Ageing Australia®

Support at Home Program Inquiry

Submission to the Community Affairs References Committee

July 2026

Contents

About Ageing Australia

Ageing Australia is the national peak body representing providers across the aged care sector, including retirement living, seniors housing, residential care, home care, community care and related services.

We represent the majority of service providers, working together to create a sector that empowers older Australians to age with dignity, care and respect.

We advocate for a sector that champions excellence, sustainability and innovation, ensuring our members have the tools, resources and guidance they need to deliver exceptional services.

We use our united voice to amplify our members' contributions and concerns to government, media and the wider community.

We are committed to reshaping the future of ageing in Australia by fostering collaboration and driving meaningful change, making it a fulfilling journey.

Executive Summary

The success of Australia's Support at Home program should be judged on whether older people can access the care they need, when they need it.

Support at Home will not achieve its purpose of helping older people to remain in their own homes if needs are met with delayed funding, reduced service use or unavailable services because of pricing, workforce or administrative settings. It should help older people to retain or regain function, exercise choice, sustain relationships and participate in community life.

Every major implementation issue becomes an access issue when it delays, reduces or prevents care. These issues include assessment and funding allocations, contributions, pricing, care management, workforce capacity and digital administration.

Ageing Australia's recommendations are targeted adjustments to protect access, service viability and participant safety while strengthening prevention, reablement and independence.

Key Ageing Australia recommendations include (*full list detailed in Summary of Recommendations below*):

- reduce waits for approved services to no more than one month;
- remove the Minimum Service Offer;
- strengthen human oversight and urgent access;
- provide additional funding for people with exceptional needs;
- enhance reablement, social connection and participation outcomes.

The program must also properly fund care management, strengthen workforce and digital capability, reduce administrative red-tape and improve access to specialist,

restorative, assistive technology and end-of-life supports. Together, these reforms would help older people receive support before deterioration, carer fatigue, avoidable hospitalisation or premature entry to residential aged care occurs.

Evidence from older people and providers shows that the current settings are reducing service use, placing pressure on service availability, under resourcing care management and diverting workforce capacity toward administration rather than caring for older people. Support at Home Program, and its intersection with the Commonwealth Home Support Program (CHSP), can be elevated to enhance reablement, social connection and participation.

Support at Home will not achieve its purpose of helping older people to remain in their own homes if needs are met with delayed funding, reduced service use or unavailable services because of pricing, workforce or administrative settings.

Ageing Australia welcomes recent improvements, including the Government's decision to fully fund personal care for eligible participants from 1 October 2026.[1] Further adjustments are now needed where assessment, funding, contribution, pricing, care-management and administrative settings are delaying or reducing access to care.

Support at Home should ultimately be judged by whether it delivers timely access to care and supports in practice - where older people can receive the right support early enough to remain safe, independent and connected at home. Key outcomes for older people should include whether it helps them retain or regain function, exercise choice, sustain relationships and participate in community life.

Summary of Recommendations

1. Access to services to live safely and with dignity at home

R1 Establish a national objective that older people wait no more than one month between approval and the allocation of full Support at Home funding, supported by a funded implementation pathway to:

a) release sufficient funded places immediately to begin reducing the existing wait list and transition people from Minimum Service Offers to Full Service Offers;

b) remove the Minimum Service Offer and provide participants with their Full Service Offer from the point of funding allocation;

c) publish a quantified supply-and-demand plan that shows projected demand, supply, and investment required to meet the one month objective; and

[1] Department of Health, Disability and Ageing, Support at Home participant contributions, Updated May 2026

d) invest in navigation supports, including coordination with state and territories' health and community service navigation systems, to reduce 'invisible wait lists'.

2. Access through the Single Assessment System and Integrated Assessment Tool

R2 Strengthen assessment accuracy, clinical oversight and urgent access under the Single Assessment System and Integrated Assessment Tool by:

a) establishing an authorised clinical pathway to correct errors, omissions, missing service types, and amend classifications and priority outcomes that do not reflect need, risk or professional judgement, supported by specialist clinical advice where required;

b) revising classification and priority criteria to better recognise clinical complexity, cognition, medication and safeguarding risks, environmental factors, emergency capacity and the availability of sustainable informal support, including where risks cannot be observed through a phone assessment;

c) broadening the clinical urgent-access framework established for Motor Neurone Disease to include other time-critical circumstances, with priority based on deterioration, risk of hospitalisation, residential care or carer breakdown, and the maximum safe waiting period; and

d) providing a simple, timely and supported reconsideration process for participants and their representatives, including assistance for people experiencing cognitive, communication, cultural, digital or other barriers.

3. Access to sufficient funded support for care continuity

R3 Ensure assessed need is matched by sufficient funding and viable pricing by:

a) establishing an exceptional needs pathway or higher classification for participants whose needs exceed the current highest classification;

b) reassessing Support at Home subsidies and thin market funding against the real cost of service delivery, including travel and digital requirements; and

c) supporting transparent and reasonable pricing through clear participant information, contemporary pricing evidence and informed consumer choice, enabling sustainable price setting.

