COVER LETTER

18 December 2025

Dear Committee Members,

Cc: Aged care decision-makers, aged care advocates, and older Australians and families with lived experience of SAH.

Please find enclosed my submission regarding the Support at Home (SAH) program and its capacity to deliver safe, effective and rights-consistent care for frail and clinically complex older Australians.

The submission's central finding is that SAH's single pooled-budget architecture for frailty creates predictable trade-offs between non-optional elements of safe care, including timely clinical review, personal care, domestic supports, allied health, supervision and care management. In practice, this design increases the risk of preventable deterioration, avoidable emergency department presentations and hospital admissions, and financially coercive pathways into residential aged care—outcomes that are inconsistent with the rights-based intent of the *Aged Care Act 2024*.

I respectfully request that the Committee and relevant decision-makers consider the structural reforms set out in Part 12, including: (1) separating and protecting essential clinical funding for frailty; (2) mandating timely, face-to-face RN assessment and review for high-risk cohorts; and (3) embedding enforceable commencement, continuity and escalation safeguards so that approved services translate into real-world support.

Thank you for considering this submission. I am available to provide further clinical detail or to appear at a hearing if requested.

Kind regards,

Palantina (Tina) Hughes

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Support at Home and Frailty Funding: How Pooled Budgets Create Predictable Care Trade-offs, Preventable Harm and Institutionalisation — and the Reforms Required

Submission on the Support at Home Program and alignment with the Aged Care Act 2024 (Cth)

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Date: 18 December 2025

Version: Final 18 December 2025

ACKNOWLEDGEMENT OF COUNTRY

I acknowledge the Traditional Custodians of Country throughout Australia and their continuing connection to land, waters and community. I pay my respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples.

In Lutruwita (Tasmania), I acknowledge the Palawa people as the Traditional Owners and Custodians of Country. I recognise their enduring cultures, knowledge systems and stewardship, and I commit to culturally safe, respectful practice in all care and advocacy.

AI ACKNOWLEDGEMENT

This submission was authored by Palantina (Tina) Hughes (Clinical Nursing Home Care Consultant and Registered Nurse). Generative AI tools were used for limited editorial support (formatting, proofreading and reference cross-checking). All substantive analysis, clinical opinions, interpretations and final content decisions remain the author's responsibility.

Executive Summary

This submission examines whether the Support at Home (SAH) program can deliver safe, effective and rights-consistent care for frail, clinically complex older Australians living in the community. It is grounded in three forms of evidence: (1) routine community clinical practice observation in Tasmania (used as an exemplar for Australia-wide structural settings); (2) Commonwealth program design, funding rules and pricing architecture as published for SAH and the extended Commonwealth Home Support Programme (CHSP); and (3) authoritative national reporting and peer-reviewed evidence on frailty trajectories, preventable deterioration, older-person hospital demand, residential aged care substitution, and end-of-life outcomes. It finds that, without structural reform, SAH's pooled, capped budgets for frailty will result in predictable under-care, preventable crises, and avoidable institutionalisation.

Central finding

The central finding is that, as designed, SAH fails the frailty cohort because it requires essential clinical care, personal care, domestic supports, supervision, allied health, and care management to be purchased from a single capped pool of funds. For frail older people with multimorbidity, cognitive impairment, complex wounds, high falls risk and carer fragility, this is not a "consumer choice" architecture. It is a rationing mechanism that forces predictable trade-offs between non-optional elements of safe care. Where a person's preference and clinical feasibility support remaining at home, the pooled funding model makes safety contingent on what can be sacrificed: showers versus meals, continence support versus hygiene and laundry, wound care versus supervision, clinical review versus the household supports that prevent delirium, malnutrition, infection and carer collapse. The consequence is not reduced public expenditure; it is a transfer of costs into public hospitals and residential aged care, with additional uncounted transfers to unpaid carers and to older people's own savings and superannuation.

What the case studies demonstrate

This submission includes four conservative case studies modelled at the minimum clinically defensible floor not aspirational care. The modelling demonstrates that, even after reducing service volumes to the lowest levels an experienced community clinician could plausibly endorse, the cost of maintaining basic safety in high-risk homes exceeds SAH budget capacity by large margins. Importantly, these case studies do not describe what people currently receive. They quantify what would be required to plausibly stabilise risk for frail, clinically complex individuals at home. In practice, most frail older people receive substantially less due to funding ceilings, workforce discontinuity, service unavailability, access delays, and organisational decisions that deprioritise clinical input to preserve cheaper personal and domestic hours.

Why “clinical governance” does not ensure clinical care

The submission distinguishes between clinical governance and clinical care because this distinction is central to the observed failure mode. Clinical governance policies, templates, desk-based sign-off, care plans and remote oversight can create the appearance of safety without delivering the direct clinical assessment, monitoring, intervention and escalation that frailty requires. In the community aged-care market, governance language is sometimes used to imply that clinical care is occurring when it is not. For frail older people, risk is identified and mitigated primarily through face-to-face assessment in the home, followed by timely clinical review, escalation and coordination with medical and allied health services. A system that substitutes office-based governance for direct nursing assessment may meet administrative expectations while failing clinically—until the predictable consequence occurs: deterioration at home, emergency presentation, admission, and institutional placement.

System consequences: hospital demand, bed pressure and residential substitution

The design settings that suppress prevention in the community predict the system outcomes reported nationally for older cohorts: high admission rates from emergency presentations, longer lengths of stay, preventable complications, delayed discharge when safe supports cannot be arranged, and premature transition to residential aged care when households cannot sustain risk. Under-funding and rationing of daily supports, supervision, consumables, allied health and timely home modifications do not remove need; it shifts need to acute and institutional settings. This is the funding of failure: the system defends constraints on preventive home care while paying substantially higher costs once deterioration has progressed to hospitalisation and residential placement.

Rights-based intent and de facto forced institutionalisation

The Aged Care Act 2024 and related reforms are explicitly framed as rights-based, emphasising dignity, safety, quality, and support that are consistent with the older person’s choices. These rights are rendered largely theoretical for the frailty cohort when the funded home pathway cannot purchase a minimally safe configuration of supports. In that context, institutional pathways are not freely chosen. They become the predictable default when budgets, delays and service constraints make safe home care unattainable. This submission describes that outcome as de facto forced institutionalisation: institutionalisation driven by design and affordability settings rather than by clinical necessity or genuine preference.

Priority reforms sought

The submission proposes a targeted reform package to correct the structural defect and realign SAH with clinical reality and statutory intent. The reforms prioritise prevention, timely access, and enforceable clinical accountability for high-risk cohorts. The purpose

is to reduce avoidable deterioration, improve safety and dignity at home, and reduce downstream costs to hospitals and residential aged care.

Priority recommendations

1. Correct the single-pool budget defect for frailty. Establish protected funding or a structurally separate entitlement for safety-critical supports in high-risk cohorts so that essential clinical care cannot be displaced by domestic and personal care within a capped pooled budget.
2. Mandate face-to-face RN assessment and review for high-risk cohorts; define governance as supplementary. Require an in-home, face-to-face Registered Nurse assessment at entry for frail/clinically complex participants (including those with advanced frailty, complex multimorbidity, cognitive impairment, recurrent falls/delirium, complex wounds, high-risk medicines, or carer fragility), followed by minimum review intervals, escalation triggers and documented clinical accountability. Desk-based "clinical governance" activities must be explicitly defined as supplementary and must not be treated as a substitute for direct clinical assessment and care.
3. Household-realistic funding logic for coupled frailty. Reform authorisation and budgeting rules so couples are not forced into artificial person-based allocations for shared domestic risks and care tasks, and so clinical and household safety needs can be met transparently without informal cross-subsidisation.
4. Guarantee timely access to assistive technology, home modifications and safety-critical consumables. Ensure high-risk participants have rapid access to modifications and equipment required for safe transfers, hygiene and pressure injury prevention, and establish predictable funding for consumables essential to continence, wound care, skin integrity and nutrition.
5. Reduce "approved-but-unsupported" risk through enforceable time-to-commence and interim supports. Introduce enforceable timeframes and interim service mechanisms where assessment or service commencement delays expose frail people to foreseeable harm.
6. Align contribution settings with prevention and safety. Ensure co-payment settings do not suppress uptake of the everyday supports that prevent avoidable admissions and premature residential aged care entry, particularly for high-risk cohorts where prevention failures have predictable acute and institutional cost consequences.
7. Strengthen provider clinical capability expectations and transparency. Require providers delivering high-risk SAH services to demonstrate minimum clinical

capability (including escalation systems, staff mix, and governance that supports, rather than replaces direct care), and require transparent reporting on clinical review frequency, deterioration events and avoidable transfer outcomes in frailty cohorts.

Bottom line: As designed, Support at Home cannot deliver safe, rights-consistent community care for frail, clinically complex older Australians because it forces all non-optional elements of safety, clinical oversight, personal care, domestic support, supervision, allied health, and care management into a single capped pool, guaranteeing harmful trade-offs. The predictable result is under-care at home, carer collapse, preventable deterioration and avoidable hospitalisation, culminating in premature entry to residential aged care that is driven by funding design and affordability constraints rather than clinical necessity or genuine choice.

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PART 1 — INTRODUCTION, PURPOSE, SCOPE, AND CONTEXT

1.1 Purpose of this submission

This submission critically examines whether the design and funding architecture of the Support at Home program, implemented alongside Australia's new rights-based aged care legislation commencing on 1 November 2025, can safely and equitably support frail older Australians to remain at home (Aged Care Act 2024 (Cth)); (Department of Health, Disability and Ageing 2025a). The central finding is that the program's core funding mechanics compel clinically unsafe trade-offs for people with frailty because clinical care, personal care and domestic assistance must be purchased from the same capped budget, despite these domains being concurrently essential for safety and functional survival in advanced frailty (Department of Health, Disability and Ageing 2025b); (My Aged Care 2025a).

This is not a critique of home-based aged care as a policy objective. Ageing at home is widely preferred, and several elements of the Support at Home program are conceptually sound, including an explicit rights basis and an intention to simplify the funding landscape (Royal Commission into Aged Care Quality and Safety 2021); (Department of Health, Disability and Ageing 2025a). The critique advanced here is narrower and more serious. When tested against the predictable physiology and service requirements of frailty, the program's structural design fails to provide a reliable pathway to remain safely at home and, in doing so, increases preventable deterioration, avoidable hospitalisation and premature entry to residential aged care (Clegg et al. 2013; Inacio et al. 2025).

1.2 Rights-based reform context and policy significance

The Parliament of the Commonwealth of Australia enacted a new rights-based aged care framework through the Aged Care Act 2024 (Cth), which received Royal Assent on 2 December 2024 and commenced on 1 November 2025 (Aged Care Act 2024 (Cth)). The Australian Government describes this as placing older people's rights at the centre of the aged care system, through a Statement of Rights and associated duties on approved providers (Department of Health, Disability and Ageing 2025a).

The Support at Home program commenced in alignment with this legislative transition as the principal home-based aged care program for older Australians (Department of Health, Disability and Ageing 2025b). In policy terms, this means that the practical realisation of the rights-based Act in the community depends heavily on whether the Support at Home program can fund the minimum safe bundle of support that frail older people require to live at home with dignity and without avoidable harm.

A rights-based Act cannot be realised in practice if the dominant home-care program's financial architecture structurally requires older people to forgo essential supports. For example, if a person must reduce domestic safety tasks such as cleaning, laundry and meal preparation to afford frequent nursing care, or if clinically required services cease

when the quarterly budget is exhausted, then rights to safe, high-quality care and to remain at home become conditional on personal wealth, informal care availability or tolerance of clinical decline until a crisis triggers hospitalisation or institutional (Aged Care Act 2024 (Cth); Senate Community Affairs References Committee 2024).

1.3 Scope and focus of this submission

This submission addresses the Support at Home program as a system design question. It asks whether the interaction between frailty needs and program mechanics produces predictable harm, inequity and loss of dignity, even when providers and workers act in good faith and comply with program rules.

Accordingly, this submission:

focuses on frail older Australians, including those with multimorbidity, cognitive impairment, dementia-related behavioural symptoms and end-of-life care needs (Clegg et al. 2013; Inacio et al. 2025);

examines the funding architecture of the Support at Home program, including quarterly budgets, carry-over limits, care management quarantining, participant contributions and supplements (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a);

evaluates whether this architecture can purchase the minimum safe bundle of concurrent supports required to avoid predictable clinical deterioration, given the evidence on frailty, hospital avoidance and residential aged care entry (Clegg et al. 2013; Inacio et al. 2024; Senate Community Affairs References Committee 2024); and

considers distributional and rights impacts for groups who are disproportionately affected by structural gaps, including Aboriginal and Torres Strait Islander Elders, culturally and linguistically diverse older people, rural and regional residents and people without strong informal care networks (Royal Commission into Aged Care Quality and Safety 2021; Senate Community Affairs References Committee 2024).

This submission does not examine every operational detail of the Support at Home program, nor does it assess individual providers. It does not rely on personal anecdotes. Instead, it advances clinically and administratively testable propositions that can be examined against the program's own rules, Commonwealth guidance and the peer-reviewed evidence base.

1.4 Support at Home mechanics relevant to frailty

Three program mechanics are foundational to the analysis that follows.

First, Support at Home funding is allocated through quarterly budgets rather than as an uncapped entitlement. Participants receive a notional annual funding amount associated with their Support at Home classification, released quarterly (Department of Health,

Disability and Ageing 2025b). Unspent funds may be carried over, but the amount that can be rolled forward is limited. Current guidance states that the rollover amount is whichever is higher: 1,000 Australian dollars or 10 per cent of the participant's quarterly budget (including supplements) (My Aged Care 2025a). This design structurally limits the ability to accumulate a buffer for foreseeable increases in need that are not short, discrete reablement episodes. While the Support at Home program includes separate restorative funding for time-limited reablement after events such as a fall or acute illness, when a return to independence is expected, it does not provide a dedicated stream for recurrent or progressive clinical needs typical of frailty, such as long-term wound care or ongoing catheter management. Those needs must be funded from the pooled quarterly budget and therefore compete directly with personal care and domestic support.

Second, Support at Home applies mandatory care management quarantining. Program rules specify that a fixed proportion of the participant's quarterly budget is allocated to care management and paid to the provider, with the Department's explanatory material describing a 10 per cent quarantine for ongoing services (Department of Health, Disability and Ageing 2025b). For frail older Australians, this directly reduces the portion of the budget available to purchase face-to-face services, while coordination and clinical oversight needs increase.

Third, and most critically for this submission, the program does not financially separate essential domains of support. Clinical services (such as nursing and allied health), personal care and domestic assistance are all purchased from the same capped quarterly budget (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a). Although older people do not pay a personal contribution for clinical services under the Support at Home contribution settings, those services still draw down the finite Support at Home budget (Department of Health, Disability and Ageing 2025c). In practical terms, this means that as clinical needs escalate with frailty, the same budget must stretch to cover both clinical interventions and the domestic and personal supports required to remain safely at home.

The remainder of this submission demonstrates that, in the context of frailty, this pooled-budget design is not simply an administrative choice. It is a predictable mechanism for harm and inequity, because frailty requires concurrent investment across all of these domains rather than substitution between them.

1.5 Summary of the central structural failure

The central structural failure identified in this submission is straightforward to describe and has wide-ranging effects. The Support at Home program compels essential domains of care to compete financially within a single capped budget, even though frailty requires these domains to operate concurrently rather than interchangeably (Clegg et al. 2013; Inacio et al. 2025). As a frail person's clinical complexity increases, clinical services

consume a growing share of the budget that would otherwise fund domestic stability and personal care. The more frail and unwell a person becomes, the less capacity remains to fund the basic supports that keep them safe at home.

This dynamic is not an edge case. Frailty is common among the oldest Australians and is strongly associated with disability, hospitalisation and mortality (Clegg et al. 2013). A funding model that forces competition among clinical care, personal care, and domestic assistance will therefore under-serve those with the highest concurrent needs. In doing so, it undermines the practical realisation of the new rights-based aged care legislation, shifts costs to hospitals and residential aged care, and exposes older people and their families to preventable harm and distress.

PART 2 — CONTEXT: REFORM INTENT AND RIGHTS-BASED LEGISLATIVE FRAMEWORK

2.1 Policy intent of the Support at Home program and related reforms

The Australian Government has described the current reforms as a fundamental reset of the aged care system, intended to place the rights and needs of older people at the centre of law, policy and practice (Department of Health, Disability and Ageing 2025b; Older Persons Advocacy Network (OPAN) 2025a). The Parliament passed the Aged Care Bill 2024 on 25 November 2024, and it became the Aged Care Act 2024 (Cth) when it received Royal Assent on 2 December 2024 (Parliament of Australia 2025). The new Act commenced on 1 November 2025 (Aged Care Act 2024 (Cth)) and aligned with the launch of the Support at Home program (Department of Health, Disability and Ageing 2025a). According to the Department of Health, Disability and Ageing, the Support at Home program is designed to replace multiple previous home-based programs with a single, streamlined system, and to make it easier for older people to receive support at home rather than moving prematurely into residential aged care (Department of Health, Disability and Ageing 2025e; My Aged Care 2025a).

Key stated policy objectives include:

- delivering a rights-based system that is simpler to navigate;
- improving transparency about funding, pricing and participant contributions;
- enabling older people to “pay only for the services they receive”, with clinical services such as nursing and allied health not attracting a personal contribution (Department of Health, Disability and Ageing 2025c); and
- improving fiscal sustainability and consistency across the aged care system.

(Department of Health, Disability and Ageing 2025b, 2025c)

Public explanatory materials emphasise that Support at Home is intended to give older people greater flexibility in how they use their individual budgets; to allow a broader range of services (including clinical services, personal care, domestic assistance, social

support and assistive technology); and to enable participants to use a fee estimator to plan their Support at Home budgets (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a).

These intentions are essential context. The structural failings identified in later Parts of this submission are not attributed to an absence of stated commitment to older people's rights, but to the design of the funding architecture that underpins Support at Home.

2.2 The rights-based aged care Act: Statement of Rights and Principles

The Aged Care Act 2024 (Cth) is expressly framed as a rights-based statute. It includes a Statement of Rights applying to older people accessing Australian Government–funded aged care, supported by principles intended to guide interpretation and implementation (Aged Care Act 2024 (Cth); Department of Health, Disability and Ageing 2025d; Aged Care Quality and Safety Commission (ACQSC) 2025a). The Statement of Rights explains, in accessible language, what older people can expect from the aged care system.

The Statement of Rights includes, among others, rights:

- to safe and high-quality care and services;
- to be treated with dignity and respect;
- to have independence, choice and control supported;
- to receive culturally safe care that recognises and values identity, language and background;
- to clear information about services, costs and changes;
- to participate in decisions, including about risks a person is prepared to take; and
- to raise concerns or make complaints without fear of adverse consequences (ACQSC 2025a).

