- **75%** of providers identified inconsistent government guidance as a major risk
- **75%** found communication “unclear or very unclear”

Providers report being expected to implement changes without clear, consistent information about what is required. The communication problem is not about volume, it is about clarity, consistency, and timing. Information arrives late, changes frequently, and often lacks the operational detail providers need to actually implement it.

Providers are left to interpret requirements on the fly, risking non-compliance despite their best efforts:

"The transition and shift to Support at Home has been monumental for home care providers on top of implementing other requirements of the Act and the SAQS. With fragmented information drip fed from the Department and very late in the piece, so many aspects of implementation have been left to last minute and with many gaps."

"Have the Government give better communication around expectations for invoicing, they have twice now changed the line items to be used, so are rejecting invoices. There must be communication to managers of packages about time frames for funding release. Clients must be told what % they are to pay as they ring the package provider who may not have been told."

Information overload without clarity is as problematic as no information at all. Several providers captured the frustration:

"Monumental shift for home services whilst many know about the S@H program. There have been new Acts and new quality standards. The volume of information coming from Services Australia has been crazy—changes ongoing but limited information when trying to implement."

"I think there has been almost too much information available to the extent that it has been hard to prioritise and read the information and attend webinars and training whilst also doing the doing and implementing the changes required."

Inter-Agency Communication and System Misalignment

Providers also reported significant breakdowns in communication between Services Australia, hospital-based assessors, assessment teams, and service providers.

Conflicting information is frequently given to clients regarding contribution requirements, funding approvals, and available care pathways. Providers are often left to clarify or correct this information after the fact, increasing administrative burden and undermining client confidence.

Hospital-based assessors are reportedly unaware that they can request support plan reviews while a client is admitted. As a result, discharge planning is delayed unnecessarily, particularly when clients are waiting for Support at Home approvals.

When clients receive inconsistent advice from different parts of the system, trust erodes. In regional communities, where hospital capacity and workforce availability are already constrained, these coordination failures have amplified consequences.

Providers report that inter-agency communication gaps are contributing to:

- **Delayed hospital discharges and bed block**, where clients remain admitted while awaiting funding clarity
- **Avoidable deterioration in client health**, as services cannot commence in a timely manner
- **Increased emergency department presentations**, particularly when home supports lapse or are delayed
- **Duplicated administrative work**, as providers re-explain, re-document, and re-clarify information across agencies
- **Client disengagement**, where confusion or perceived unfairness leads older people to withdraw from services

In a regional setting, where hospital beds are limited and workforce capacity is already stretched, even small breakdowns in coordination create disproportionate impacts.

National Evidence Confirms:

Invox reports that this system is *"causing delays, disputes and confusion"* with providers finding that often *"the system is contradicting itself."*[9] As a result, providers are required to spend additional time verifying and clarifying information with the department, adding to their already heavy administrative burden, while they work to remain compliant.

[9] Naufal, R. (2025, December 11). *A Letter to the Minister: Provider Feedback on the Support at Home Reform*. Invox.

The Impact:

When invoicing requirements change mid-implementation, and previously submitted invoices get rejected, providers face cash flow problems. When clients call asking about their contribution percentage and the provider has not been told what it is, trust breaks down. When the system shows one classification, but the assessment says another, providers do not know which to follow, and risk being non-compliant regardless of which choice they make.

This is not providers resisting change or failing to read updates. It is a structural communication failure where those tasked with implementing reform do not have the right information, at the right time, in a format that enables compliance. Providers are making good-faith efforts to comply with requirements that keep shifting under their feet. That is not sustainable.

Actions Required:

- Create a direct provider hotline with guaranteed response times
- Stop mid-implementation changes to invoicing and claiming requirements

4. Pricing, Funding Arrangements, and Financial Sustainability

Local Evidence:

- **63%** of providers identified pricing and funding arrangements as most challenging
- **50%** listed financial viability as a major risk

Providers consistently report that pricing, funding arrangements, and financial sustainability are among the sector's most pressing challenges. Providers face ongoing uncertainty about whether funding will cover actual service costs, particularly in regional and remote areas:

> *"Concerned that there is no funding certainty. There are big risks that organisations in far-reaching areas will not be able to maintain services as the cost is too great. They don't know what the cap introduced will be, so they don't know if they will be able to continue after it."*

The issue of client contributions adds another layer of complexity and risk:

> *"There are concerns about inflexibility, backlog of support plan reviews, how client contributions will play out, and people falling through the cracks. Affordability means different things to different people. Providers have to carry the financial burden and then bear the brunt of charging the client if hardship is not approved."*

Providers describe being placed in impossible positions, navigating unclear pricing guidance while absorbing implementation costs:

> *"Providers were pinned against the wall with indicative pricing, leaving them to communicate pricing to older people for seven months. Providers are doing the hard yards for ACHPA. Training had to happen internally before rollout, but systems had no ability to manage two pricing systems. Across the sector, there has been provider frustration as government has not given enough info to clients. Transition costs now need to be factored in, but not explained to clients."*

The government has effectively outsourced the communication burden to providers while providing inadequate funding certainty. One provider noted the vulnerability of thin-market rural supports:

"Rural and remote thin-market grants are almost not worth the paper they are written on."