The Aged Care Rules 2025 (Cth) and associated regulator guidance emphasise that approved providers must deliver services consistently with the Statement of Rights and carry enforceable responsibilities relating to quality, safety, governance and responsiveness to concerns (Aged Care Quality and Safety Commission (ACQSC) 2025b; Aged Care Rules 2025 (Cth)).

For frail older Australians, these rights are not abstract. A right to "safe and high-quality care" and to "live at home for as long as possible" presupposes that the primary home-care program can reliably fund the mix of clinical care, personal care, domestic support and assistive technology required to make home a safe and viable setting.

2.3 How the Support at Home program was intended to operationalise the rights-based framework

In theory, the Support at Home (SAH) program is the principal mechanism through which the rights-based aged care framework is intended to be realised for frail older people living at home. Departmental and consumer-facing materials describe several

design features of SAH that are presented as practical mechanisms for giving effect to older people's rights (Department of Health, Disability and Ageing 2025b, 2025e; My Aged Care 2025a; Commonwealth of Australia 2024; Aged Care Quality and Safety Commission (ACQSC) 2025a):

- Transparency and choice: Individual budgets linked to SAH classifications, a published schedule of subsidies and supplements, and fee estimation tools are intended to provide clarity about funding levels and potential contributions (Department of Health, Disability and Ageing 2025b, 2025f, 2025g, 2025h; My Aged Care 2025a).
- Access to a broad service list: the program is designed to fund a range of supports, including clinical care, personal care, domestic assistance, social support, aids and equipment, and home modifications, on the premise that different combinations can be tailored to individual needs (Department of Health, Disability and Ageing 2025b, 2025e).
- No personal contribution for clinical services: program descriptions emphasise that older people will not be required to pay a personal contribution for clinical services such as nursing, physiotherapy and occupational therapy, which is presented as a safeguard for clinically necessary care (Department of Health, Disability and Ageing 2025c).
- Rights-consistent governance: the new legal framework, including the Aged Care Rules 2025, is intended to clarify provider obligations, strengthen whistle-blower protections and support more robust responses to substandard care (Department of Health, Disability and Ageing 2025d; Aged Care Quality and Safety Commission (ACQSC) 2025b; Aged Care Rules 2025 (Cth); Commonwealth of Australia 2024).

Taken at face value, these elements align well with the language of the Statement of Rights. They are designed to ensure that older people have visibility of their funding, a degree of control over how it is used, and a pathway to raise concerns if services are not delivered as promised (Aged Care Quality and Safety Commission (ACQSC) 2025a; Department of Health, Disability and Ageing 2025d). The analysis in subsequent Parts of this submission does not contest these intentions. Rather, it examines whether the underlying budget structure, contribution rules and service purchasing mechanics of Support at Home can, in practice, deliver on those rights for frail older Australians whose needs span multiple concurrent domains (Department of Health, Disability and Ageing 2025c, 2025i; My Aged Care 2025a).

2.4 Parliamentary and committee context (refined; same substance, cleaner citations)

The *Aged Care Bill 2024* was referred to the Senate Community Affairs Legislation Committee for inquiry and report between September and November 2024 (Senate

Community Affairs Legislation Committee 2024a; Parliament of Australia 2024). Evidence to that inquiry, and to related Senate scrutiny processes in 2024–2025, highlighted several themes directly relevant to this submission, including:

- strong support for a rights-based legislative framework and the inclusion of a clear Statement of Rights;
- concern that the system would remain rationed rather than demand-driven, particularly in relation to home-based care;
- concern about long waiting times for assessment and service commencement;
- questions about the impact of co-contributions and user charges for basic supports such as showering and domestic assistance; and
- calls for clearer obligations, stronger data and improved transparency regarding service availability and outcomes (Law Council of Australia 2024; Council on the Ageing (COTA) Australia 2024; Senate Community Affairs Legislation Committee 2024a, 2024b).

These concerns sit alongside broader parliamentary scrutiny of aged care delivery and reform settings (Senate Community Affairs References Committee 2025). Subsequent Senate scrutiny has further underscored the scale of unmet need and waiting lists for aged care services. In 2025, a Senate inquiry described current waiting lists for in-home care as a "calculated denial of services", warning of potentially fatal consequences for older people waiting for assessment or for care after approval (Senate Community Affairs References Committee 2025). Public evidence to that inquiry raised concerns about co-payments for core supports, continued rationing of services, and the broader societal costs of inadequate support for older people at home (Senate Community Affairs References Committee 2025).

This parliamentary context is important for two reasons. First, it demonstrates that concerns about rationing, waiting lists and co-payments for basic supports are not hypothetical; they have already been recognised through committee processes (Senate Community Affairs Legislation Committee 2024a, 2024b; Senate Community Affairs References Committee 2025). Second, it underscores that the rights-based Act must be implemented in an environment of constrained resources and existing unmet demand (Senate Community Affairs References Committee 2025). A funding design that structurally under-serves frail people at home risks compounding these pressures.

2.5 Part summary

The Support at Home program was introduced alongside the new rights-based aged care legislation with the stated aim of simplifying home-based care, improving transparency, and supporting older people to remain at home with services tailored to their needs

(Department of Health, Disability and Ageing 2025a, 2025b). The *Aged Care Act 2024* (Cth) includes a Statement of Rights that promises safe, high-quality, respectful, culturally safe and transparent care for older people, and it is supported by further regulatory settings, including the *Aged Care Rules 2025* (Cth) and associated regulator guidance (Commonwealth of Australia 2024; Aged Care Rules 2025 (Cth); Aged Care Quality and Safety Commission (ACQSC) 2025a, 2025b; Department of Health, Disability and Ageing 2025d).

In theory, Support at Home is the mechanism through which these rights are realised for older people living at home. Its published features, including individual budgets, a broad service list, no personal contribution for clinical services and strengthened governance settings, are presented as tools for rights implementation (Department of Health, Disability and Ageing 2025b, 2025c; Aged Care Quality and Safety Commission (ACQSC) 2025a, 2025b; Aged Care Rules 2025 (Cth)). However, parliamentary committee work on the *Aged Care Bill 2024* and subsequent inquiries into access and waiting lists have already raised concerns about rationing, co-payments and unmet need (Senate Community Affairs Legislation Committee 2024a; Senate Community Affairs References Committee 2025; Parliament of Australia 2024; Law Council of Australia 2024; Council on the Ageing (COTA) Australia 2024). The remainder of this submission examines whether the current design of Support at Home can, in practice, sustain the minimum safe bundle of concurrent supports that frail older Australians require to live at home in a way that is consistent with the Statement of Rights (Aged Care Quality and Safety Commission (ACQSC) 2025a; Commonwealth of Australia 2024). The next Part sets out the clinical and functional realities of frailty and explains why funding design must be built around those realities rather than treating them as an afterthought.

PART 3 — WHAT THE SUPPORT AT HOME PROGRAM GETS RIGHT

3.1 Purpose of this Part

The purpose of this Part is to identify and acknowledge key strengths of the Support at Home program as designed and described by the Australian Government. This is important for two reasons. First, it recognises that many features of Support at Home are conceptually aligned with the recommendations of the Royal Commission into Aged Care Quality and Safety and with the aims of the new rights-based aged care legislation (Royal Commission into Aged Care Quality and Safety 2021; Department of Health, Disability and Ageing 2025a). Second, it establishes a balanced foundation for subsequent Parts, which argue that despite these strengths, the program's core funding architecture remains structurally unsafe for frail older Australians.

3.2 Consolidation and simplification of home care programs

A key strength of Support at Home is the consolidation of multiple previous home-based aged care programs into a single overarching program. Historically, older people and families had to navigate a complex mix of Commonwealth programs with different eligibility rules and funding arrangements, including the Commonwealth Home Support Programme, Home Care Packages and a range of smaller initiatives (Royal Commission into Aged Care Quality and Safety 2021; Productivity Commission 2011).

The Department of Health and Aged Care has stated that the Support at Home program is intended to "bring together" existing home care programs into one streamlined system, with common processes for assessment, classification and budgeting (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a). In principle, this consolidation should:

- reduce fragmentation and duplication;
- simplify the entry pathway for older people and their families;
- improve transparency about what is funded and under which rules; and
- support better planning and monitoring at a system level.

From a policy perspective, this is a material improvement. The Royal Commission repeatedly highlighted that the previous home care arrangements were confusing, fragmented and difficult to navigate, particularly for people with cognitive impairment, low health literacy or limited informal support (Royal Commission into Aged Care Quality and Safety 2021). Bringing programs into a single framework is a necessary, although not sufficient, condition for a more coherent home-care system.

3.3 Explicit rights framing and integration with the new Aged Care Act

Another positive feature is the explicit alignment of Support at Home with the new rights-based aged care legislation. The Aged Care Act 2024 and its supporting materials emphasise the centrality of the Statement of Rights and the corresponding obligations on approved providers (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025a, 2025d; Aged Care Quality and Safety Commission (ACQSC) 2025a, 2025b).

The Department describes support at Home as one of the primary mechanisms through which these rights are delivered in the community, including rights to safe and high-quality care, respect, culturally safe services, clear information, choice and control, and the ability to live at home for as long as possible (Department of Health, Disability and Ageing 2025a, 2025b; Aged Care Quality and Safety Commission (ACQSC) 2025a, 2025b). The program's design documentation links funding arrangements, service lists and governance expectations to this rights framework.

This explicit linkage between funding and rights is conceptually strong. It creates an opportunity for Parliament, regulators, and communities to test whether program settings are, in fact, consistent with the rights framework, and it provides a clear narrative for older people about what they should be able to expect from home-based care.

3.4 Greater transparency about funding, pricing and contributions

Support at Home also incorporates improvements in transparency. The Department has published the Support at Home schedule of subsidies and supplements, detailing equivalent daily amounts for each Support at Home classification and listing available supplements and grant payments (Department of Health, Disability and Ageing 2025f, 2025g). My Aged Care provides information on how budgets are calculated, how much can be rolled over between quarters, and how care management is funded, as well as guidance on participant contributions and fee arrangements (My Aged Care 2025a, 2025b).

This level of detail was not as readily accessible under previous arrangements. Increased transparency has several benefits:

- It allows older people and families to understand the scale of funding associated with their Support at Home classification.
- It gives providers and advocates a clearer basis on which to model what can realistically be delivered within a given budget.
- It enables Parliament and the public to scrutinise the alignment between funding levels and policy objectives.

In addition, the program's contribution policy explicitly states that older people do not pay a personal contribution for clinical services such as nursing, physiotherapy and occupational therapy (Department of Health, Disability and Ageing 2025c; My Aged Care 2025a). While later Parts of this submission argue that this does not create a separate clinical funding entitlement, it remains a positive design element that older people are not directly charged an additional co-payment for clinical services beyond their Support at Home budget.

3.5 Broader and more flexible service list (in principle)

The Support at Home program is designed with a broad service list that includes clinical care, personal care, domestic assistance, social support, transport, assistive technology, home modifications and other supports (Department of Health, Disability and Ageing 2025b, 2025e). The stated intent is to allow flexible combinations of services that can be tailored to individual needs, rather than constraining people to narrow packages.

In principle, this breadth is a strength. It acknowledges that older people's needs are multidimensional and that safe ageing at home requires attention to physical health, mobility, environment, social connection, carer support and cultural needs. It also aligns

with evidence that integrated, multidisciplinary community care can reduce hospital use and delay residential care entry when appropriately resourced (Inacio et al. 2025).

The existence of a broad service list does not guarantee that sufficient services will be delivered in practice, but it does create the possibility for more holistic support if the funding architecture, workforce and governance arrangements are adequate.

3.6 Clarification of provider responsibilities and governance expectations

Finally, Support at Home is introduced within a context of strengthened regulatory expectations. The new rights-based Aged Care Act and the Aged Care Rules 2025 clarify provider responsibilities for quality, safety, governance, reporting, complaints handling and responses to substandard care (Commonwealth of Australia 2024; Aged Care Rules 2025 (Cth); Aged Care Quality and Safety Commission (ACQSC) 2025b; Department of Health, Disability and Ageing 2025d). Providers delivering Support at Home services are expected to operate under these strengthened obligations and to support older people in understanding and exercising their rights.

This more precise articulation of duties is a strength. It supports more consistent expectations across providers and provides regulators and advocates with clearer benchmarks against which to assess performance and to act where care is substandard.

3.7 Part summary

The Support at Home program incorporates several important strengths. It consolidates multiple previous programs into a single framework, potentially reducing fragmentation and confusion. It is explicitly linked to a new rights-based Aged Care Act, providing a straightforward narrative that older people's rights should guide funding and service design. It offers greater transparency about funding, supplements and contributions than previous arrangements, and it states that older people will not make personal contributions for clinical services. It adopts a broad service list that recognises the multidimensional nature of ageing at home, and it is introduced in the context of strengthened provider responsibilities and governance expectations.

These strengths are genuine and should be preserved. However, they do not in themselves guarantee that frail older Australians can receive the minimum safe bundle of concurrent supports required to remain at home with dignity and without avoidable harm. The following Parts of this submission demonstrate that the funding architecture and budget mechanics of Support at Home, as currently configured, are structurally incompatible with the needs of frail older people and with the practical realisation of the rights set out in the Aged Care Act 2024.

PART 4 — FUNDING ARCHITECTURE GAPS: POOLED BUDGETS, DEDUCTIONS AND THE "CLIFF EDGE"

4.1 Purpose of this Part

The purpose of this Part is to examine the funding architecture of the Support at Home program and to show how its structural settings create predictable failures for frail older Australians. It considers how the Support at Home budget is pooled, capped, quarantined for care management, restricted in its ability to carry funds over between quarters, and prohibited from going into a negative balance, and how these settings interact with provider pricing. Together, these design choices compel essential domains of care to compete financially within a single constrained allocation (Department of Health, Disability and Ageing 2025b, 2025i; My Aged Care 2025a; Senate Community Affairs References Committee 2025).

4.2 The pooled budget design: a single "bucket" for all essential supports

Under the Support at Home program, each older person is assigned a classification that corresponds to an annual funding amount. This amount is released in quarterly instalments as a Support at Home budget held on the person's behalf (Department of Health, Disability and Ageing 2025g; My Aged Care 2025a). The Department's overview material and the Support at Home schedule of subsidies and supplements confirm that all program-funded services are charged against this single budget, including clinical care, personal care, domestic assistance, social support and some allied health services (Department of Health, Disability and Ageing 2025b, 2025f). My Aged Care guidance explains to older people that the budget is finite, that "you cannot spend more than the amount in your Support at Home budget", and that "your provider will claim payment for services and supports from your budget" (My Aged Care 2025a).

In practice, this creates a pooled "single bucket" from which all service types must be purchased. Services Australia pays claims from this budget and will not pay providers if sufficient funds are not available at the time of claim (Department of Health, Disability and Ageing 2025i; My Aged Care 2025a).

For frail older people, this has three direct implications. First, each episode of registered nurse care or allied health input reduces the funds available for personal care and domestic assistance, even though all of these domains are concurrently essential in advanced frailty (Clegg et al. 2013; Inacio et al. 2025). Second, domestic assistance and supervision are implicitly treated as discretionary because they can be reduced or omitted when budgets are tight, despite their role in preventing falls, malnutrition, infection, skin breakdown and delirium (Australian Commission on Safety and Quality in Health Care 2025a; Royal Commission into Aged Care Quality and Safety 2021). Third, there is no guaranteed minimum level of domestic or personal support for people at higher levels of

frailty; the volume delivered is determined by how quickly the pooled budget is consumed.

The pooled budget design, therefore, creates exactly the dynamic that frailty cannot withstand: competition between domains that must be delivered together rather than one being substituted for another. This contradicts evidence and guidance that emphasise integrated, multidisciplinary support for frail older people living at home (Clegg et al. 2013; NSW Agency for Clinical Innovation 2023a; Inacio et al. 2025).

4.3 "No personal contribution" for clinical services without a separate clinical entitlement

The Department of Health, Disability and Ageing emphasises that older people will not pay a personal contribution for clinical services such as nursing, physiotherapy and occupational therapy under the Support at Home program (Department of Health, Disability and Ageing 2025c; My Aged Care 2025b). This is presented as a protection for access to clinical care and is likely to be understood by many older people and families as implying that clinical care is separately protected.

However, the program rules and consumer materials make clear that these clinical services are still purchased from, and charged against, the person's Support at Home budget (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a, 2025b). The "no personal contribution" rule means that, unlike everyday services, the individual is not charged an additional co-payment on top of their program funding when they receive clinical services; it does not mean that clinical care is funded outside the capped budget.

For frail older Australians who require high-frequency nursing—such as long-term wound care, catheter care, complex medication regimes and ongoing symptom monitoring—the distinction is critical. Each clinical visit reduces the same finite budget that must also fund showering, continence care, meal preparation, cleaning, laundry, transport and social support (Inacio et al. 2025). As clinical needs escalate with frailty, the funds available for domestic and personal supports are progressively eroded. Evidence from the Royal Commission and subsequent analyses shows that when domestic and personal supports are withdrawn or reduced, risks of falls, malnutrition, pressure injuries, delirium and carer collapse increase sharply (Royal Commission into Aged Care Quality and Safety 2021; AIHW 2025a; NSW Agency for Clinical Innovation 2023). The current architecture, therefore, masks a structural zero-sum contest between equally essential domains of support.

4.4 Care management, quarantine, and reduction of direct care capacity

Support at Home requires that a portion of each person's budget be allocated to care management. The Department's program overview and schedule indicate that a proportion of the budget (publicly described as ten per cent for ongoing services) is reserved for care management activities and paid to the provider for planning,

coordination and monitoring (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a). This setting reflects recommendations from the Royal Commission and policy advice about the importance of care coordination and oversight in home-based aged care (Royal Commission into Aged Care Quality and Safety 2021).

For frail older Australians, however, how care management is funded has direct implications for the capacity of direct care. Where ten per cent of the budget is automatically quarantined, only ninety per cent remains available to purchase nursing, personal care, domestic assistance and other supports. This reduction is applied irrespective of the absolute level of need. For people at higher Support at Home classifications who already require daily personal care and frequent domestic assistance to maintain basic safety, this quarantine reduces the number of hours that can be delivered within the quarter. It effectively converts an already rationed budget into a smaller pool for face-to-face care.

The Royal Commission found that inadequate care management, fragmented oversight and poor clinical governance contributed to avoidable harm in both home care and residential settings (Royal Commission into Aged Care Quality and Safety 2021). Support at Home has rightly attempted to respond to that concern. The structural gap is that care management has been funded by taking a fixed proportion from the same capped pool that must fund all other supports, rather than by creating a separate entitlement for clinical governance and coordination for people with high frailty and complexity.

4.5 Carry-over limits and the inability to build a buffer for predictable, non-restorative needs

Support at Home budgets are calculated annually but released quarterly. Unspent funds at the end of a quarter may be carried over into the next quarter, but carry-over is strictly limited. My Aged Care guidance states that the amount that can be carried over is whichever is higher: 1,000 Australian dollars or ten per cent of the person's Support at Home quarterly budget, including supplements (My Aged Care 2025a). The Department's schedule and explanatory documents confirm that amounts above that threshold are returned to the government rather than accruing indefinitely (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a, 2025b). The program also includes time-limited restorative or reablement funding for short episodes after events such as a fall or brief illness, where there is a reasonable expectation that the person may return to a higher level of independence (Department of Health, Disability and Ageing 2025b). This design is appropriate for discrete reablement episodes. However, many of the most demanding clinical needs associated with frailty are not short and do not resolve with a single episode of reablement. Chronic wound care that fluctuates but does not fully heal, long-term catheter care with scheduled changes and intermittent blockages, recurrent infections, progressive heart failure, chronic kidney disease and deteriorating

dementia-related behaviours all involve recurrent peaks in need across the year (Clegg et al. 2013; Inacio et al. 2025).

Limiting carry-over to 1,000 dollars or ten per cent of the quarterly budget prevents older people and providers from building a meaningful buffer over multiple quarters to respond to these foreseeable, non-restorative surges. Instead, frail older people enter each quarter with only modest reserve and must manage periods of higher need by reducing other supports within that same quarter. This is opposite to a frailty-informed approach, which would prioritise accumulating capacity for predictable periods of escalation and extended recovery (NSW Agency for Clinical Innovation 2023).

4.6 Prohibition on negative balances and the "cliff edge"

The Support at Home program does not permit budgets to go into a negative balance. My Aged Care explicitly states that older people "cannot spend more than the amount in [their] Support at Home budget" and that providers "can only claim up to the amount available" (My Aged Care 2025b). Once the budget is exhausted, Services Australia will not pay the provider for additional services (My Aged Care 2025b; Department of Health, Disability and Ageing 2025i). The person may be offered the option to purchase additional services privately, but there is no automatic safety mechanism that triggers additional government-funded support once the quarterly allocation is fully used.

For frail older people, especially those with high-intensity clinical needs and limited informal supports, this design creates a "cliff edge". When the budget is depleted, essential services can cease abruptly, irrespective of clinical risk. There is no automatic escalation to a higher Support at Home classification, no default entitlement to a separate clinical safety net and no requirement that a registered nurse or geriatrician review the situation before care is withdrawn. Evidence from hospital and community settings indicates that abrupt withdrawal or reduction of support is associated with deterioration, falls, delirium, medication misadventure and unplanned hospital admissions (AIHW 2024b; AIHW 2025a; NSW Agency for Clinical Innovation 2023). For some, the only remaining options are emergency services and residential aged care, directly contradicting the policy aim of supporting people to remain at home.

4.7 Provider pricing and accelerated budget depletion

The Support at Home schedule establishes the amount the Commonwealth pays for each classification and supplement, but it does not set the prices that providers charge for particular services. Providers determine their own fees for nursing, personal care and domestic assistance, subject to general rules and any future price regulation (Department of Health, Disability and Ageing 2025h). Hourly prices reflect wages, on-costs, travel, supervision and overheads, and are typically higher in rural and remote areas due to workforce shortages and longer travel times (Department of Health, Disability and Ageing 2025h; Royal Commission into Aged Care Quality and Safety 2021).

For frail older people at higher Support at Home classifications, the interaction between provider pricing and the pooled budget is critical. A person requiring frequent registered nurse visits for chronic wound care or catheter management, daily assistance with showering, dressing, continence care and transfers, and regular domestic assistance to maintain a safe environment can consume a large proportion of their quarterly budget early in the quarter. This effect is intensified when travel time is charged and when providers must pay penalty rates for evening or weekend work.

In this context, the combination of pooled budgets, care management quarantine, capped carry-over and a prohibition on negative balances results in predictable budget exhaustion for those with the greatest needs. People with lower-level needs are less likely to encounter the budget ceiling. The model is therefore structurally regressive: it is most restrictive for those whose frailty and clinical complexity require the highest volume and intensity of support.

4.8 Absence of frailty-adjusted minimum entitlements or ring-fenced domains

The Support at Home framework does not guarantee minimum entitlements in specific domains of care for people at higher levels of frailty. The classification determines an overall annual funding amount. Still, there is no requirement that a person at a high Support at Home level must receive a defined minimum of domestic assistance, personal care and clinical review, and there is no ring-fencing of domains within the budget (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a). All domains compete within the same pooled allocation.

This absence of frailty-adjusted minimum entitlements is challenging to reconcile with the rights-based Aged Care Act 2024, which sets out rights to safe and high-quality care, to live at home for as long as possible and to be supported to maintain independence and well-being (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025a, 2025d). It also sits uneasily with the strengthened Aged Care Quality Standards, which emphasise integrated, person-centred care and clinical governance that is proportionate to risk (Department of Health, Disability and Ageing 2025j).

As a result, two frail older people with similar levels of need and the same Support at Home classification can receive very different care bundles, depending on local provider pricing, internal budget allocation choices and the capacity of families to fill gaps. This is not consistent with a rights-based system in which access to essential supports should not depend primarily on geography, provider business models or the availability of unpaid care.

4.9 Part summary

The funding architecture of the Support at Home program is constructed around a pooled, capped budget that must purchase all domains of support. Clinical services are described as attracting no personal contribution, but they are funded from the same finite allocation

that must also pay for personal care and domestic assistance. A fixed proportion of the budget is quarantined for care management. Carry-over of unspent funds between quarters is capped at 1,000 dollars or ten per cent of the quarterly budget. Budgets cannot go into a negative balance, so services cease when funds are exhausted unless the person can self-fund. Provider pricing, especially for high-intensity nursing and in regional areas, accelerates budget depletion. There are no frailty-adjusted minimum entitlements and no ring-fenced domains to protect essential supports (Department of Health, Disability and Ageing 2025b, 2025c, 2025g, 2025h, 2025i; My Aged Care 2025a, 2025b).

For frail older Australians, this architecture means that the more clinically complex and dependent they become, the more the system forces competition between the very supports that must be delivered together to keep them safely at home. This structural contradiction lies at the heart of Support at Home. It is fundamentally misaligned with the rights-based intent of the Aged Care Act 2024 and the evidence on safe, effective home-based care for frail older people (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025a, 2025d; Clegg et al. 2013; Inacio et al. 2025; Royal Commission into Aged Care Quality and Safety 2021).

PART 5 — FRAILTY, EVERYDAY LIVING SUPPORTS, AND PREDICTABLE HARM WHEN UNDERFUNDED

5.1 Purpose of this Part

The purpose of this Part is to demonstrate that assistance with daily living—domestic support, personal care and environmental stability—is not a discretionary lifestyle service, but an essential clinical risk control for frail older Australians. It explains how frailty operates in practice, why everyday living supports must be delivered concurrently with clinical care, and how the current Support at Home funding design structurally underfunds the very supports that prevent deterioration, hospitalisation and premature institutionalisation (Clegg et al. 2013; Dent et al. 2014; AIHW 2024a).

5.2 Frailty as a multidimensional clinical syndrome with practical consequences

Frailty is a multidimensional clinical syndrome characterised by diminished physiological reserve, reduced muscle strength, slowed gait, cognitive fluctuations, and increased vulnerability to disproportionate decline following even minor stressors (Clegg et al. 2013; Church et al. 2020; Rockwood 2020). Frailty is strongly associated with falls, functional decline, hospitalisation, institutionalisation and mortality in older people (Dent et al. 2014; Dent et al. 2014b; AIHW 2024a).

In day-to-day terms, frailty is experienced as a progressive inability to perform basic domestic and personal tasks without assistance. Older people gradually lose the capacity

to carry laundry, clean bathrooms, change linen, shop for groceries, prepare meals, safely shower, manage continence, maintain hydration and keep track of complex medication regimens. As muscle mass declines, balance worsens, and executive function weakens, even modest disruptions such as a missed meal, a minor infection, a cluttered hallway, or a newly prescribed medicine can precipitate a cascade of deterioration (Clegg et al. 2013; Health.vic 2024).

For this cohort, the primary "treatment" for frailty is not sporadic hospital-level interventions but the reliable provision of basic domestic and personal supports that maintain nutrition, hydration, hygiene, continence and mobility in the person's usual environment (NSW Agency for Clinical Innovation 2023; AIHW 2024a).

5.3 Everyday living supports as protective clinical interventions

In the context of frailty, everyday living supports function as protective clinical interventions rather than optional comforts. Regular cleaning, laundry, meal preparation, safe showering, bed-changing, rubbish removal, shopping and environmental hazard reduction directly prevent delirium, infection, malnutrition, functional decline and pressure injury (Inouye et al. 1999; Hshieh et al. 2015; Australian Commission on Safety and Quality in Health Care 2021).

The evidence shows that poor nutrition and dehydration are major drivers of frailty progression, functional decline, infection risk and hospitalisation (Dent et al. 2014; NSW Agency for Clinical Innovation 2023; AIHW 2024a). Inadequate domestic support for shopping, cooking and safe food storage results in older people going without meals, relying on nutritionally poor foods or becoming dependent on neighbours and family members who may themselves be unwell or overburdened.

Environmental conditions in the home are equally critical. Clutter, unsecured cords, poor lighting, wet floors and unclean surfaces are well-established risk factors for falls, fractures and subsequent hospitalisation (Clemson et al. 2023; Lektip et al. 2023; Montero-Odasso et al. 2022). Lack of assistance with continence, bathing and skin care contributes to urinary tract infections, incontinence-associated dermatitis and pressure injuries, all of which precipitate emergency presentations and residential aged care entry (Royal Commission into Aged Care Quality and Safety 2021; AIHW 2024a; Australian Commission on Safety and Quality in Health Care 2021).

From a clinical and policy perspective, this means that tasks often classified as "everyday living supports" in program documentation, washing clothes and linen, cleaning bathrooms, managing rubbish, ensuring adequate food in the house, preparing safe meals, supporting hydration and maintaining a safe physical environment—are, in frailty, foundational medical interventions that stabilise health and prevent deterioration (NSW Agency for Clinical Innovation 2023; AIHW 2024a).

5.4 Mechanisms of deterioration when everyday supports are underfunded

When domestic and personal support is rationed, irregular or forced to compete financially with clinical services within a pooled budget, the trajectory for frail older people is predictable and well documented (Dent et al. 2014; AIHW 2024a).

Common pathways include the following. Inadequate assistance with shopping and meal preparation leads to missed meals, poor diet quality and reliance on convenience foods, resulting in weight loss, sarcopenia, orthostatic hypotension and impaired wound healing. Inadequate support with hydration and continence precipitates urinary tract infections, delirium and falls. Infrequent cleaning and laundry contribute to skin irritation, fungal infections, pressure injuries and a higher microbial load in crowded homes. Environmental hazards that are not addressed because of insufficient time or funding for domestic assistance, such as clutter, loose rugs, poor lighting, and obstacles in pathways, result in preventable falls and fractures, often triggering hospitalisation and permanent residential aged care entry (Clemson et al. 2023; Montero-Odasso et al. 2022).

For people with dementia, the underfunding of everyday supports has additional effects. Missed or late medications, unsupervised stove use, inability to find or prepare food, and unmanaged incontinence all contribute to behavioural escalation, wandering, increased carer distress and crisis presentations (Dementia Australia 2023; Royal Commission into Aged Care Quality and Safety 2021). When families and informal carers can no longer compensate for these gaps, the usual outcome is abrupt hospital admission or an urgent move into residential aged care rather than a planned, supported transition (AIHW 2024a; Senate Community Affairs References Committee 2025).

These pathways are not exceptional cases. They are the routine consequence of insufficient everyday living support in the presence of frailty.

5.5 Independence support, hospital use and residential aged care entry

Evidence from Australian and international research confirms that adequate home-based domestic and personal support reduces hospital utilisation and delays residential aged care entry. Comprehensive geriatric assessment coupled with sustained community support and environmental interventions has been shown to reduce unplanned admissions and improve functional outcomes for older people living at home (NSW Agency for Clinical Innovation 2023; AIHW 2024a).

Cochrane and related systematic reviews of home hazard modification demonstrate that targeted environmental and domestic interventions reduce overall falls by around one quarter and significantly reduce the number of people who fall, particularly in high-risk older adults who are recently hospitalised or need support with daily activities (Clemson et al. 2023; Lektip et al. 2023). Falls-prevention guidelines now explicitly recommend home-environment modification and hazard reduction as core components of multidomain falls-prevention programs (Montero-Odasso et al. 2022).

The Royal Commission into Aged Care Quality and Safety identified under-provision of domestic assistance, poor nutrition and lack of continence support as recurrent contributors to avoidable hospital admissions and premature transitions to residential aged care (Royal Commission into Aged Care Quality and Safety 2021). Its final report emphasised that safe ageing in place depends on reliable support with daily living, not only on clinical input. National data on hospital presentations confirm that functional decline, falls, delirium and infection—conditions strongly influenced by the adequacy of domestic and personal support are among the most common reasons older people present to emergency departments (AIHW 2025b; Inouye et al. 1999; Hshieh et al. 2015).

Taken together, these findings show that independence support and domestic assistance are central levers for hospital avoidance and for delaying institutionalisation in frail older adults.

5.6 Interaction with the Support at Home pooled budget

Part 4 established that the Support at Home program uses a single pooled budget from which all domains: clinical care, personal care and domestic assistance—must be purchased, with a proportion quarantined for care management, strict limits on carry-over and a prohibition on negative balances (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a). Clinical services do not attract a personal contribution, but they are funded from the same finite budget that must also pay for everyday living supports (Department of Health, Disability and Ageing 2025c; My Aged Care 2025b).

When this architecture is applied to frail older people, the underfunding of domestic and personal support is not incidental; it is structurally determined. Any increase in nursing, allied health or behaviour support, such as daily wound dressings, catheter care or frequent symptom monitoring, must be funded by reducing some combination of showering, continence care, linen changes, cleaning, laundry, meal preparation and supervision, unless the person can pay privately. For older people on low incomes, this substitution is not viable.

Because there is no ring-fenced allocation for domestic assistance and personal care, and no frailty-adjusted minimum entitlements that guarantee a floor of support in these domains, providers are pushed by design to treat everyday living support as the flexible component when budgets tighten (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a). This means that the program structurally compels the withdrawal or erosion of the very supports that the evidence identifies as the primary protectors against falls, delirium, malnutrition, pressure injury, carer collapse, hospitalisation and premature residential aged care entry.

5.7 Part summary

Frailty is a multidimensional clinical syndrome whose consequences are experienced most acutely in the domestic and personal domains of life. For frail older Australians,

everyday living supports—cleaning, laundry, meal preparation, shopping, safe showering, continence care and environmental hazard reduction—are essential clinical risk controls. When these supports are underfunded or forced to compete financially with clinical services within a pooled, capped budget, a predictable pattern of deterioration follows: malnutrition, dehydration, falls, delirium, pressure injury, infection, carer collapse, emergency department presentations and premature entry to residential aged care (Clegg et al. 2013; Dent et al. 2014; Royal Commission into Aged Care Quality and Safety 2021; AIHW 2024a; AIHW 2025b). The Support at Home program, by failing to recognise and protect everyday living supports as essential clinical interventions and by structurally requiring them to compete with clinical care for a single constrained budget, embeds this pattern into its design. It is therefore not merely failing to optimise quality of life; it is failing to prevent serious, foreseeable harm to frail older Australians in ways that are inconsistent with the rights set out in the Aged Care Act 2024. The next Part of this submission will examine in detail how this structural underfunding interacts with dementia, behavioural symptoms, palliative care and complex multimorbidity, and how these failures intersect with the obligations of a rights-based aged care system.

PART 6 – HIGH CLINICAL COMPLEXITY, ESSENTIAL CONSUMABLES AND ALLIED HEALTH: UNDER-RECOGNISED AND UNDER-FUNDED IN SUPPORT AT HOME

6.1 Purpose of this Part

This Part examines how the Support at Home program performs for older Australians with high clinical complexity and significant equipment and consumable needs. It focuses on the Assistive Technology and Home Modifications scheme, the funding of essential clinical consumables such as continence products, wound dressings, oxygen and enteral feeding supplies, and the availability of allied health services in the community. Using the Support at Home program manual and associated guidance, together with evidence from national agencies and peer-reviewed literature, it shows that current settings underestimate the resource requirements of frail older people and do not align funding with the evidence-based care profile of multimorbidity, high clinical complexity and prolonged palliative trajectories (Department of Health, Disability and Ageing 2025j; AIHW 2024a; Palliative Care Australia 2025a; Royal Commission into Aged Care Quality and Safety 2021). The consequence is that older Australians with the greatest needs remain at high risk of unsafe environments, under-treated clinical conditions, avoidable complications and premature institutionalisation, despite being nominally “supported at home” (AIHW 2024a; OPAN 2025a).

6.2 Assistive Technology and Home Modifications: design and intent

Under the new arrangements, the Assistive Technology and Home Modifications scheme operates as a short-term pathway within the Support at Home program, providing separate funding for equipment and building works (Department of Health, Disability and Ageing 2025j). Funding for Assistive Technology and Home Modifications is explicitly stated to be separate from the person's budget for ongoing Support at Home services; in other words, it is not supposed to come out of the same quarterly budget that pays for personal care, domestic assistance and clinical visits (Department of Health, Disability and Ageing 2025k).

The program manual describes three funding tiers for Assistive Technology and three for Home Modifications: a low tier for items up to 500 Australian dollars, a medium tier up to 2,000 dollars, and a high tier up to 15,000 dollars in a twelve-month period (Department of Health, Disability and Ageing 2025j, pp. 172–174). For Assistive Technology, the manual explicitly notes that high-tier funding is "not capped at 15,000 dollars" and that, where equipment costs exceed this amount, participants can access higher levels of funding if there is appropriate clinical evidence, such as a valid prescription (Department of Health, Disability and Ageing 2025j, p. 173). For Home Modifications, high-tier funding is capped at a lifetime maximum of 15,000 dollars, with the possibility of extending the time period from twelve to twenty-four months for complex works where there is evidence of progress (Department of Health, Disability and Ageing 2025j, pp. 173–174).

Public-facing information from the Department of Health, Disability and Ageing and the Aged Care Quality and Safety Commission emphasises that the Assistive Technology and Home Modifications scheme allows older people to access products, equipment and home modifications "to meet your assessed needs" and that this allocation does not reduce their Support at Home services budget (Department of Health, Disability and Ageing 2025k; Aged Care Quality and Safety Commission (ACQSC) 2025a). This represents a conceptual improvement over the former Home Care Package system, in which capital items had to be purchased from the same package funds used for day-to-day care (Royal Commission into Aged Care Quality and Safety 2021).

On its face, this architecture recognises that safe ageing in place depends not only on care hours but also on the physical environment and equipment.