Hardship Applications

A significant proportion of feedback from the provider forum held related to the hardship application process, which is widely regarded as burdensome, duplicative, and distressing for clients. Many clients, but particularly full pensioners, perceive the hardship process as invasive and unnecessary, given that Services Australia already holds detailed financial information about their circumstances.

As one provider stated:

"Services Australia already has all the details for full pensioners, so why do they need to go through the hardship process all over again?"

Providers report that clients are often reluctant to initiate hardship applications due to privacy concerns, confusion, or limited capacity to navigate complex forms. In practice, the burden frequently falls on providers to guide clients through the process, despite there being no funded mechanism to recover the time and administrative costs involved.

The inefficiency of the process is further illustrated by a recent case in which:

"One hardship application took over a month to process, only to require a $0.05 contribution. The administrative cost of issuing and managing a charge of this magnitude exceeds the value of the contribution itself, and in most cases, we would waive the fee."

In another case:

"A client was informed that they were required to contribute; however, as they knew of other friends in the system who did not, they perceived the system as unfair and decided to cancel all services. After 3 days, we were contacted by the local hospital to advise that the client had experienced a fall at home, resulting in injury and is now in the hospital needing more care."

These examples illustrate that hardship settings are not mere administrative annoyances; they directly affect service continuity, client well-being, and hospital demand. Slow, complex, or obscure processes drive vulnerable older people away from care.

Price Caps and Funding Uncertainty

Providers also raised concerns regarding price caps and uncertainty around future pricing arrangements.

Regional providers face higher operational costs due to travel distances, dispersed populations, workforce shortages, and competition with metropolitan markets. Capped pricing limits their ability to reflect genuine service costs. For not-for-profit providers in thin markets, margins are already tight, and uncertainty prevents workforce planning, service expansion, or long-term investment. Many are relying on reserves or cross-subsidisation, a practice that is not sustainable.

Without greater flexibility, regional loadings, or transparent forward pricing, service availability in regional communities is at risk. This is not a question of profit, but of viability: if providers cannot make informed decisions, people in small towns may be left without essential services.

National Evidence:

On a national scale, the Invox consultation output is clear about the funding gap: *"$10,000 transition grant barely scratches the surface…Frontline teams stretched to breaking point because there is simply no funding to resource the change properly."*[10] They note that providers are absorbing major unfunded costs across workforce, systems, IT, administration capacity and compliance work while being expected to maintain quality and continuity of care.

On the client side, Invox reports that *"full pensioners on transitioned packages suddenly being hit with 5% + 17.5% contributions, even when they have unspent funds available…Clients in end-of-life care at home being unable to afford the daily supports they need."*[11]

ABC confirms this, reporting clients on full pension now facing unexpected $60/week costs, with one stating: *"I can't afford to eat properly and pay for my care."*[12]

---

[10] Naufal, R. (2025, December 11). *A Letter to the Minister: Provider Feedback on the Support at Home Reform*. Invox.

[11] [as above]

[12] ABC News. (2025, December 13). *Aged care package reform: Clients worse off amid confusion, despair, and lengthy waitlists*. Australian Broadcasting Corporation.

Impact:

This is creating a financial squeeze from both directions. Providers are absorbing costs they cannot sustain long-term while also being put in the position of having to charge clients, many of them pensioners, contributions they cannot afford. When providers choose to absorb client costs rather than cause hardship, they are subsidising the system from their own reserves. That is not viable, particularly for smaller providers without deep financial buffers.

The uncertainty about funding caps means providers in regional areas cannot make informed decisions about whether they can continue delivering services in outer areas. If they commit to serving a community and the price cap makes it financially impossible, do they abandon clients mid-care? If they do not commit, do people in those communities simply go without services?

The result is an emerging pattern where people in rural communities have been approved for Support at Home services but cannot find a provider willing to take them on. They are stuck in limbo, technically eligible for care, but practically unable to access it. For someone in a small town who needs support to stay in their own home, this is not a minor inconvenience. It is the difference between aging in their community and being forced to relocate.

Meanwhile, clients who thought they understood what they would be paying are being hit with unexpected costs. Pensioners are making impossible choices between food, medications, and care. People at the end of their lives cannot afford the support to stay at home with dignity. This is not the person-centred care that was promised.