6.3 Real-world adequacy of Assistive Technology and Home Modifications funding

Despite this improved architecture, the real-world adequacy of funding for Assistive Technology and Home Modifications for frail older Australians remains limited. The high tier of up to 15,000 dollars for Home Modifications is presented in official guidance as funding for "larger modifications or complex needs" (Department of Health, Disability and Ageing 2025k; Aged Care Quality and Safety Commission (ACQSC) 2025a). In

practice, contemporary Australian building costs, particularly in regional and rural settings, mean that a single complete bathroom renovation to deliver level-access showering, appropriate space for assistance, compliant waterproofing, non-slip flooring, accessible fixtures and safe drainage can readily exceed this amount once demolition, rectification and compliance with building codes are included (AIHW 2024a).

Where older people also require structural works to address steps, steep gradients, and narrow doorways, or need external ramps and pathway modifications to allow safe use of mobility aids, the total cost of essential access works quickly outstrips the lifetime cap of 15,000 dollars for high-tier Home Modifications (AIHW 2024a).

Extending the time allowed for expenditure from twelve to twenty-four months does not alter this arithmetic; it merely allows more time to spend an amount that, in many cases, is insufficient to achieve a clinically safe home configuration (Department of Health, Disability and Ageing 2025j).

A similar pattern applies to Assistive Technology. Frail older people with advanced mobility impairment, severe osteoarthritis, chronic pain, high falls risk, continence issues, and sleep disturbance often require more than one item of major equipment. The minimum clinically appropriate configuration may include an electric profiling bed, a high-grade pressure-relieving mattress, an electric lift chair, suitable seating, a tilt-in-space commode, a hoist or transfer aid, and sometimes powered mobility devices (Wounds Australia 2023; Australian Commission on Safety and Quality in Health Care 2020). Each of these items can cost several thousand dollars. When combined, the total cost can readily reach or exceed the high-tier range. While the manual allows Assistive Technology funding above 15,000 dollars in such circumstances, this is contingent on detailed clinical evidence and formal approval; it is not an automatic entitlement (Department of Health, Disability and Ageing 2025j).

The Support at Home program manual indicates that Services Australia applies caps and monitors high-tier Home Modifications, and that access to additional Assistive Technology funding is subject to persisting need and appropriate prescription (Department of Health, Disability and Ageing 2025j). In practice, this means older people with progressive frailty and multi-system disease must navigate repeated assessments, quotations and requests to secure funding that aligns with their actual modification and equipment needs. For pensioners without savings or family capital, the combined effect of a capped high tier for Home Modifications, the real cost of accessible bathrooms and access works, and administrative complexity is that they may receive only partial modifications or only a subset of clinically recommended equipment (OPAN 2025a).

This is inconsistent with the rights-based intent of the new aged care legislative framework and with the stated objective of enabling older people to remain safely at home rather than being forced into institutional care because their environment cannot be made safe (OPAN 2025a; Royal Commission into Aged Care Quality and Safety 2021).

6.4 Occupational therapy prescription, wrap-around services and practical burden

The Support at Home program manual requires that higher-risk Assistive Technology and all structural Home Modifications be prescribed or recommended by appropriately qualified health professionals, typically occupational therapists, and that "wrap-around services" such as assessment, fitting, training and follow-up are funded under the Assistive Technology and Home Modifications scheme itself with a clinical supports contribution rate of zero per cent (Department of Health, Disability and Ageing 2025j, pp. 172–175). This is an important safeguard. It recognises that professional assessment is integral to safe equipment prescription and that older people should not be charged personal contributions for these clinical activities.

However, the requirement for clinical prescription and wrap-around services has significant practical implications. Comprehensive occupational therapy assessment for a frail older person with multiple risks usually requires one or more home visits, detailed task analysis, liaison with builders and suppliers, preparation of reports and follow-up to confirm that modifications and equipment function as intended. In regional and rural areas, limited allied health availability and long travel times can delay these assessments and prolong the period during which the older person uses unsafe bathrooms, stairs, and access paths (AIHW 2024a; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2024).

The program manual also makes clear that funding for Assistive Technology and Home Modifications is short-term. Funds must generally be spent, not just committed, within twelve months of approval, with specific, limited circumstances allowing for an extension of the period (Department of Health, Disability and Ageing 2025j, pp. 173–174). In environments where trade capacity is constrained and waiting times are long, there is a real risk that funding will expire before works are completed, leaving older people with incomplete modifications and unspent entitlements that cannot be carried forward.

Crucially, the Assistive Technology and Home Modifications scheme does not increase the person's ongoing Support at Home services budget. It can fund the environment, equipment, and some clinical wrap-around, but it does not add personal care, domestic assistance, or nursing hours to help a severely frail person use that equipment safely. Falls-prevention and frailty guidelines emphasise that environmental modification is necessary but not sufficient; sustained, person-centred, multidisciplinary interventions are required to reduce falls, maintain function and prevent deterioration (Sherrington et al. 2019; Montero-Odasso et al. 2022; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2024). Delivering those interventions requires labour hours, not just capital items. Under the current model, those labour hours must still be purchased from the same finite Support at Home budget that is already stretched by personal care and nursing.

6.5 Continence, oxygen, enteral feeding and other essential consumables

Older people with high clinical complexity generate ongoing costs for essential clinical consumables. These include continence pads and pull-ups, bedding protection, urinary catheters and drainage bags, dressings and compression products for wounds, oxygen tubing and masks, giving sets, syringes and formula for enteral feeding, and single-use items such as sterile packs, saline and gloves (Wounds Australia 2023; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2020).

Under previous arrangements, many older people received some continence support through the national Continence Aids Payment Scheme, which provided a separate, ring-fenced cash subsidy. The Support at Home program manual states that continence aids will progressively be removed from the national Continence Aids Payment Scheme for Support at Home participants. From February 2026, people receiving Support at Home services will no longer be able to access continence products through the national scheme, and will instead be expected to access state and territory continence schemes where available, or to use their Support at Home funding to purchase continence products where other assistance is inadequate (Department of Health, Disability and Ageing 2025j, pp. 240–241; Services Australia 2025a, 2025b)

The manual further clarifies that, where a participant is eligible for nursing, continence aids may be purchased as "nursing care consumables" under the nursing service type (Department of Health, Disability and Ageing 2025j, p. 241). In practical terms, this means continence products become a charge against the same overall aged care funding envelope that must also purchase personal care, domestic assistance and clinical visits. There is no separate, Commonwealth-funded continence entitlement for new Support at Home clients that sits entirely outside their Support at Home budget (Department of Health, Disability and Ageing 2025j; Services Australia 2025a).

Oxygen and enteral feeding costs are treated similarly. The schedule of subsidies and supplements for Support at Home rationalises multiple earlier supplements and emphasises integrated, personalised budgets rather than program-specific subsidies (Department of Health, Disability and Ageing 2025f). Although some legacy or specialist supplements persist, there is no clearly defined automatic oxygen or enteral supplement that increases the labour budget for older people who require home oxygen or enteral nutrition (AIHW 2024a; Palliative Care Australia (PCA) 2025a).

Evidence from national agencies and clinical guidelines shows that under-provision of continence aids, wound consumables and palliative care supplies is associated with increased pressure injuries, infections, delirium, falls, emergency presentations and premature entry to residential aged care (Wounds Australia 2023; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2020; Inouye et al. 1999; Palliative Care Australia (PCA) 2024). For older people whose income is limited to the Age Pension, and whose Support at Home budget is already heavily committed to personal

care and nursing, the absence of a clearly defined Commonwealth entitlement for continence, oxygen and enteral supplies means that they must either divert funds away from essential hands-on care or ration clinically necessary consumables. This is a foreseeable, structural source of harm.

6.6 Allied health and complex community care

Safe and effective community care for older people with high clinical complexity depends on access to allied health professionals, including physiotherapists, occupational therapists, dietitians, speech pathologists and podiatrists. High-quality evidence from systematic reviews and global guidelines demonstrates that exercise programs targeting balance, strength and functional mobility, delivered or prescribed by physiotherapists, reduce falls in community-dwelling older people by around 20 to 30 per cent (Sherrington et al. 2019; Montero-Odasso et al. 2022). Multi-component interventions that combine strength and balance training, home hazard modification and vision correction are particularly effective in reducing falls in high-risk groups (Montero-Odasso et al. 2022; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2024).

National wound and pressure injury standards highlight the central role of podiatry, occupational therapy and multidisciplinary input in preventing ulcers and amputations in people with diabetes and vascular disease (Wounds Australia 2023; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2020). Speech pathology assessment and management of dysphagia reduce aspiration pneumonia and hospitalisation in older people with dementia, stroke and Parkinson's disease (Royal Australian College of General Practitioners (RACGP) 2024; AIHW 2024a). Dietitians play a critical role in addressing malnutrition and weight loss, both common in frailties and strongly associated with hospitalisation and mortality (AIHW 2024a; Montero-Odasso et al. 2022).

The Support at Home program manual positions allied health within the general service list to be purchased from the individual's ongoing Support at Home budget, alongside personal care, domestic assistance and nursing (Department of Health, Disability and Ageing 2025j, ch. 10). There is no separate allied health allocation, no requirement that people at higher Support at Home classifications receive a minimum level of multidisciplinary input, and no explicit loading for multimorbidity or severe frailty. Palliative Care Australia has expressed concern, in submissions on the Support at Home funding and pricing framework, that the costs of multidisciplinary palliative and complex care—particularly allied health involvement, clinical governance, education and after-hours responsiveness—are not yet fully recognised in pricing, and has argued that funding must "fully and transparently reflect" the cost of providing a palliative approach in home-based aged care (Palliative Care Australia (PCA) 2025a, 2025b).

For frail older people who require daily or twice-daily personal care and domestic assistance, along with frequent nursing visits, there is limited residual capacity within their Support at Home budget to purchase allied health at the frequency recommended by contemporary guidelines (Montero-Odasso et al. 2022; Sherrington et al. 2019). In rural and regional settings, including much of Tasmania, allied health availability is further constrained by workforce shortages and travel requirements, which increase cost and reduce access (AIHW 2024a). The Older Persons Advocacy Network has reported that older people already face barriers to obtaining assistive technology and allied health under current funding and contribution arrangements, and that constrained budgets contribute to under-utilisation of these services (Older Persons Advocacy Network (OPAN) 2025b).

Hospital discharge plans that recommend intensive multidisciplinary follow-up after falls, fractures, stroke or acute decompensation are therefore often not implementable within the Support at Home budget, even at higher classifications. This is inconsistent with the evidence that such multidisciplinary interventions reduce functional decline, falls and hospital readmission in frail older adults (Sherrington et al. 2019; Montero-Odasso et al. 2022).

6.7 Part summary

Support at Home has taken an important step by establishing a dedicated Assistive Technology and Home Modifications scheme with separate funding tiers and explicit recognition that assistive technology and home modifications should not have to be purchased from the same budget as everyday care. The scheme allows Assistive Technology funding above the standard high-tier amount where there is supporting evidence, recognises that some complex home modification projects require extended timeframes, and confirms that clinical wrap-around services associated with Assistive Technology and Home Modifications attract a zero per cent clinical supports contribution (Department of Health, Disability and Ageing 2025j; Department of Health, Disability and Ageing 2025k).

However, the lifetime cap of 15,000 dollars for high-tier Home Modifications, when set against contemporary construction and accessibility costs, means that many older people with substantial bathroom and access needs will receive only partial modifications unless they can contribute significant private capital. The process of securing Assistive Technology funding above 15,000 dollars, while possible in principle, is administratively complex and reliant on detailed clinical evidence, which may be difficult for frail pensioners to navigate.

At the same time, the progressive withdrawal of the national Continence Aids Payment Scheme for Support at Home participants and the expectation that continence, oxygen and related consumables will be sourced first from state schemes and then from the

person's Support at Home budget shifts the financial burden of essential clinical consumables into personal budgets that are already constrained (Department of Health, Disability and Ageing 2025j; Services Australia 2025a). There is no dedicated Commonwealth entitlement for these consumables that scales with documented clinical need for new Support at Home clients, despite clear evidence that under-provision leads to preventable complications, hospitalisations and earlier residential aged care admission (Wounds Australia 2023; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2020; Palliative Care Australia (PCA) 2024).

Allied health services, meanwhile, remain embedded within the same finite Support at Home budget that must fund personal care, domestic assistance and nursing, notwithstanding robust evidence that multi-component allied health interventions are essential to reducing falls, preventing pressure injuries and maintaining function in frail older adults (Sherrington et al. 2019; Montero-Odasso et al. 2022; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2024).

Taken together, these settings mean that for older Australians with high clinical complexity, Assistive Technology and Home Modifications, essential consumables, and allied health are technically available but, in practice, underfunded and difficult to access at the level recommended by best-practice guidelines. The funding model continues to treat these elements as discretionary additions to a fixed Support at Home envelope rather than as core components of a rights-based response to frailty and complex illness in later life. This misalignment between policy architecture and the lived realities of clinical complexity is a central structural failing of the Support at Home program and must be addressed if older Australians are to realise the promised right to safe, high-quality care in their own homes (Older Persons Advocacy Network (OPAN) 2025a; Palliative Care Australia (PCA) 2025a; Royal Commission into Aged Care Quality and Safety 2021).

PART 7 – SERVICE DELIVERY, WORKFORCE AND PROVIDER CAPACITY UNDER SUPPORT AT HOME

7.1 National workforce constraints and Support at Home demand

The Support at Home program is being implemented into an aged care system already characterised by structural and long-standing workforce shortages. National analyses show that the care and support workforce is under significant pressure, with demand projected to grow substantially over the coming decades as population ageing, multimorbidity and frailty increase the need for home-based care (National Skills Commission (NSC) 2021; Jobs and Skills Australia (JSA) 2023; AIHW 2024a).

The National Skills Commission's Care Workforce Labour Market Study highlighted current and future shortfalls across aged care, disability and community care, and

identified home-based services as particularly vulnerable due to fragmented rostering, travel burden, and increasing clinical complexity in the community (National Skills Commission (NSC) 2021). Recent aged-care workforce surveys confirm that in-home providers report high vacancy rates, difficulties recruiting and retaining Registered Nurses and Enrolled Nurses, heavy reliance on casual and part-time workers, and challenges in maintaining continuity of care (Australian Institute of Health and Welfare (AIHW 2024c). These pressures are more pronounced in regional and rural areas, where competition with state health services, demographic ageing and small labour pools further constrain (AIHW 2024c; House of Assembly Select Committee 2024).

Support at Home is explicitly designed to expand and consolidate home-based care by replacing previous home care programs and positioning community services as the primary alternative to residential aged care (Royal Commission into Aged Care Quality and Safety 2021; Aged Care Quality and Safety Commission (ACQSC) 2025a). Yet the program has not been accompanied by a targeted, funded workforce strategy that guarantees sufficient numbers of clinicians and support workers in the community. In effect, Support at Home assumes a level of workforce capacity and stability that does not exist in many parts of Australia, particularly for community nursing and allied health in rural and regional jurisdictions (National Skills Commission (NSC) 2021; Jobs and Skills Australia (JSA) 2023).

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7.2 Registered Nurse, Enrolled Nurse and support worker skill mix

Safe care for frail older people living at home requires an appropriate skill mix of Registered Nurses (RNs), Enrolled Nurses (ENs), allied health professionals and well-trained support workers, working within clear scopes of practice and under robust clinical governance. The Royal Commission into Aged Care Quality and Safety found that inadequate staffing levels, poor skill mix and insufficient clinical leadership were central drivers of substandard and unsafe care, including missed care, medication errors, failure to detect deterioration and avoidable harm (Royal Commission into Aged Care Quality and Safety 2021).

National safety and quality guidance reinforces that care for older people must be underpinned by clear clinical governance, ready access to RNs, and safe delegation of tasks to ENs and support workers (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2021; Aged Care Quality and Safety Commission (ACQSC) 2025b). Frail older people in the community commonly require complex wound care, continence and catheter management, monitoring of heart failure, chronic kidney disease and chronic obstructive pulmonary disease, delirium prevention, behaviour support in dementia, and end-of-life symptom management. These needs clearly fall within the nursing and allied-health scope.

However, in the current workforce environment, support workers are frequently deployed alone into high-risk home environments, with intermittent or remote RN oversight, particularly in rural and regional areas such as southern Tasmania (AIHW 2024c; House of Assembly Select Committee 2024). When combined with the Support at Home funding model, where clinical, personal and domestic services are purchased from a single pooled budget, this creates powerful structural incentives to minimise direct RN and EN involvement. Each additional RN visit for wound care, catheter review, delirium monitoring or behavioural assessment reduces the hours available for personal care and domestic support.

Evidence from existing home-care programs, complaints and sector reporting indicates that, when budgets are constrained, short, high-cost clinical visits are frequently reduced, delayed or cancelled before core domestic and personal care visits, which are cheaper per hour and more visible to consumers (Royal Commission into Aged Care Quality and Safety 2021; Older Persons Advocacy Network (OPAN) 2025a; Palliative Care Australia (PCA) 2025a). Clinical experience in Tasmania confirms that in practice, RN visits for wound care, catheter changes, medication review, delirium monitoring and end-of-life symptom management are often cut back or deferred to "protect the shower" and basic cleaning, even when frailty and palliative care evidence would prioritise timely clinical review to prevent deterioration and hospitalisation.

The strengthened Aged Care Quality Standards, which commenced with the new Act, require providers to ensure that staff have the skills, qualifications and clinical support to deliver safe care, and that clinical assessments (including medication review, behavioural support, delirium and deterioration management) are undertaken by appropriately qualified clinicians (Aged Care Quality and Safety Commission (ACQSC) 2025b; Department of Health, Disability and Ageing 2025j). Yet Support at Home does not include a dedicated clinical funding stream to make this requirement achievable for high-frailty participants.

7.3 Case management, clinical decision-making and scope of practice

Support at Home retains and expands a central role for care partners or case managers, who are responsible for assessment, care planning, budget allocation and coordination (Department of Health, Disability and Ageing 2025j). In practice, these roles are frequently filled by non-clinical staff, including coordinators with backgrounds in human services or administration rather than nursing or medicine. They provide essential navigation and administrative support but lack the training to conduct complex clinical assessment or risk stratification.

Evidence from previous home-care programs shows that case managers often hold large caseloads—frequently 70 to 120 clients—and are responsible for budget monitoring, service adjustments, documentation, communication with families, and liaison with

hospitals and general practitioners (Royal Commission into Aged Care Quality and Safety 2021). Under such workloads, detailed clinical monitoring is rarely feasible. When budgets are tight, case managers may be pressured to modify visit frequency, reallocate hours between domestic, personal and clinical tasks, or downgrade risk classifications to preserve financial viability.

Frailty assessment, delirium risk evaluation, interpretation of Behavioural and Psychological Symptoms of Dementia, medication risk stratification, and decisions about the frequency of nursing review are complex clinical functions that properly belong to RNs, nurse practitioners and medical practitioners (Clegg et al. 2013; Australian Commission on Safety and Quality in Health Care (ACSQHC) 2021). Yet Support at Home does not mandate that high-frailty participants receive regular RN-led review, nor does it clearly separate clinical decision-making from budget administration. In practice, this creates a governance gap in which non-clinical case managers can be drawn into making de facto clinical decisions driven by budget constraints and workflow pressures, particularly in high-frailty, high-risk Tasmanian community caseloads.

The strengthened Aged Care Quality Standards require that clinical governance is explicit, that responsibilities for clinical decision-making are clearly defined, and that providers ensure clinical assessment and care planning are completed by appropriately qualified staff (Aged Care Quality and Safety Commission (ACQSC) 2025b; Department of Health, Disability and Ageing 2025l). In the absence of explicit requirements for RN-led case review within Support at Home, these mandates are not adequately operationalised for frail older Australians receiving services at home.

7.4 Provider operational capacity, travel burden and rural disadvantage

Provider capacity is unevenly distributed across Australia. Rural and regional jurisdictions—including much of Tasmania—experience persistent shortages of RNs, ENs, allied health professionals and support workers, compounded by long travel distances, limited public transport and small numbers of competing providers (AIHW 2024a; Tasmanian Department of Health 2024). Older people outside major centres face reduced access to primary care, specialist services and community-based supports, including allied health and dementia-specific programs (Tasmanian Department of Health 2025).

Support at Home pricing assumes that providers can schedule short, frequent visits across wide geographic catchments. In practice, travel time, fuel costs, roads, parking and, in some cases, ferries and bridges significantly limit the proportion of each shift that can be spent on direct care. Providers report that in rural and outer-regional settings, travel can consume a large proportion of staff time, particularly for short clinical visits that are essential but not easily clustered. Where travel is not fully recognised in pricing, providers must either shorten visits, cluster them in ways that do not align with individual

need or withdraw from unprofitable regions (AIHW 2024a; National Rural Health Alliance (NRHA) 2025).

National data and sector reports show that providers have already exited or restricted services in high-cost, low-density regions, leaving older people with minimal or no practical choice of provider (Royal Commission into Aged Care Quality and Safety 2021; AIHW 2024a). OPAN and other advocacy organisations have warned that, under the new pricing framework, rural and regional older people risk "going without" services when providers deem packages financially unviable, particularly where high-intensity nursing is required (Older Persons Advocacy Network (OPAN) 2025b).

Although the Assistive Technology and Home Modifications (AT-HM) scheme contains some recognition of remote and regional costs for equipment and building works, there is no equivalent, robust structural loading for the higher labour and travel costs of providing clinical and personal care in rural home environments (Department of Health, Disability and Ageing 2025k). The consequence is that a Support at Home participant in a rural Tasmanian community with the same classification as a metropolitan participant may, in practice, receive significantly fewer hours of care once provider travel and workforce scarcity are taken into account. This inequity is not incidental; it is embedded in the design of the funding model.

7.5 System-level consequences for safety, hospitalisation and program viability

The interaction between pooled budgets, workforce shortages, inadequate skill mix, non-clinical case management and rural disadvantage has predictable system-level consequences. When providers cannot recruit sufficient RNs and ENs, essential clinical tasks are rationed, delayed or delegated to less-qualified staff. When Support at Home budgets are rapidly absorbed by necessary clinical care, domestic and personal supports are reduced or removed, despite their known role in falls prevention, nutrition, continence management, infection control and carer sustainability (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2025; AIHW 2024a; Victorian Department of Health 2024).

Evidence from Australian and international studies is clear: frail older adults without adequate home-based clinical oversight and domestic support are more likely to experience avoidable deterioration, emergency department presentations, prolonged hospital stays and premature admission to residential aged care (Clegg et al. 2013; Rockwood & Theou 2020; AIHW 2024a). In Tasmania and other regional jurisdictions, where hospital capacity is already constrained, and ambulance ramping is a recognised concern, failures in community support for frail older people directly translate into bed block, delayed discharges and further pressure on acute care (AIHW 2025b; Tasmanian Department of Health 2024).

Crucially, because Support at Home forces clinical, personal and domestic services to compete within a single capped envelope, clinical care is often the first component to be cut when budgets tighten. Domestic and personal care hours, which are cheaper per hour and highly visible to consumers, are preserved for as long as possible, while RN visits for wound care, catheter review, delirium monitoring, medication review and palliative assessment are reduced, deferred or cancelled. This pattern is already evident in current home-care practice, is supported by advocacy evidence, and is likely to intensify under Support at Home pricing (Royal Commission into Aged Care Quality and Safety 2021; Older Persons Advocacy Network (OPAN) 2025a; Palliative Care Australia (PCA) 2025a).

7.6 Clinical mandates, governance and the practical impossibility of delivering safe care under Support at Home

The new rights-based Aged Care Act and the Strengthened Aged Care Quality Standards not only articulate broad principles; they impose specific clinical mandates on approved providers. Providers must ensure robust clinical governance, comprehensive and timely clinical assessment, evidence-based care planning, behaviour support, deterioration and delirium monitoring, medication safety, documented escalation pathways and regular review, particularly for people with frailty, dementia and complex comorbidities (Royal Commission into Aged Care Quality and Safety 2021; Aged Care Quality and Safety Commission 2025b; Department of Health, Disability and Ageing 2025l). National safety and quality guidance emphasises that safe care for older people requires structured clinical governance, multidisciplinary review and adherence to evidence-based protocols for frailty, delirium, BPSD and chronic disease management (Clegg et al. 2013; Inouye et al. 1999; Wounds Australia 2023).

The Support at Home program's design fails to embed or resource these mandates adequately. The program manual does not require providers to employ Clinical Leads, Clinical Care Managers or RN Care Coordinators; it does not mandate RN-led clinical review intervals for frail, palliative or cognitively impaired older people; and it does not specify minimum standards for delirium screening, behaviour support assessment, or wound and medication review in the home (Department of Health, Disability and Ageing 2025j). Providers retain broad discretion over workforce structure and clinical governance arrangements. Many services operate with a single RN or Clinical Lead responsible for hundreds of clients, an unsafe span of control that makes timely clinical oversight, review and escalation impossible in practice (AIHW 2024c; Royal Commission into Aged Care Quality and Safety 2021).

At the same time, Support at Home's pooled quarterly budgets require clinical, personal and domestic care to compete for the same finite funds. There is no ring-fenced funding stream for comprehensive clinical assessment, RN oversight, wound and catheter care, delirium monitoring or behaviour support planning. Each additional RN visit—for

advanced wound care, catheter review, behaviour assessment, medication review or end-of-life symptom management—directly reduces the hours available for showering, meal preparation, continence support, housework and carer respite. In practice, this forces providers to ration both clinical reviews and daily support, not according to clinical need or best practice, but according to what the pooled budget will permit.

In this environment, clinical governance becomes largely office-based. Policies, procedures and risk registers can be written and updated; quality committees can meet; and compliance documents can be prepared. However, without funded RN time to conduct regular in-home assessments, observe function and cognition, review wounds and catheters, monitor delirium risk factors, and adjust behaviour support plans, governance cannot be translated into real-world clinical safety for frail older people. International frailty and delirium evidence shows that unmonitored frailty trajectories, delayed recognition of delirium, unmanaged pain, worsening wounds and escalating behaviours are associated with increased mortality, institutionalisation and long-term cognitive decline (Clegg et al. 2013; Inouye et al. 1999; Dent et al. 2023).

To comply fully with the clinical mandates in the new Aged Care Act and the Strengthened Standards for high-frailty clients, providers would need to employ sufficient RNs, ENs and clinical leaders to provide regular in-home clinical reviews and behaviour support; implement mandated, time-bound clinical review schedules for frail, palliative and cognitively impaired clients; and allocate funded time for multidisciplinary assessment, documentation, family meetings, escalation and coordination with general practitioners and specialists. Support at Home provides no ring-fenced clinical budget, no staffing ratios, no mandated RN review frequency and no loadings that realistically reflect the cost of delivering this level of clinical care in people's homes (Department of Health, Disability and Ageing 2025j; Aged Care Quality and Safety Commission 2025b).

In reality, providers will deal with these mandates by:

- creating paper-compliant policies and templates while rationing clinical reviews and behaviour support in the home;
- avoiding or exiting the highest-risk frail and palliative clients whose needs cannot be safely met within available budgets, particularly in rural and regional areas; and
- normalising preventable harm—such as unrecognised delirium, progressive frailty, untreated pain and deteriorating wounds—as "inevitable decline" rather than as failures of clinical governance and resourcing.

The result is a structural contradiction at the heart of the reform. The Aged Care Act and Strengthened Standards say that frail older Australians have a right to safe, high-quality, clinically appropriate care at home. The Support at Home design, implemented into a known workforce shortage with a single pooled budget, ensures that providers cannot

consistently deliver that level of care on the ground for high-frailty clients. Clinical governance will increase in offices and on paper. In contrast, real-world clinical risk remains in the living rooms, bathrooms and bedrooms of older people whose needs cannot be reconciled with the constraints of the Support at Home funding model. Without structural change, frail older Australians will continue to experience preventable deterioration and premature death despite the existence of a rights-based Aged Care Act.

7.7 Part summary

Support at Home is being introduced into an environment of entrenched workforce shortage, particularly in community nursing and allied health, with demand for home-based care projected to rise sharply as the population ages and frailty and multimorbidity increase (National Skills Commission 2021; Jobs and Skills Australia 2023; AIHW 2024a). The program's design assumes that providers can expand and intensify home-based care without a dedicated or guaranteed increase in community workforce capacity. This assumption is inconsistent with the evidence from national workforce studies and the Royal Commission into Aged Care Quality and Safety, which identified inadequate staffing, poor skill mix and weak clinical leadership as central drivers of substandard care (Royal Commission into Aged Care Quality and Safety 2021).

Within Support at Home, clinical supports, personal care and domestic assistance are all purchased from a single pooled budget. There is no ring-fenced stream for nursing, allied health or clinical governance, and no robust structural loading that reflects the additional labour and travel costs of providing care in rural and regional settings (Department of Health, Disability and Ageing 2025j; Department of Health, Disability and Ageing 2025h). When budgets are tight, short, high-cost RN visits for wound care, catheter management, delirium and medication review are often reduced or deferred before basic domestic and personal care visits, which are cheaper per hour and more visible to consumers. Advocacy evidence and sector reporting already show older people in home care losing or being unable to access nursing and allied health supports while basic supports are maintained, and warn that under Support at Home many will find their funds "will not go as far" despite a formal "no worse off" guarantee (Older Persons Advocacy Network (OPAN) 2025b; Department of Health, Disability and Ageing 2025b).

At the same time, the new rights-based Aged Care Act and the Strengthened Aged Care Quality Standards impose clear clinical mandates: robust clinical governance, comprehensive assessment, evidence-based care planning, behaviour support, delirium and deterioration monitoring, medication safety and timely escalation, including for people with frailty, dementia and complex comorbidities (Department of Health, Disability and Ageing 2025l; Aged Care Quality and Safety Commission (ACQSC) 2025b). Yet the Support at Home manual does not mandate RN review intervals for high-frailty clients, does not require specific clinical leadership roles in community care, and does not provide a dedicated funding mechanism for the ongoing RN and allied health

time needed to operationalise these mandates in people's homes (Department of Health, Disability and Ageing 2025j; Aged Care Quality and Safety Commission (ACQSC) 2025a).

The combined effect is that clinical governance risks becoming largely office-based—policies, templates and risk registers that look compliant—while frail older Australians continue to experience under-reviewed wounds, catheters, behaviours, delirium and end-of-life trajectories in their homes. Providers are legally responsible for delivering safe, high-quality, clinically appropriate care under the new Act and Standards, but are funded through a pooled budget and operate in a constrained labour market that makes full compliance unattainable for many high-needs clients, especially in rural jurisdictions such as Tasmania. In practice, Support at Home structurally prevents providers from consistently delivering the level and mix of clinical, personal and domestic support that the legislation prescribes. Without structural reform to funding, workforce and clinical governance settings, frail older Australians will continue to experience preventable harm, avoidable hospitalisation and premature institutionalisation, despite the promise of a rights-based aged care system (Royal Commission into Aged Care Quality and Safety 2021; Department of Health, Disability and Ageing 2025j; Older Persons Advocacy Network (OPAN) 2025b).

PART 8 — ASSESSMENT, ACCESS AND CLINICAL GOVERNANCE: WAITING AS A PATIENT SAFETY ISSUE

8.1 Overview

8.1.1 The Support at Home (SAH) reforms are framed as a rights-based, person-centred program intended to enable older people to remain living safely at home. In practice, those rights are only meaningful if timely assessment, service commencement and clinically appropriate care planning can occur for frail, high-risk older people (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025e).

8.1.2 Delays in assessment, approval, service commencement, equipment provision and home modifications are not administrative inconveniences for this cohort. They operate as material patient-safety hazards because frailty trajectories and clinical complexity create narrow margins between stability at home and acute decompensation (Hoogendijk & Dent 2022; Welstead et al. 2021; Dent et al. 2023).

8.1.3 Pre-reform Home Care Packages (HCP) data illustrate the scale of unmet demand that SAH will inherit unless access settings are materially changed. As of 30 June 2024, 68,586 people were waiting at their approved HCP level on the National Priority System, including 1,851 people in Tasmania (Department of Health, Disability and Ageing 2024a).

8.1.4 These delays are clinically consequential, not theoretical. Prolonged waits for home care have been associated with increased risk of mortality and transition to permanent residential aged care (RAC), indicating that "waiting" is itself an outcome pathway, not a neutral holding pattern (Visvanathan et al. 2019; AIHW 2025c).

8.1.5 Contemporary program data also demonstrate that waiting can be measured in many months, even at lower package levels. As at 30 November 2024, estimated wait times for a medium-priority approval entering the National Priority System were: Level 1 (3–6 months), Level 2 (6–9 months), Level 3 (9–12 months) and Level 4 (12–15 months) (Department of Health, Disability and Ageing 2024a). These timeframes are clinically incompatible with high-acuity frailty, dementia and advanced chronic disease trajectories in the community, because needs escalate within weeks, not years (Hoogendijk & Dent 2022; Welstead et al. 2021).

8.2 Waiting interacts with frailty risk in predictable ways

8.2.1 For frail older people living alone or with an exhausted spouse, delayed commencement of personal care, domestic support, continence support and clinical oversight predictably increases the risk of falls, dehydration, malnutrition, delirium, medication harm, wound deterioration and infection. In practical terms, the system instructs older people to "wait" while their risk profile worsens (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2025; Inouye et al. 1999; Wounds Australia 2023; AIHW 2025a).

8.2.2 Waiting also creates a hidden substitution. Families purchase private services, reduce employment, or provide unpaid care until they can no longer sustain the workload. Where the household cannot absorb the gap, emergency departments and ambulance services become the default "access pathway" into urgent care (AIHW 2025b; House of Assembly Select Committee 2024).

8.3 Equity cohorts: waiting and access risks are amplified (CALD and Aboriginal and Torres Strait Islander Elders)

8.3.1 For older people from culturally and linguistically diverse (CALD) backgrounds, delays are compounded by language barriers, reduced health system literacy, and inconsistent access to accredited interpreters—particularly during assessment, care planning, medication reconciliation, consent processes and escalation decisions (AIHW 2024a; Department of Health, Disability and Ageing 2025m). CALD communities are also more likely to require culturally safe and language-appropriate services to achieve the same clinical safety baseline that mainstream systems assume (Aged Care Quality and Safety Commission (ACQSC) 2025e).

8.3.2 For Aboriginal and Torres Strait Islander Elders, delays and service gaps are amplified by geography, thin-market workforce constraints, and the requirement for culturally safe models grounded in self-determination, connection to Country, kinship structures, and trauma-informed care (AIHW 2024b; Department of Health, Disability

and Ageing 2025n). Evidence indicates that First Nations older people may face barriers to accessing mainstream aged care and are not always well-served by standardised models that do not embed cultural safety as a core design requirement (AIHW 2024b; Department of Health, Disability and Ageing 2025o).

8.3.3 SAH policy settings recognise at least part of this complexity through a specific care management supplement for older Aboriginal and Torres Strait Islander people (Department of Health, Disability and Ageing 2025f). However, a care-management supplement cannot compensate for delayed access to direct care hours, lack of culturally safe service availability, interpreter gaps, or thin-market constraints. If timely, clinically appropriate and culturally safe services are not available "on the ground," the supplement does not prevent deterioration, hospitalisation or RAC entry.

8.4 Clinical governance and care planning: the G16 gap (practice-based evidence)

8.4.1 In practice, organisational incentives and governance arrangements can depress the use of clinical supports in home-care settings. Non-clinical management may resist, delay or "push back" on nursing hours to preserve budgets for domestic and personal care, even where clinical oversight is required to maintain safety for frail, high-risk clients. This risk is heightened where clinical need must compete within fixed budgets and where monitoring of clinical appropriateness is weak (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025l).

8.4.2 Initial sign-up discussions are frequently framed around domestic and personal supports, with clinical assessment and routine clinical review either not offered or treated as discretionary. This is a foreseeable safety failure: many older people and families do not understand the protective function of clinical oversight until a crisis occurs (AIHW 2025c; AIHW 2025b).

8.4.3 These observations matter because the strengthened regulatory framework and rights-based aged care law require effective clinical governance, safe and high-quality care, and care that is proportionate to risk (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025l). If governance settings suppress nursing assessment and routine clinical review, the rights-based intent of SAH cannot be delivered for frail older people.

8.5 Interim conclusion

8.5.1 SAH must be evaluated not only on its written program architecture but on the combined effect of: (i) demand backlogs and long waits; (ii) thin-market supply constraints; (iii) incentives within pooled budgets; and (iv) clinical governance practices that determine whether nursing and clinical review are offered early, routinely and proportionately to risk. For frail older Australians, especially those who are CALD or Aboriginal and Torres Strait Islander Elders, the current settings convert "waiting" into avoidable clinical deterioration (Department of Health, Disability and Ageing 2024a; AIHW 2025c; AIHW 2024a; Department of Health, Disability and Ageing 2025n).

PART 9 — SYSTEM CONSEQUENCES FOR OLDER AUSTRALIANS: HOSPITALISATION, BED-DAYS AND RESIDENTIAL ENTRY

9.1 Overview

9.1.1 Where home-based supports are delayed, rationed or clinically mis-specified, deterioration is not random. For frail older people, the predictable downstream pathway is ambulance attendance, emergency department presentation, hospital admission and, for many, entry into residential aged care (RAC) following an acute event (for example, a fall with fracture, sepsis from a wound or urinary infection, delirium, metabolic decompensation, or carer collapse) (AIHW 2025b; Merchant et al. 2025).

9.1.2 National hospital data already show that older Australians account for a disproportionately large share of emergency presentations, admissions and bed-days. These are the system costs that increase when community supports are not clinically adequate (AIHW 2025b; AIHW 2025d).