Actions Required:

- Clarify funding caps and long-term arrangements immediately
- Strengthen thin-market grants for rural/remote sustainability with realistic funding levels and provide block funding guarantees for rural/remote services
- Provide transition funding covering actual implementation costs
- Waive co-contributions for people in end-of-life care and genuine financial hardship
- Monitor and publish service availability data by region

5. Workforce and Morale Crisis

Local Evidence:

While workforce capacity was not the top statistical concern, the qualitative feedback reveals a human toll:

> *"I think the sector will lose a lot of good people over this rollout. The changes have put Care Partners in a very difficult situation and have Operations Managers tearing out their hair. We all just want to support older people to live safely at home for as long as possible, and the government has made this a lot harder to do."*

The new framework for service agreements seems to be a source of much of this burnout, with:

- **50%** of providers identified service agreements as highly challenging
- **100%** of providers reported operational impact (**50%** as a significant challenge)

> *"Clients with four providers have now been bombarded with four new service agreements. Four different client contribution frameworks, all different. Other providers do not know what clients are paying. Clients interpret this as being charged for every conversation."*

The Impact:

Experienced, committed staff are burning out:

- **Aged care workers and associated providers** are struggling to meet the increased requirements of the newly introduced compliance training
- **Care partners** who used to spend their days building relationships with clients and delivering support are drowning in paperwork.
- **Operations managers** who used to focus on service quality are spending all their time trying to interpret changing requirements and fix system errors.
- **Managers** are bearing the brunt of difficult conversations with confused and distressed clients about costs and changes they cannot fully explain.

When skilled workers leave the sector, they take years of knowledge, relationships, and expertise with them. In regional areas, this loss is even more significant. The pool of potential workers is smaller, recruitment is harder, and replacing experienced staff can take months

or years. When a small provider loses a key staff member, it can threaten the viability of the entire service.

Actions Required:

- Adequate workforce funding for fair wages to retain experienced staff
- Allow a grace period for compliance during transition

6. “No Worse Off” Promise Breaking Down

The “no worse off” principle was central to the government’s promise during the reform, intended to reassure existing care recipients that they would not lose support during the transition. On the ground, however, that promise is proving impossible to uphold.

Local Evidence:

One provider kindly shared a case study of a transitioned HCP client:

> *“One client was receiving daily medication prompting under their previous HCP service arrangements. After the reforms and the subsequent price increase for hourly services, the client had to choose to reduce their essential daily medication prompting service to only twice a week. Within 2 weeks, the provider was alerted that the client had been admitted to their local hospital due to a medication-related incident”*

The Impact:

Clients with established care patterns are finding the new system unable to replicate their previous support. Some are reclassified into packages that provide less funding, while others face new co-contributions that make maintaining their prior service level unaffordable. Many are caught in reassessment queues, with old packages ended and new arrangements not yet in place. The outcome is that people are rationing essential care, placing both their well-being and safety at risk.

Implications and Risks – Next 6 Months

The issues outlined in this report are already having operational consequences. If not addressed urgently, the following impacts are likely within the next six months.

For Providers:

- **Financial distress and potential closures (particularly smaller/rural providers):** Rejected invoices due to changing claiming rules, delayed funding releases, hardship processing delays, and MSO funding gaps are creating immediate cash flow strain. Several providers report absorbing unrecoverable administrative costs simply to maintain continuity of care. Smaller regional providers operating on thin margins will not be able to sustain this indefinitely.
- **Ongoing workforce burnout and exodus:** Managers are spending increasing time resolving system contradictions, clarifying client contribution information they have not been provided, and navigating assessment inconsistencies. This diverts attention from service quality and staff support. Sustained administrative overload will accelerate burnout and drive experienced staff out of the sector.
- **Reduced service capacity as resources shift to administration:** Time spent correcting invoice rejections, assisting with hardship applications, and resolving inter-agency miscommunication directly reduces time available for care coordination and workforce support. This is already constraining service responsiveness.
- **Compliance failures despite good-faith efforts:** When guidance changes mid-implementation, or systems display classifications that contradict assessment documentation, providers are placed in an impossible position. Even when acting in good faith, they risk non-compliance due to unclear or conflicting direction.

For Clients:

- **Service disruptions and delays in care:** Assessment bottlenecks, inability to request timely support plan reviews during hospital admissions, and delays in funding confirmation are contributing to interruptions in service delivery.
- **Confusion and stress navigating complex systems:** Clients are contacting providers seeking clarification about contribution percentages or approval outcomes that providers themselves have not been formally advised of. This erodes confidence and creates anxiety for older people and their families.