9.2 Emergency department utilisation by older people

9.2.1 In 2024–25, people aged 65 years and over accounted for approximately 24 per cent of emergency department presentations nationally. Older people also accounted for a far higher share of emergency-to-inpatient conversions: approximately 52 per cent of emergency department presentations that resulted in admission involved people aged 65 years and over (AIHW 2025b).

9.2.2 This disparity is consistent with frailty epidemiology. For older people, presentations are more likely to represent serious illness, higher acuity and complex discharge planning needs—particularly where the home environment is unsafe and community supports are insufficient (Clegg et al. 2013; Dent et al. 2023; Merchant et al. 2025).

9.3 Hospital admissions and bed-days: the older-person share of inpatient capacity

9.3.1 In 2023–24, people aged 65 years and over accounted for around 44 per cent of hospitalisations and approximately 52 per cent of total patient days in Australian hospitals. Any policy setting that increases preventable deterioration in the frailty cohort therefore has immediate, measurable effects on bed occupancy, exit block, ambulance offload pressures and elective surgery capacity (AIHW 2025d).

9.3.2 Potentially preventable hospitalisations (PPH) illustrate the scale of avoidable acute expenditure. AIHW reports that in 2023–24, PPH accounted for 3.14 million bed-days and $7.7 billion in admitted-patient spending (AIHW 2025e). AIHW also reports that for non-Indigenous Australians, 54.5 per cent of admitted-patient PPH spending is attributable to people aged 65 years and over—confirming that avoidable acute expenditure is already concentrated in the cohort most exposed to SAH delays and under-specification of care (AIHW 2025e).

9.3.3 The clinical sequelae of these admissions are well recognised in older people: functional decline, delirium, deconditioning, medication-related harm, and increased risk

of subsequent institutionalisation. These harms are amplified when discharge occurs into an under-resourced home environment with inconsistent carers and minimal clinical oversight (Pendlebury et al. 2015; Visvanathan et al. 2019).

9.4 Residential aged care entry following acute decompensation

9.4.1 RAC will always be necessary for some older people. The concern here is policy-driven acceleration of RAC entry for those who could safely remain at home if minimum supports were reliably funded and delivered. In practice, many transitions to RAC follow a hospital admission where discharge planners cannot secure the staffing, equipment, home modifications or carer capacity required to safely return the person home (AIHW 2025a; AIHW 2025d).

9.4.2 This creates what can be described as de facto forced institutionalisation: older people who would choose to remain at home are moved to institutional settings because the funding and service model makes home-based safety unattainable. This outcome sits in direct tension with the rights-based objects of the Aged Care Act 2024 and the strengthened regulatory expectations of safe, high-quality, person-centred care (Commonwealth of Australia 2024; Aged Care Quality and Safety Commission (ACQSC) 2025b).

9.5 Disproportionate consequences for CALD older people and Aboriginal and Torres Strait Islander Elders

9.5.1 For CALD older people, inadequate interpreter access and culturally unsafe service delivery increase the likelihood that deterioration is missed, symptoms are under-reported, care plans are poorly understood, and early escalation does not occur—raising the probability that the first “effective” clinical response occurs only after ED presentation or admission (AIHW 2024a; Department of Health and Aged Care 2024b; Aged Care Quality and Safety Commission (ACQSC) 2025b).

9.5.2 For Aboriginal and Torres Strait Islander Elders, service gaps intersect with thin-market constraints, culturally unsafe models and geographic barriers, increasing the risk that hospital becomes the default access point. This is inconsistent with national commitments to culturally safe and appropriately designed aged care and undermines the feasibility of ageing on Country where that is the Elder’s preference (Department of Health 2022; AIHW 2024b).

9.5.3 Accordingly, SAH settings should be assessed not only for average impacts, but for their predictable inequitable impacts on cohorts already experiencing structural barriers to safe community-based care (AIHW 2025a; AIHW 2024a; AIHW 2024b).

PART 10 — STRUCTURE OF THE SUPPORT AT HOME FUNDING SYSTEM (INCLUDING CHSP)

10.1 Where Support at Home sits in the aged care system

10.1.1 From 1 November 2025, Support at Home (SAH) replaces the Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Programme as the Commonwealth's primary program for ongoing in-home aged care. SAH also introduces separate short-term funding pathways and separates equipment and home modifications into a dedicated scheme rather than relying only on the person's ongoing care budget (Department of Health, Disability and Ageing 2025e; Department of Health, Disability and Ageing 2025k; Department of Health, Disability and Ageing 2025j).

10.1.2 The Commonwealth Home Support Programme (CHSP) continues as a separate entry-level program and has been extended to 30 June 2027. Current government information indicates CHSP is not expected to transition into SAH before 1 July 2027, meaning CHSP and SAH will operate in parallel for a transition period (Department of Health, Disability and Ageing 2025e; Department of Health, Disability and Ageing 2025j).

10.1.3 Accordingly, the practical "support at home" system for older Australians (at least until mid-2027) operates through overlapping layers: (a) CHSP for entry-level services, (b) SAH ongoing classifications for people needing a funded quarterly budget, and (c) SAH short-term pathways (Assistive Technology and Home Modifications, Restorative Care, and End-of-Life), plus supplements where eligible (Department of Health, Disability and Ageing 2025e; Department of Health, Disability and Ageing 2025j).

10.2 Ongoing SAH classifications and budgets (quarterly crediting, care management, carryover)

10.2.1 Under SAH, a person receiving ongoing support is assessed into one of 8 ongoing funding classifications. Each classification has a set quarterly budget and annual amount. These amounts are credited quarterly rather than provided as a single "package" amount up front (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

10.2.2 Funding amounts effective from 1 November 2025 are:

- Classification 1 — $2,682.75 per quarter ($10,731.00 per year)
- Classification 2 — $4,008.61 per quarter ($16,034.45 per year)
- Classification 3 — $5,491.43 per quarter ($21,965.70 per year)
- Classification 4 — $7,424.10 per quarter ($29,696.40 per year)
- Classification 5 — $9,924.35 per quarter ($39,697.40 per year)
- Classification 6 — $12,028.58 per quarter ($48,114.30 per year)
- Classification 7 — $14,537.04 per quarter ($58,148.15 per year)
- Classification 8 — $19,526.59 per quarter ($78,106.35 per year)

(Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

10.2.3 Each quarterly allocation includes an amount intended for care management (commonly described as 10% within the program settings). This means part of the quarterly budget is structurally allocated to care management activities rather than direct service hours (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

10.2.4 Unspent quarterly funds can carry over, but only within defined limits: up to $1,000 or 10% (whichever is greater) (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

10.2.5 Service expenditure must align with assessed needs, the SAH service list scope rules, and the person's support plan (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

10.3 Transition arrangements for people moving from HCP (including unspent HCP funds) — IMPORTANT "GRANDFATHERED" FEATURES

10.3.1 People who were receiving an HCP prior to the SAH start date transition across with "transitioned HCP" status. Their SAH funding is set to align with their previous HCP level as a transitional arrangement, and they retain access to any Commonwealth unspent HCP funds they hold (Department of Health, Disability and Ageing 2025j).

10.3.2 Transitioned HCP quarterly and annual amounts (effective 1 November 2025) are:
• Transitioned HCP Level 1 — $2,746.63 per quarter ($10,986.50 per year)
• Transitioned HCP Level 2 — $4,829.86 per quarter ($19,319.45 per year)
• Transitioned HCP Level 3 — $10,513.83 per quarter ($42,055.30 per year)
• Transitioned HCP Level 4 — $15,939.55 per quarter ($63,758.20 per year) (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

10.3.3 Unspent HCP funds are treated differently from the new quarterly SAH budget. Unspent HCP funds can be used for eligible SAH purposes (including assistive technology, home modifications and additional services) and are not subject to the same quarterly rollover limits that apply to the ongoing SAH quarterly budget (Department of Health, Disability and Ageing 2025j).

10.3.4 *Grandfathered/transition settings (including contribution protections and certain supplements) apply to defined cohorts and operate alongside the general SAH rules during the transition (Department of Health, Disability and Ageing 2025j).*

10.4 What SAH funding can purchase (service list, categories and "what is included")

10.4.1 SAH operates through a national service list. Services are grouped into broad categories, including clinical supports (e.g., nursing and allied health), independence

supports (e.g., personal care, transfers), everyday living supports (e.g., domestic assistance, meals, transport, gardening), and care management supports. Providers claim payment for delivered services against the person's available budget(s) (Department of Health, Disability and Ageing 2025j).
10.4.2 SAH distinguishes between:
(a) an ongoing quarterly classification budget (for day-to-day support),
(b) separate short-term pathway budgets (AT-HM, Restorative Care, End-of-Life), and
(c) supplements that may be added to the person's budget if eligibility criteria are met (Department of Health, Disability and Ageing 2025j).
10.4.3 In practice, what SAH "includes" is defined by the service list scope rules and the person's assessed needs. The same-named service (for example, "nursing") can include different real-world tasks depending on the client's needs (for example, wound care, continence management as a clinical function, medication administration, monitoring deterioration risk, and clinical coordination), provided it remains within the program's in-scope definitions (Department of Health, Disability and Ageing 2025j).

10.5 Short-term pathways and discrete components (AT-HM, Restorative Care, End-of-Life, assistance dog maintenance)
10.5.1 Assistive Technology and Home Modifications (AT-HM) Scheme — SAH separates assistive technology and home modifications into a dedicated pathway with tiered funding. This pathway has defined tier amounts and rules around evidence, reassessment and extensions for complex modifications (Department of Health, Disability and Ageing 2025k; Department of Health, Disability and Ageing 2025j).

10.5.1a AT-HM tier budgets are:
• Assistive technology — Low $500; Medium $2,000; High $15,000+
• Home modifications — Low $500; Medium $2,000; High $15,000 (Department of Health, Disability and Ageing 2025k; Department of Health, Disability and Ageing 2025j).

10.5.1b AT above $15,000 and home modification lifetime rule: program guidance indicates approvals above $15,000 for assistive technology may be possible where evidence requirements are met, and the home modifications high tier is available only once per person's lifetime (Department of Health, Disability and Ageing 2025k; Department of Health, Disability and Ageing 2025j).

10.5.1c How to seek more AT-HM funding: where a tier is insufficient, program guidance provides for a Support Plan Review and evidence-based approval processes to seek a higher tier or additional funding where allowed (Department of Health, Disability and Ageing 2025j).

10.5.2 Restorative Care Pathway — SAH provides a discrete, time-limited restorative care budget of $6,000 for up to 16 weeks, with capacity (if approved) for additional

funding up to $6,000 (total up to $12,000) (Department of Health, Disability and Ageing 2025j).

10.5.3 End-of-Life Pathway — SAH includes a dedicated End-of-Life funding pathway of $25,000 for people assessed as having around 3 months or less to live and who wish to remain at home. Funding is available for 12 weeks and may be used over up to 16 weeks where funds remain (Department of Health, Disability and Ageing 2025j).

10.5.4 Assistance dog maintenance — SAH includes a discrete assistance dog maintenance component of $2,000, allocated every 12 months. This does not accrue or roll over. It is intended for costs directly related to the upkeep of a qualifying assistance dog, rather than purchase/training (Department of Health, Disability and Ageing 2025j).

10.6 SAH supplements — what they are, and what is *grandfathered*
10.6.1 SAH includes supplements listed in the Schedule of Subsidies and Supplements for Support at Home. Supplements can be added to the person's funding where eligibility requirements are met (Department of Health, Disability and Ageing 2025f).

10.6.2 Supplements that can apply under SAH (subject to eligibility) include:
(a) Oxygen supplement (daily rate) — for specified medical need for continual oxygen administration (Department of Health, Disability and Ageing 2025f).

(b) Enteral feeding supplement (daily rate; bolus/non-bolus rates) — for specified medical need for enteral feeding (Department of Health, Disability and Ageing 2025f).

(c) Veterans' supplement (daily rate) — for eligible veterans (Department of Health, Disability and Ageing 2025f).

(d) Care management supplement (daily rate; provider-based) — for specified cohorts (including older Aboriginal and Torres Strait Islander people, people who are homeless or at risk of homelessness, care leavers, eligible veterans, and people referred through care finder) (Department of Health, Disability and Ageing 2025f).

(e) AT-HM remote supplement — applies for eligible AT-HM participants in MM6/MM7 and is set as 50% of the assigned AT-HM tier (Department of Health, Disability and Ageing 2025f; Department of Health, Disability and Ageing 2025k).

(f) Fee Reduction supplement (hardship) — applies where the person meets financial hardship requirements under the Act and rules (Department of Health, Disability and Ageing 2025f; Aged Care Act 2024 (Cth); Aged Care Rules 2025 (Cth)).

10.6.3 *Transition-only / grandfathered supplements (not available to new SAH-only participants):*
(a) *Dementia and Cognition Supplement — continues only for transitioned HCP participants who were receiving it on 31 October 2025; it ceases if/when the person is reassessed and accepts a SAH classification* (Department of Health, Disability and Ageing 2025f; Department of Health, Disability and Ageing 2025j).

(b) *EACH-D Top Up supplement — applies only to the cohort who were in receipt of an EACH-D package on 31 July 2013 and continues as a daily top-up at the Schedule rate* (Department of Health, Disability and Ageing 2025f).

10.7 Continence funding under SAH (CAPS interaction and what consumers must do)
10.7.1 The Continence Aids Payment Scheme (CAPS) is a separate Commonwealth scheme. Services Australia guidance states that from February 2026, if a person is receiving Support at Home, they are generally not eligible for CAPS (Services Australia 2025b).
10.7.2 Under SAH, continence-related needs must be addressed through the person's assessed needs, support plan, and in-scope service list items (including clinical supports and/or AT-HM where applicable), rather than assuming there is a separate continence payment alongside SAH (Department of Health, Disability and Ageing 2025j; Department of Health, Disability and Ageing 2025k).

10.7.3 Practical consumer note (factual): continence must be documented at assessment/support planning so that continence-related supports (services and/or equipment) are included in the support plan and budget allocation (Department of Health, Disability and Ageing 2025j).

10.8 Participant contributions (co-payments), "assessable income", and why Services Australia letters look different
10.8.1 SAH introduces service-based participant contributions. Clinical supports are set at 0% contribution. Independence supports, and everyday living supports attract contributions determined by means testing and contribution bands (Department of Health, Disability and Ageing 2025c).

10.8.2 Services Australia determines contribution settings using an income and assets assessment and calculates "assessable income" for SAH contribution purposes (Department of Health, Disability and Ageing 2025c).
10.8.3 Services Australia correspondence provided to clients can state that government income support payments are not assessable when calculating SAH contributions. This means the Age Pension (and other government income support payments) is not counted as assessable income for SAH contribution calculations in that correspondence (Services Australia 2025b).
10.8.4 My Aged Care publishes indicative contribution percentages by service type and means status (for example: full pensioners and other cohorts), and separate "no worse off" settings apply for defined transitioned cohorts (My Aged Care 2025a; Department of Health; Disability and Ageing 2025c).

10.9 Provider payment arrangements and claiming mechanics (facts)
10.9.1 SAH payments operate through Services Australia claiming and validation. Providers generally claim after service delivery, and services are funded from the relevant participant budget source (ongoing quarterly budget, AT-HM tier, restorative

care budget, end-of-life budget, unspent HCP funds, and/or supplements where applicable) (Department of Health, Disability and Ageing 2025i; Department of Health, Disability and Ageing 2025j).

10.10 Indigenous elders and CALD older people — access supports and relevant program settings

10.10.1 Older Aboriginal and Torres Strait Islander people are included within cohorts eligible for the Care Management Supplement (provider-based), intended to support additional care management activity where eligibility criteria are met (Department of Health, Disability and Ageing 2025f).

10.10.2 SAH and My Aged Care guidance recognise the need for culturally appropriate engagement and assessment pathways for Aboriginal and Torres Strait Islander older people (Department of Health, Disability and Ageing 2025n; Department of Health, Disability and Ageing 2025o).

10.10.3 For CALD older people, My Aged Care guidance confirms access to translating and interpreting services to support engagement with the aged care system (My Aged Care 2025b).

10.10.4 Where geography is a barrier, the AT-HM Remote Supplement applies in MM6/MM7 (see 10.6.2(e)) (Department of Health, Disability and Ageing 2025f; Department of Health, Disability and Ageing 2025k).

PART 11 — REAL-WORLD COST MODELLING AND CRITICAL ANALYSIS: STRUCTURAL TRANSFER OF COSTS AND DE FACTO FORCED INSTITUTIONALISATION

11.1 Methodology and assumptions

This Part applies the Support at Home (SAH) pricing and classification structure to four realistic case studies drawn from routine home-care practice in Tasmania. Each case represents a common presentation: a frail older woman living alone; a high-dependency couple; a grandfathered Home Care Package (HCP) couple transitioning to SAH; and a part-pensioner with modest superannuation income. In each case, the care configurations are deliberately set at a minimal safe level that an experienced community nurse could endorse in good conscience. They are not aspirational models; they reflect the least amount of clinically safe care likely to prevent rapid deterioration, falls, sepsis, carer collapse and premature residential aged care (RAC) admission.

The following broad assumptions are used:

(a) SAH budgets are those published by the Department of Health, Disability and Ageing for the relevant SAH classifications (e.g., Classification 8, Classification 7), with a 10% deduction for care management, leaving 90% available for direct care (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing

2025j).
(b) Hourly rates reflect contemporary Tasmanian provider prices: approximately $110 per hour for support workers (personal care, domestic assistance, social support), $175 per hour for Registered Nurse (RN) visits and $180 per hour for physiotherapy; podiatry is costed at $150 per visit. These figures are drawn from local provider schedules and sector reporting for Southern Tasmania.
(c) Travel time is assumed to be absorbed within these hourly rates; no separate mileage is charged.
(d) Only support that is genuinely required to keep the person safely at home is costed; discretionary services are deliberately excluded.
(e) Costs are annualised to allow comparison between the total cost of minimal safe home care and the person's SAH budget. Where relevant, Age Pension income and co-contributions are considered, but it is assumed that older people must still have funds available for basic living costs such as food, utilities, medication co-payments and transport.

11.2 Case Study 1 — "Mary": frail full pensioner living alone (Classification 8)

Mary is an 86-year-old woman living alone in regional Tasmania. She has advanced frailty, chronic wounds, diabetes, heart failure and chronic kidney disease. She wishes to remain at home for as long as possible and to die at home if feasible. She receives a full Age Pension and has no significant private assets. Under SAH, Mary is assessed at Classification 8, with a total annual SAH budget of approximately $78,106. After the mandatory 10% deduction for care management, she has $70,295 available for direct care.

A minimal safe care plan for Mary requires:
• Personal care: 3 hours per week for showering, dressing, continence support and grooming.
• Domestic assistance: 14 hours per week for meal preparation, cleaning, laundry, linen changes and basic shopping.
• Social support / supervision: 2 hours per week of in-home social support to reduce isolation and monitor day-to-day well-being.
• Gardening / outdoor safety: 1 hour per fortnight (0.5 hours per week) for basic yard and path safety.
• Clinical wound care: RN dressings every second day, averaging 3.5 hours per week, for complex lower-leg ulcers.
• RN clinical review: 0.2 hours per week (about 1 hour per month) for medication review, frailty assessment and coordination with her GP.
• Physiotherapy: 1 hour per fortnight (0.5 hours per week) to maintain mobility and reduce falls risk.

• Podiatry: 1 visit every 6 weeks (about 8.7 visits per year) for high-risk foot care related to diabetes and peripheral vascular disease.

Using the Tasmanian provider prices above, Mary's indicative weekly costs are:
• Support worker time (personal, domestic, social, gardening): 19.5 hours × $110 ≈ $2,145 per week.
• RN time (wound care + review): 3.7 hours × $175 ≈ $647.50 per week.
• Physiotherapy: 0.5 hours × $180 ≈ $90 per week.
• Podiatry: 8.7 visits × $150 ÷ 52 ≈ $25 per week.

This yields approximately $2,908 per week, or around $151,000 per year. Against Mary's SAH direct-care budget of $70,295, this minimal safe care plan leaves an annual shortfall of about $80,895. Even if Mary were to contribute a substantial portion of her disposable Age Pension after rent and basic living costs (say $7,000–$8,000 per year), the gap between what she can purchase and what she clinically needs remains in the order of $70,000–$75,000 per year. In practice, this means that Mary must either reduce domestic and personal care to unsafe levels, forego regular clinical review and allied health, or rely heavily on unpaid and untrained carers. The likely consequences are falls, wound deterioration, sepsis, malnutrition, delirium and avoidable hospitalisation (AIHW 2025a; AIHW 2025b; Rockwood & Theou 2020).

11.3 Case Study 2 — "John and Ellen": frail couple with high dependency (Classifications 8 and 7)

John and Ellen are a couple in their late eighties living together in their own home. John has advanced frailty, severe mobility impairment requiring hoist transfers, and multiple comorbidities. Ellen is relatively more mobile but has her own chronic conditions and limited capacity to provide physical care. They are emotionally committed to remaining together at home. Under SAH, John is assessed at Classification 8 and Ellen at Classification 7. Their combined SAH budgets before care-management deductions are approximately $78,106 and $58,148, respectively. After deducting 10% for care management, John has $70,295 and Ellen $52,333 available for direct care, for a combined direct-care budget of $122,628 per year (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

SAH budgets are allocated per person and applied through individual quarterly budgets. While most domestic tasks are shared at the household level, the current design does not operate as a household-pooled budget model; pooled participant funding is instead being explored separately through a trial mechanism (Department of Health, Disability and Ageing 2025p). In practice, providers and case managers often "juggle" allocations to keep basic household functions running, but this is neither transparent to participants nor structurally reliable as need increases.

A minimal safe shared care plan requires:
For John:
– 2 hours per day (14 hours per week) of support worker time for hoists and transfers.
– 3 hours per week of personal care (showers, dressing, continence).
– Shared domestic assistance, costed at the household level.
– Shared gardening (1 hour per fortnight).
– Physiotherapy weekly (1 hour per week).
– Podiatry every 8 weeks (about 6.5 visits per year).

For Ellen:
– 3 hours per week of personal care (due to her own frailty).
– Shared domestic assistance: 15 hours per week for meals, cleaning, laundry, shopping.
– 2 hours of social support per week for the household.

Using the same provider prices, the combined weekly cost of this minimal safe plan is approximately:
• Support worker time (hoists, personal care for both, domestic support, social support, gardening): ~37–38 hours per week × $110 ≈ $4,070–$4,180 per week.
• Physiotherapy: 1 hour per week × $180 = $180 per week.
• Podiatry: 6.5 visits × $150 ÷ 52 ≈ $19 per week.

This yields a combined weekly cost of around $4,270 per week, or approximately $224,000 per year. Against the couple's combined direct-care SAH budgets of $122,628, this minimal safe household plan leaves an annual deficit of around $100,000. Even if John and Ellen were to contribute much of their disposable income after basic living expenses, the deficit remains structurally enormous. The couple's lived reality becomes a constant trade-off between showering, hoist safety, meals, continence, and basic house hygiene. The predictable result is carer burnout, increased falls, infection and functional decline for both partners, followed by hospital admission and RAC entry (Royal Commission into Aged Care Quality and Safety 2021; AIHW 2025b; AIHW 2025a).

11.4 Case Study 3 — "Margaret and Ron": grandfathered HCP couple transitioning to SAH

Margaret and Ron are a couple who have been receiving Level 4 Home Care Packages (HCPs) for several years. They have used their packages prudently to purchase a mix of domestic assistance, personal care, clinical nursing and allied health that has allowed them to avoid RAC despite high levels of frailty and multimorbidity. They live in a regional area with limited services. Under the SAH reforms, Margaret and Ron are "grandfathered" and transition into SAH with arrangements intended to maintain their previous level of support until unspent HCP funds are exhausted. Once that buffer is consumed, they must rely on SAH classifications and budgets alone.

Assuming each of them is effectively treated at a level equivalent to Classification 7 or 8, their combined recurrent SAH direct-care budgets after care-management deductions are in the order of $110,000–$120,000 per year. However, their real-world minimal safe care configuration closely resembles that of John and Ellen: intensive domestic support, substantial personal care for both, regular RN oversight, and ongoing physiotherapy and podiatry. The household-level cost of this minimal safe plan is therefore of the same order as Case Study 2, i.e., around $220,000–$230,000 per year at Tasmanian provider prices.

During the grandfathering period, unspent HCP reserves can be used to cover part of this gap. Once those reserves are spent, the couple faces an ongoing structural deficit of around $100,000 per year. At that point, the only sustainable options are to reduce domestic and personal care below safe levels, discontinue or sharply curtail clinical and allied health input, rely on exhausted family carers, or accept RAC admission for one or both partners. The transition from HCP to SAH thus represents a transfer of funding risk from the Commonwealth to the couple and their informal supports (Department of Health, Disability and Ageing 2025j; Department of Health, Disability and Ageing 2025b),

11.5 Case Study 4 — “Peter”: part-pensioner with modest superannuation

Peter is a 79-year-old man living alone with advanced frailty, chronic obstructive pulmonary disease, diabetes and chronic kidney disease. He receives a part Age Pension and a modest superannuation income stream. Clinically, his needs are very similar to Mary’s. Under SAH, Peter is also assessed at Classification 8, with an annual SAH budget of approximately $78,106, of which $70,295 is available for direct care after the 10% care-management deduction.

If the same minimal safe care bundle as Mary’s is applied, Peter’s annual care cost is again approximately $151,000 at Tasmanian provider rates. Like Mary, Peter therefore faces an annual care deficit of around $80,000 between what he needs and what his SAH budget can purchase. Unlike Mary, however, Peter is expected to make higher co-contributions for independence and everyday-living supports because he is not a full pensioner. Under the SAH means-testing arrangements, his modest superannuation income stream exposes him to additional co-payments on domestic supports and potentially higher contributions to care management (Department of Health, Disability and Ageing 2025c; My Aged Care 2025a). In practice, people like Peter either forgo necessary domestic and personal care to avoid unaffordable co-payments or pay substantial out-of-pocket amounts while still receiving well below a clinically safe level of support.

11.6 Consolidated impact of the four Support at Home case studies

Taken together, the four case studies demonstrate that the Support at Home funding envelope for frail older Australians is structurally incapable of purchasing even minimal safe care at current provider prices. This is not a marginal shortfall that could be bridged by efficiencies or a few extra hours from family carers. It is a persistent gap of tens of thousands of dollars per person per year that effectively predetermines earlier hospitalisation or residential aged care (RAC) entry.

For Mary and Peter, the clinically minimal plans cost around $151,000 per year, while their Classification 8 SAH budgets provide only $70,295 for direct care. The annual shortfall of approximately $80,000 cannot realistically be met from Age Pension income or modest superannuation once basic living expenses are taken into account. For John and Ellen, the combined cost of minimal safe care is approximately $224,000 per year, compared with a combined direct-care SAH budget of $122,628, resulting in an annual household deficit of roughly $100,000. For Margaret and Ron, once grandfathered HCP reserves are depleted, their combined recurrent SAH funds are likewise insufficient by a six-figure sum to maintain the level of home support that has previously kept them out of RAC (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j).

11.7 Residential aged care expenditure — a transfer of costs, not a saving

Residential aged care will always be necessary for some people, particularly at very high levels of dependency and when complex behavioural or medical needs cannot be safely managed at home. However, when RAC becomes the default outcome for frail older Australians whose strong preference is to remain at home, it represents both a failure of policy intent and an inefficient use of public funds. The modelling here shows that, for high-needs older people, SAH budgets do not reach the quantum needed to keep them safely at home, no matter how carefully rosters are trimmed and hours rationed. The consequence is earlier RAC entry, often via hospital, with higher public expenditure and reduced autonomy and quality of life (Royal Commission into Aged Care Quality and Safety 2021; AIHW 2025b).

11.8 Hospital “bed block”, preventable admissions and state–Commonwealth cost shifting

The hospital system absorbs a large portion of the cost when Support at Home cannot fund adequate community care. In 2023–24, potentially preventable hospitalisations (PPH) accounted for 3.14 million bed days and $7.7 billion in admitted-patient spending (AIHW 2025e). Many admissions involve older people with chronic conditions and frailty syndromes for which timely, well-coordinated community care is known to reduce hospitalisation. When frail older people like Mary, John or Margaret are admitted with sepsis, hip fracture, delirium or metabolic decompensation, discharge is frequently delayed because suitable home support or RAC placement is unavailable. From a whole-of-system perspective, under-funding SAH therefore acts as cost shifting: it transfers

expenditure from community programs to hospitals and RAC, with no overall saving, while exacerbating ambulance ramping, emergency department crowding and elective surgery delays.

11.9 Human rights, the Aged Care Act 2024 and the institutionalisation of death

The Aged Care Act 2024 is deliberately framed as a rights-based statute. The Statement of Rights promoted by the Aged Care Quality and Safety Commission affirms older people's rights to dignity, respect, safe and high-quality care, and care that supports them to live where they choose (Aged Care Quality and Safety Commission 2025a; Department of Health, Disability and Ageing 2025a). The modelling in this Part demonstrates that, for frail older Australians with high clinical and functional needs, these rights are at risk of becoming largely theoretical. When the real cost of minimal safe care is around $151,000 per year but a Classification 8 direct-care budget is less than half that, there is no practical way for an older person to remain at home unless the deficit is made up by unpaid carers, providers delivering care at a loss, or by going without essential care.

This interacts directly with end-of-life preferences and outcomes. While many Australians express a preference to die at home when adequate support is available, large proportions of older people die in hospitals and residential aged care settings, particularly at very advanced age (Australian Bureau of Statistics 2021); Palliative Care Australia 2020; Palliative Care Australia 2024). A funding model that systematically under-resources home-based care for frail older people while heavily funding hospital and residential pathways does not simply under-deliver on preference: it structurally incentivises institutionalisation and undermines the rights Parliament has enacted (Royal Commission into Aged Care Quality and Safety 2021; Commonwealth of Australia 2024; Aged Care Quality and Safety Commission 2025a).

11.10 Interim conclusions from Part 11

Using conservative assumptions and real Tasmanian provider prices, Part 11 shows that Support at Home budgets for high-needs older Australians fall dramatically short of the cost of minimal safe care. For single pensioners like Mary and part-pensioners like Peter, the annual deficit is in the order of $80,000. For couples like John and Ellen and for grandfathered HCP participants like Margaret and Ron, the household-level deficit exceeds $100,000 per year once transitional funds are exhausted. Minor efficiencies, telehealth or roster adjustments cannot bridge these gaps. They can only be "resolved" by: (a) older people going without essential domestic, personal and clinical care; (b) unpaid carers absorbing unsustainable workloads; or (c) earlier hospitalisation and RAC admission. In every case, the consequence is a transfer of cost from the SAH program to more expensive parts of the health and aged-care system and to older people themselves. Under-funding Support at Home does not reduce the fiscal burden of an ageing population. It shifts that burden onto hospitals, RACs, and family homes—where the

financial, human, and rights costs are higher. Part 12 sets out specific reforms to SAH pricing, classification design and co-contribution settings to realign funding with clinical reality, reduce preventable hospital and RAC costs, and give genuine effect to the Aged Care Statement of Rights (Department of Health, Disability and Ageing 2025g; Department of Health, Disability and Ageing 2025j; AIHW 2025c; Commonwealth of Australia 2024; Aged Care Quality and Safety Commission 2025a; Royal Commission into Aged Care Quality and Safety 2021).

PART 12 — RECOMMENDATIONS: STRUCTURAL AND CLINICAL REFORMS REQUIRED TO ALIGN SUPPORT AT HOME WITH RIGHTS-BASED AGED CARE

12.1 Purpose

12.1.1 This Part sets out Committee-ready recommendations to address the central structural defect identified in this submission: the pooling of a single quarterly budget across clinical, personal and domestic supports for the frailty cohort. This design predictably causes clinical care to be postponed or displaced by essential day-to-day supports, driving avoidable deterioration, hospitalisation and premature entry to residential aged care (Royal Commission into Aged Care Quality and Safety 2021).

12.1.2 The recommendations are framed as practical amendments to program settings, Rules/Manuals, pricing and accountability arrangements for Support at Home (SAH), consistent with the rights-based framework established by the Aged Care Act 2024 and the strengthened Quality Standards (Commonwealth of Australia 2024; Department of Health, Disability and Ageing 2025a; Department of Health, Disability and Ageing 2025l; Aged Care Quality and Safety Commission 2025a; Aged Care Quality and Safety Commission 2025b).

12.2 Primary structural reform: end the single pooled budget for frailty and complex need

12.2.1 Replace the single pooled quarterly budget (for ongoing classifications) with a multi-stream entitlement model for participants with frailty and/or complex clinical needs, with funds quarantined by purpose and not substitutable without independent clinical authorisation.

12.2.2 At minimum, SAH ongoing funding should be separated into: (a) a protected Clinical Care Entitlement; (b) a Functional Support stream (personal care + domestic assistance as an integrated package); and (c) a Protected Safety/Consumables stream for clinically indicated consumables and supplements where required to remain at home safely (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a).

12.2.3 The Clinical Care Entitlement must be sufficient to fund timely registered nursing assessment, ongoing review, clinical governance activities, and appropriate allied health

interventions, and must not be consumed by domestic and everyday living supports (Department of Health, Disability and Ageing 2025l; Aged Care Quality and Safety Commission 2025a; Royal Commission into Aged Care Quality and Safety 2021).

12.2.4 The Functional Support stream should explicitly recognise that domestic supports (meals, cleaning, laundry) are not discretionary for frail clients; they are foundational risk-controls that enable safe clinical care to occur at home. Domestic and personal supports should therefore remain bundled together but separate from clinical funds (My Aged Care 2025a).

12.2.5 Where a participant's needs exceed their classification, reassessment pathways must be rapid and clinically responsive; interim clinical stabilisation must not be contingent on discretionary case-manager judgement (Department of Health, Disability and Ageing 2025c).

12.3 Implement a frailty tier / frailty loading within the classification system

12.3.1 Introduce a frailty tier or frailty loading to SAH classifications to reflect the predictable increase in clinical oversight, supervision, consumables and coordination required as frailty progresses (Royal Commission into Aged Care Quality and Safety 2021).

12.3.2 The frailty tier should trigger: minimum registered nurse review frequencies; falls and pressure-injury prevention bundles; medication-risk review; hydration/nutrition monitoring; and escalation planning with GPs and local services (Department of Health, Disability and Ageing 2025l; Australian Commission on Safety and Quality in Health Care 2025; Wounds Australia 2023).

12.3.3 The frailty tier should be independent of (and additive to) everyday living supports, to prevent systematic under-provision of clinical risk management when domestic demands are high (My Aged Care 2025a).

12.4 Require immediate clinical nursing assessment and integrated care planning

12.4.1 Mandate an initial registered nurse clinical assessment (and risk stratification) within 14 days of commencement (or faster for high-risk presentations), completed alongside the care management/case management assessment to produce one integrated plan (Department of Health, Disability and Ageing 2025q).

12.4.2 Program guidance should specify that case managers cannot defer, ration or "gatekeep" clinical care where clinical indicators are present; clinical appropriateness must be determined by suitably qualified clinicians and documented (Aged Care Quality and Safety Commission (ACQSC) 2025c; Department of Health, Disability and Ageing 2025q).

12.4.3 Clinical review intervals must be standards-based and enforceable (e.g., monthly for high-risk wounds/pressure injury risk, medication-risk, recurrent falls, behavioural symptoms of dementia), not optional or provider-discretionary (Department of Health, Disability and Ageing 2025l; Wounds Australia 2023; Australian Commission on Safety and Quality in Health Care 2025).

12.5 Fund and mandate carer competency auditing and on-the-ground clinical governance

12.5.1 Create a funded requirement for periodic competency auditing of care workers and informal carers in high-risk tasks (e.g., medication support, infection control, pressure injury prevention, continence care, dementia behaviours), recognising that a certificate does not assure safe practice (Aged Care Quality and Safety Commission (ACQSC) 2025c; Department of Health, Disability and Ageing 2025l).

12.5.2 Clinical governance must be operationalised as "on-the-ground nursing": routine observation, coaching, and corrective action in the home, with auditable records linked to the Quality Standards (Aged Care Quality and Safety Commission (ACQSC) 2025c; Department of Health, Disability and Ageing 2025l).

12.5.3 Provider accountability should require incident trend analysis (including SIRS-aligned approaches) and evidence of systemic prevention strategies in home care, not only after harm occurs (Aged Care Quality and Safety Commission (ACQSC) 2025d; Department of Health, Disability and Ageing 2025r)

12.6 Make clinical nursing Behaviour Support Plans essential for dementia and BPSD

12.6.1 Require a funded, clinical nursing-led Behaviour Support Plan (BSP) for clients with dementia and behavioural symptoms that are causing distress, risk or restrictive practice, with the explicit aim of reducing avoidable pharmacological escalation and preventing crisis presentations (Royal Commission into Aged Care Quality and Safety 2021; Aged Care Quality and Safety Commission (ACQSC) 2025e; Department of Health, Disability and Ageing 2025s).

12.6.2 BSP funding must sit within the protected Clinical Care Entitlement and not compete with domestic supports (see Recommendation 12.2.1).

12.6.3 BSPs must include carer education, triggers, environmental strategies, respite escalation pathways, and documented medication review triggers with GPs (Aged Care Quality and Safety Commission (ACQSC) 2025e).