- **Reduced access to care (particularly in regional/rural/remote areas):** If even one local provider reduces capacity or exits the market, there are limited alternative options. In thin markets, service contraction has immediate consequences.
- **Financial hardship and disengagement from services:** The hardship process has been described as invasive and duplicative. Clients are already reported to be reducing or cancelling necessary care services.

For the Health and Aged Care System:

- **Increased hospital pressure and bed block:** Delays in approvals and service commencement mean some older people remain in hospital longer than clinically necessary, while others are readmitted due to preventable deterioration at home.
- **Undermining of reform intent:** the program was meant to improve person-centred care, but implementation is creating the opposite
- **Erosion of sector trust:** providers who support reform principles are losing faith in government capacity to implement effectively
- **Reputational damage:** poor rollout reflects badly on government and reduces public confidence in the aged care system

This is not hypothetical. National reporting (Invox, ABC, Australian Ageing Agenda) confirms these patterns are emerging across Australia. What we are seeing locally aligns with national trends. This is a systemic implementation failure.

Conclusion

The Support at Home Program was designed with the right intentions: to improve person-centred care, increase flexibility, and deliver better outcomes for older Australians. Providers across southern NSW understand and support these principles. They want the reforms to succeed because they believe in what the program is trying to achieve.

However, the implementation is not working as intended.

What should be a transformation toward better care has instead become an administrative and operational strain that is overwhelming provider capacity, burning out dedicated staff, confusing and distressing clients, and threatening service sustainability, particularly in regional and rural communities.

Assessment bottlenecks are delaying care. The rigidity of the Integrated Assessment Tool is limiting clinical judgment. Hardship processes are burdensome and, in some cases, produce negligible outcomes after lengthy delays. Interim and Minimum Service Offer packages are creating funding confusion. Inter-agency communication gaps are contributing to delayed hospital discharges and unnecessary health system pressure. Administrative demands are redirecting time and resources away from direct client care.

These are not abstract policy issues. They are resulting in cancelled services, delayed support, increased hospital presentations, and growing financial pressure on not-for-profit providers operating in thin regional markets.

This is not a case of providers resisting reform. These are organisations that chose to work in aged care because they care deeply about supporting older Australians. They have mobilised internal resources, absorbed unfunded costs, and stretched their capacity to breaking point trying to make this work. However, they cannot continue to succeed when government guidance is unclear and contradictory, when funding certainty is absent, when assessment systems create bottlenecks instead of enabling care, when administrative burdens overwhelm operational capacity, and when clients are confused and distressed by a system that's meant to help them.

Without targeted and timely intervention, we risk:

- Reduced service availability in regional communities
- Financial distress for smaller providers
- Workforce exodus
- Increasing Bed Block numbers

- Older people being forced to leave their communities to access care

The intent of the reforms is sound. The implementation requires urgent recalibration to ensure it delivers on its promise.

Regional providers stand ready to work constructively with government to stabilise delivery and ensure that Support at Home achieves its intended outcomes. The sector's commitment is clear. What is needed now is coordinated action.

Appendix

Community Industry Group Consultation: The Community Industry Group consulted aged care providers delivering Support at Home (SaH) services across the southern regions of NSW through a combination of individual consultations and survey responses conducted during December 2025 and January 2026.

Provider Profile: Respondents deliver a broad range of services, including allied health, personal care, domestic assistance, social support, transport, home maintenance /modifications, lawn and garden maintenance, flexible respite, and nursing.

Data Collection and Analysis: Survey responses were systematically collected and analysed to identify key themes, challenges, and actionable recommendations. Provider quotes are presented anonymously to protect organisational confidentiality while ensuring that provider perspectives are authentically represented.

In-Home Aged Care Provider Forum: In February 2026, the Community Industry Group hosted an In-Home Aged Care Provider Forum to gather collective feedback from providers delivering SaH services throughout the Illawarra, Shoalhaven, and Southern NSW regions. Insights from this forum complement individual consultation and survey findings, providing a comprehensive understanding of sector challenges and priorities.

References

Naufal, R. (2025, December 11). *A Letter to the Minister: Provider Feedback on the Support at Home Reform*. Invox.

ABC News. (2025, December 13). *Aged care package reform: Clients worse off amid confusion, despair, and lengthy waitlists*. Australian Broadcasting Corporation.

Jones, K. (2026, February 11). *Calls for assessors to be able to override the algorithmic decision*. Australian Ageing Agenda

For More Information:

E: info@cigroup.org.au

PH: (02) 4256 4333

W: communityindustrygroup.org.au

Community Industry Group

Lot 26 Mortlock Ave,

Port Kembla, 2505

ABN 95 589 148 519

community
INDUSTRY GROUP