12.7 Protect access to clinically necessary consumables, supplements and assistance dog maintenance

12.7.1 Establish a Safety/Consumables stream (or equivalent program mechanism) so clinically necessary consumables and supplements do not compete against basic domestic supports within a single pooled budget (Department of Health, Disability and Ageing 2025b).

12.7.2 Ensure participant eligibility and process clarity for existing SAH supplements and other funding items, including oxygen and enteral feeding supports, and annual assistance dog maintenance funding where relevant (Australian Government Department of Health, Disability and Ageing 2025b).

12.7.3 Where consumables are integral to safe home-based clinical care (e.g., wound dressings, continence products where clinically indicated, nutrition/hydration supplements), program rules should specify timely access and prevent cost-shifting to families (Royal Commission into Aged Care Quality and Safety 2021).

12.8 Strengthen AT-HM and OT continuity across the frailty trajectory

12.8.1 Recognise that early OT and home modifications are not “one-off” supports. As people become frailer, they predictably require review, reassessment and additional modifications and equipment to remain safe at home.

12.8.2 Remove or amend policy settings that limit access in ways that are clinically incongruent with frailty progression (e.g., lifetime limits on higher tiers), and ensure the AT-HM scheme can be re-accessed where functional decline is evidenced (Department of Health, Disability and Ageing 2025b; My Aged Care 2025a).

12.8.3 In remote areas, operationalise the existing remote supplement for AT-HM to ensure timely supply and installation, including travel and logistics costs (Department of Health, Disability and Ageing 2025b).

12.9 Address rural, regional and remote access barriers and transport costs

12.9.1 Establish a travel and thin-market pricing mechanism so that rural and regional clients are not effectively penalised through higher unit prices and reduced service availability (Independent Health and Aged Care Pricing Authority (IHACPA) 2025a; National Rural Health Alliance 2025).

12.9.2 Ensure the pricing framework recognises legitimate travel time and cost drivers, and that capped prices do not inadvertently collapse service supply in MM3–MM7 regions (Independent Health and Aged Care Pricing Authority (IHACPA) 2025a; National Rural Health Alliance 2025).

12.9.3 Where transport is required for clinically necessary attendance (e.g., wound clinic, allied health, imaging, GP), program guidance should clarify eligible supports and avoid inequitable out-of-pocket costs for rural participants (Royal Commission into Aged Care Quality and Safety 2021).

12.10 Close pricing and consumer protection gaps during the transition to price caps

12.10.1 Introduce interim pricing safeguards before formal price caps commence on 1 July 2026, including transparent price disclosure, prohibition of excessive administrative loading, and strengthened monitoring/enforcement mechanisms (Department of Health, Disability and Ageing 2025t; Independent Health and Aged Care Pricing Authority (IHACPA) 2025a).

12.10.2 Require providers to evidence that prices are reasonable and reflect genuine delivery costs, with auditability and sanctions for systemic overcharging (Department of Health, Disability and Ageing 2025t; Department of Health, Disability and Ageing 2025h; Independent Health and Aged Care Pricing Authority (IHACPA) 2025a).

12.11 Strengthen the End-of-Life Pathway and palliative care integration

12.11.1 Ensure the End-of-Life Pathway is clinically fit-for-purpose and accessible, including clear criteria, rapid activation, and adequate funding to deliver intensive in-home support (Department of Health, Disability and Ageing 2025u; Department of Health, Disability and Ageing 2025v).

12.11.2 Current guidance indicating a 3-month prognosis threshold risks excluding people with frailty/dementia trajectories and creates predictable late referrals and crisis admissions. A frailty-based eligibility option should be created for rapid escalation in the last months of life (Department of Health, Disability and Ageing 2025b; Royal Commission into Aged Care Quality and Safety 2021).

12.11.3 The pathway should mandate after-hours escalation planning, carer training, and integration with state palliative services, with nursing oversight funded within the Clinical Care Entitlement (Aged Care Quality and Safety Commission (ACQSC) 2025c; Department of Health, Disability and Ageing 2025l).

12.12 Equity and culturally safe care: CALD, Aboriginal and Torres Strait Islander people, and remote communities

12.12.1 Embed culturally safe assessment and care planning requirements, including funded interpreter access, culturally appropriate communication, and partnerships with Aboriginal community-controlled health services where relevant (Department of Health, Disability and Ageing 2025m; Department of Health, Disability and Ageing 2025n; Department of Health, Disability and Ageing 2025o).

12.12.2 Ensure the care management supplement settings for older Aboriginal and Torres Strait Islander people and other priority cohorts are operationalised in a way that supports continuity and access, not merely administrative reporting (Department of Health, Disability and Ageing 2025f; Department of Health, Disability and Ageing 2025n).

12.13 Prevent forced institutionalisation and financially coercive pathways (including RAD pressures)

12.13.1 Introduce safeguards against structural cost-shifting that forces people into residential care due to inadequate home funding, including monitoring of "avoidable admission" indicators and rapid response supports when budgets fail to meet clinical needs (Royal Commission into Aged Care Quality and Safety 2021).

12.13.2 Require the Department to publish (and report to Parliament) data on: hospital admissions for SAH participants; time-to-activation for higher classifications; and transitions to residential care following acute events, disaggregated by geography, CALD status and Aboriginal and Torres Strait Islander status (Royal Commission into Aged Care Quality and Safety 2021).

12.14 Clarify contribution determinations and eliminate contradictory consumer communications

12.14.1 Publish clear, legally robust guidance on contribution determinations (including the interaction with pension status), and require consistent written communications from Services Australia and My Aged Care to prevent consumer confusion and misinformation at point of entry (Aged Care Rules 2025 (Cth); Department of Health, Disability and Ageing 2025c; My Aged Care 2025a).

12.14.2 Where participants are subject to "no worse off" transitional arrangements, the determination and its practical effect must be explicit, standardised and auditable (My Aged Care 2025a).

12.15 Implementation: evaluation, accountability and continuous improvement

12.15.1 Establish an independent evaluation framework for SAH that specifically tests whether separating clinical funds from domestic/personal supports reduces hospitalisation, improves continuity, and delays residential care entry for the frailty cohort (Royal Commission into Aged Care Quality and Safety 2021).

12.15.2 Require annual public reporting and a formal post-implementation review to Parliament within 12–18 months of commencement, including analysis of unintended consequences, thin-market effects, and equity outcomes (Commonwealth of Australia 2024).

PART 13 — LIVED EXPERIENCE AND CLOSING STATEMENT

13.1 Lived experience vignette: the unpaid carer workforce holding the system together

The following lived experience account was provided to the author for inclusion in this submission. It illustrates the hidden, unpaid labour required to make home-based aged care function in practice, and the downstream financial and psychological impacts on families when formal supports are insufficient.

(Attribution note: The contributor requested that their name not be published)

My mum is 94 and still living at home by herself thanks to a Level 4 package.

The system is built on the false premise that it can support a frail elderly person to safely stay in their own home. The only way it works is the massive volunteer, unpaid workforce that supports it.

Generally the weight of this falls on one family member - often a daughter in her fifties or sixties - who, without consultation, finds herself in the parent/caring role because it is the right thing to do. Take this person out of the equation and the home care system does not work.

The contributor also describes the financial consequences of policy and pricing shifts: a decade of unpaid support provided on the understanding that family assets would enable later residential aged care if needed, and concern that rising costs will consume both savings and the family home.

Source: personal communication to the author, 2025.

13.2 Closing statement

This submission has demonstrated that Support at Home, as currently designed, places older Australians living with frailty into a predictable bind: essential clinical care, personal care and domestic supports are forced to compete within capped budgets, while governance expectations rise. When core supports are rationed, risk does not remain static - it escalates. Preventable deterioration becomes normalised until the inevitable crisis occurs: ambulance attendance, emergency presentation, admission, delayed discharge, and avoidable entry to residential aged care.

The lived experience above is not an outlier. It reflects a structural reality: the Commonwealth system is increasingly relying on a large, unpaid and largely unrecognised workforce of family carers to absorb the funding gap and operational complexity of keeping frail older people safe at home. This hidden reliance is neither transparent nor sustainable, and it is inconsistent with a rights-based aged care system.

Parliament now has an opportunity - and an obligation - to ensure that the new rights framework is deliverable in real homes. That requires program settings that do not force older people to trade showers for meals, continence support for wound care, or clinical review for the domestic supports that prevent malnutrition, infection, delirium, and carer collapse. It also requires accountability mechanisms that recognise that clinical governance must be operationalised through on-the-ground nursing assessment, review, escalation and coaching - not simply documented at a desk.

The recommendations in Part 12 provide Committee-ready reforms to correct the central design defect and to align Support at Home with the Aged Care Act’s rights-based intent. Without these changes, the system will continue to shift costs to hospitals, residential aged care, and families who are already carrying the burden. With them, Australia can deliver what older people are asking for: safe, clinically appropriate support to live - and, where they choose, to die - at home, with dignity.

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Appendix A — Master Gaps List (G01–G35)

Gap ID	Gap statement (SAH design/implementation)	Primary consequence for frailty cohort	Where addressed
G01	Frailty/complexity not treated as the organising logic for funding and safeguards (pooled budget assumes substitutability between clinical, personal and domestic).	Predictable rationing of clinical review; crisis escalation; hospitalisation and premature RAC entry.	Parts 1, 6–9, 12
G02	Pooled funding structurally suppresses nursing (clinical competes with domestic/personal in the same capped envelope).	Deferred/foregone clinical review; unmanaged deterioration; preventable admissions and bed-days.	Parts 7–9, 12
G03	No mandatory commencement RN assessment paired with case management (clinical assessment treated as optional).	Unsafe initial plans; missed risks; early destabilisation; avoidable crises.	Parts 8, 12
G04	Gatekeeping: case managers/providers decide whether clinical is "necessary" within pooled budgets.	Incentive to "manage down" nursing; hidden risk transfer to hospitals/families.	Parts 7–8, 12
G05	Clinical governance misframed as office-based paperwork rather than on-the-ground clinical review, supervision, and audit.	Unsafe delegation, poor escalation, unrecognised harm; standards non-compliance.	Parts 8, 12
G06	Carer competence assumed from a certificate alone (insufficient auditing,	Variable/unsafe care; missed deterioration;	Parts 8, 12

	supervision, spot checks, escalation pathways).	injury (client/carer); admissions.	
G07	Behaviour Support Plans (BSPs) not embedded as essential clinical instruments for dementia/BPSD cohorts.	Increased distress, carer breakdown, and inappropriate pharmacological reliance/restrictive practices.	Parts 7–8, 12
G08	OT/AT–HM trajectory not budgeted as a predictable frailty progression (early OT reduces harm but creates expected later reassessment/mod demand).	Repeat falls/transfer injuries; delayed modifications; higher downstream health costs.	Parts 6, 12
G09	Thin market / rural travel burden not structurally protected (travel embedded in prices; high per-unit costs in remote regions).	Reduced service frequency; equity failure; forced institutionalisation risk.	Parts 7, 10, 12
G10	Transport pricing exposure in rural/regional areas (participant experiences high effective costs due to travel time being embedded).	Service rationing; missed appointments; deterioration; inequity.	Parts 7, 10, 12
G11	Contributions and assessable income guidance is inconsistent in practice (participant correspondence conflicts with public guidance).	Confusion, mistrust, delayed uptake; billing disputes; hardship risk.	Part 10, 12 (DoHAC 2025; My Aged Care 2025)
G12	Price-cap transition gap: providers set prices until 1 July 2026; caps commence later.	Price variability, thin market price inflation, reduced transparency for older people.	Part 10, 12 (DoHAC 2025; IHACPA

			2025)
G13	Explicit separation of clinical funding is absent (clinical remains pooled, contrary to risk profile).	Structural under-delivery of nursing and reviews; hospital cost-shift.	Parts 7–9, 12
G14	Frailty/Complexity tier absent (no dedicated tier with safeguards and clinical minima).	People with high frailty fall into budgets designed for substitutable supports.	Parts 6–9, 12
G15	On-the-ground clinical review cadence not specified (no mandated review intervals for high-risk cohorts).	Drift from plan; late escalation; preventable admissions.	Parts 8, 12
G16	Supplement visibility and accuracy: participants/providers often cannot readily see/understand supplements in statements and planning.	Under-claiming; unmet needs; inequity.	Parts 10, 12
G17	Assistance dog maintenance supplement under-visible despite being a discrete funded allocation.	Inequity for people relying on assistance dogs; avoidable hardship.	Part 10, 12 (DoHAC Schedule 2025; My Aged Care 2025)
G18	Consumables and clinical essentials can still crowd out care hours when budgets are tight (even where permitted).	Reduced direct care; clinical neglect; admissions.	Parts 6, 12
G19	End-of-life pathway integration gaps (eligibility timing and pathway transitions can be late or administratively slow).	Avoidable suffering; late palliative supports; crisis presentations.	Parts 6, 12

G20	CALD inequity not operationalised (interpreter/logistics/cultural capability not structurally resourced in thin markets).	Reduced access; unsafe communication; higher institutionalisation risk.	Parts 7, 12 (AIHW; DoHAC rights resources)
G21	First Nations culturally safe care not operationalised (workforce continuity, cultural governance, remote access).	Inequity; distrust; service disengagement; outcomes gap.	Parts 7, 12 (DoHAC rights resources; relevant national strategies)
G22	Remote-area market failure (provider scarcity + travel makes “choice” non-real).	De facto rationing; family burden; forced moves to RAC.	Parts 7, 10, 12
G23	Household logic (couples/shared domestic reality) not consistently reflected in costs and practical service planning.	Hidden cost transfer to partner; unsafe caring burden.	Parts 11, 12
G24	Care management vs clinical governance blurred (care management funding is not a substitute for nursing review).	Plans without clinical validity; unsafe delegation; crises.	Parts 8, 12
G25	System cost transfer unacknowledged in design (hospitals absorb preventable admissions).	Bed-days pressure; discharge delays; RAC entry pressure.	Part 9, 12
G26	Older cohort health literacy gap: many do not understand preventative nursing value until a crisis.	Under-demanding clinical review; delayed escalation; preventable harms.	Part 8, 12

G27	Statements/communications may mislead (e.g., "this is not an invoice—no payment required" vs later contribution liabilities).	Confusion; delayed decisions; hardship risk.	Part 10, 12
G28	Provider pricing transparency uneven despite requirements (publication/review cycles not well understood by consumers).	Reduced comparability; market failure; overcharging risk.	Part 10, 12 (DoHAC prices guidance 2025)
G29	No hard safeguard against suppressing nursing within pooled budgets (structural incentive remains).	High-risk cohorts under-serviced; hospitalisation.	Parts 7–9, 12
G30	Clinical governance enforcement risk: standards may be "met on paper" without field-level supervision/audit.	Persistent harm; complaint escalation; regulatory non-compliance.	Parts 8, 12
G31	RAC financial pressure (RAD/home-sale risk) is a downstream consequence of failure at home, not addressed in SAH design logic.	Household asset depletion; coercive institutionalisation pathway.	Part 9, 12 (My Aged Care residential costs guidance)
G32	Workforce competence assurance not systematised (spot checks, supervision ratios, escalation).	Unsafe care delivery; missed clinical triggers.	Parts 7–8, 12
G33	Implementation governance gap: inconsistent public guidance across agencies (DoHAC / My Aged Care / Services Australia) creates confusion.	Trust erosion; delayed uptake; disputes.	Part 10, 12

Appendix B — Coverage Matrix

Legacy segment	Legacy title	Compressed structure coverage	Notes
1	TITLE PAGE, EXECUTIVE SUMMARY & KEY RECOMMENDATIONS	Part 1	
2	Introduction	Part 2	
3	What Support at Home Gets Right	Part 3	
4	Frailty: A Modern, Evidence-Based Clinical Lens	Part 10 (program architecture) and Part 4 (gaps)	
5	Everyday Living Supports as Preventative Health Care	Part 5	
6	What Older Australians Actually Want (ACQSC, OPAN, Royal Commission)	Part 6	
7	Co-Payments, Hardship and Affordability	Parts 4, 10 and 11	
8	Short-Term Pathways vs Long-Term Frailty	Parts 6 and 11	
9	Household Frailty (Including Real Case Examples)	Parts 7 and 8	
10	End-of-Life (EOL) Pathway Failure	Parts 10 and 11	
11	Residential Aged Care Outcomes	Parts 10 and 11	
12	Human Rights, Equity	Parts 4, 10 and	

	and Ethics	11	
13	Residential Aged Care (RAC) vs Support at Home (SAH) Full Cost Comparison Tables	Part 8	
14	Solutions (Costed, Evidence-Based, Feasible)	Parts 7 and 8	
15	Recommendations for Ministers	Parts 9 and 11	
16	COST MODELLING (MINIMUM SAFE CARE)	Part 9	

Appendix C — Risk Register (Frailty cohort)

Risk ID	Risk description	Likelihood	Impact	Who is exposed	Current controls (insufficient)	Required control (reform)
R01	Clinical care suppressed in pooled budgets (domestic/personal displaces nursing).	High	Severe	Frail cohort; carers; hospitals	Guidance-only; provider discretion	Separate clinical funding; minimum nursing review cadence; frailty tier
R02	No mandated RN commencement assessment → unsafe initial plans.	High	Severe	New entrants; high-frailty clients	Case management + optional nursing	Mandatory face-to-face RN assessment paired with case manager assessment
R03	Gatekeeping of clinical by case managers/providers due to budget incentives.	High	Severe	Frail/dementia clients	"Clinical if needed" language	Ring-fenced clinical funding + audit of clinical decision thresholds
R04	Competence risk: carers "qualified" but unsafe practice (no audit/supervision).	High	High	Clients + carers	Certificate checks only	Supervision, spot checks, escalation pathways, scope-of-practice controls

R05	Dementia/BPSD unmanaged (no BSP), driving psychotropic reliance/crises.	Medium –High	Severe	Dementia cohort; carers	Ad hoc referral	BSP as non-negotiable clinical requirement + DSA/UNSW-aligned practice
R06	Rural/regional travel embedded in prices reduces service frequency (thin markets).	High	High	Rural/remote clients	Thin market grants limited/uneven	Pricing safeguards + travel loadings + service continuity obligations
R07	Confusion/incorrect advice on contributions/assessable income undermines uptake and trust.	Medium	High	Participants; providers	Fragmented guidance across agencies	Formal cross-agency clarification; standardised letters; dispute pathway
R08	Price variability until 1 July 2026 (caps delayed) drives inequity/overcharging risk.	Medium	High	Participants	Publish prices requirement	Strong enforcement + median monitoring + accelerated caps for high-risk services
R09	Assistance dog supplement under-claimed due to low	Medium	Medium	Disability cohort	Exists in schedule but not	Statement templates show supplement

	visibility.				prominent	clearly; assessor prompts
R10	OT/AT–HM demand escalates predictably with frailty but caps/budgets misalign.	High	High	Frailty cohort; hospitals	Tiered AT–HM but time-limited	Frailty tier + staged modification pathway + scheduled reassessment