4. Affordable access, social connection and quality of life

R4 Advance affordability, social connection and strengthen quality of life under Support at Home, and its intersection with the Commonwealth Home Support Program by:

a) reforming contribution settings, hardship arrangements or other protections where participant contributions are resulting in older people reducing, delaying or declining services they need to live safely and independently at home;

b) developing and integrating a community connection and participation social support model across Support at Home and Commonwealth Home Support Program;

c) strengthening coordination between aged care, primary care, housing, local government and community organisations to identify and respond to social isolation, and to support community engagement as part of prevention, independence and reablement; and

d) funding cottage respite through the Support at Home program.

5. Workforce and digital capacity for better service access

R5 Strengthen workforce and digital capability to ensure Support at Home can be delivered safely, efficiently and at scale by:

a) establishing a 'Digital Capability Fund' to support software updates, interoperability, automation, and innovation that reduces administrative burden and improves care outcomes;

b) requiring the System Governor to publish readiness criteria before major policy, digital, claiming or reporting changes commence;

c) reviewing workforce and service availability by service type and location, and providing targeted additional funding where shortages are linked to service type, geography or thin market delivery costs;

d) amending the Aged Care Rules 2025 so associated provider and aged care worker record keeping do not require unnecessary duplication;

e) implementing a national single-entry database for associated provider records and national worker screening records; and

f) aligning My Aged Care, Services Australia and provider-facing systems so claiming, payment and reconciliation are timely and accurate. This will enable participants to access clear and current information.

6. Care management and navigation for informed access

R6 Strengthen care management as a core service that safeguards participant rights by:

a) setting care management pooled funding at a level that reflects actual care management demand, with an increase to 15 percent as an immediate measure;

b) enabling supplementary funding for onboarding participants and for participants with intensive and complex needs; and

c) broadening the care management definition to ensure it recognises the full range of participant-facing activities required to support safe, rights-based care.

7. Equitable access across communities

R7 Improve equitable access to services by:

a) funding specialist assessment, culturally safe and relationship-based care for older people who are poorly served by mainstream models, including First Nations people, culturally and linguistically diverse communities, people experiencing homelessness and people in thin markets;

b) introducing differentiated thin market funding that reflects the real cost of delivering care where distance, workforce shortages, housing constraints and limited local services make standard pricing unworkable; and

c) allowing Support at Home funding to cover clinically necessary services and equipment when state, territory or local programs are unavailable, delayed or inaccessible, including in regional, rural and remote communities.

8. Access to Assistive Technology and Home Modification (AT-HM)

R8 Improve access to assistive technology and home modifications by streamlining delivery arrangements and enabling flexible funding that:

a) simplifies and expedites approval for low-risk and urgent safety items;

b) ensures care management is funded throughout the AT-HM pathway, including before ongoing Support at Home funding commences;

c) enables ongoing Support at Home program budget funds to be used for equipment subscriptions, maintenance and repairs where this supports safe and effective use;

d) increases access to include high tier assistive technology to be used in conjunction with EOL pathway; and

e) expand the scope of the AT-HM program to include essential health and safety supports, such as CPAP machines, as well as equipment maintenance and repairs, and ensure the program remains flexible enough to respond when state and territory health service settings change.

9. Restorative Care Program

R9 Strengthen integration and flexibility across aged care programs to support timely access to preventive, restorative and independence-supporting services by:

a) strengthening interfaces between Support at Home, CHSP, restorative care, short-term supports and hospital discharge pathways so people can move seamlessly between supports as their needs change; and

b) enabling pooled or place-based prevention models in thin markets, small towns and retirement villages where shared delivery would improve access to restorative care, allied health, nursing, transport and social support.

10. End-of-Life program

R10 Redesign and fix the End-of-Life Pathway so that:

a) approval automatically gives participants access to the full range of approved Support at Home services and all assistive technology funding tiers;
b) services are activated within 48-72 hours and extended according to clinical need rather than fixed time limits; and
c) providers are supported by clear operational and clinical guidance to deliver safe, consistent end-of-life care at home.

Background

The Support at Home program should be treated as essential social and health infrastructure within a broader ageing ecosystem including housing and community supports, with access as the central test of success.

Ageing Australia welcomes the important role of the Community Affairs References Committee in examining the implementation and impact of Support at Home. By 2035, around 1.4 million Australians are expected to benefit from Support at Home as Australia's population ages and more older people seek to remain living safely and independently at home.[2] At this scale, timely access to appropriate support must be a national priority.

Many matters before the Committee, including assessment, participant contributions, pricing, service availability, care management and transition arrangements, determine whether older people can access support. This submission addresses the practical implementation of Support at Home, including assessment and classification, wait times, pricing, service availability, workforce and administrative readiness, participant contributions, and impacts on access for diverse and thin market communities.

This submission draws on Ageing Australia's February 2026 and June 2026 Support at Home Design and Transition member surveys (member surveys with over 360 respondents), community research, provider case examples and continuing engagement with providers of different sizes, service types and geographic locations.

[2] Australian Government, 2024, Once in a generation aged care reforms

Ageing Australia's *Ageing in Australia Community Expectations Report*, 2026 based on research conducted mid-2025, found broad public support for fully funded clinical care and fair means-tested contributions for everyday living costs. However, attitudes towards contributions vary by age and circumstance, reinforcing the need to protect access to essential supports and services in thin markets.[3]

The report also found that the leading factors supporting ageing well included access to quality health care (46%), affordable aged care services (45%) and quality aged care (35%) as the leading factors supporting ageing well, alongside being close to family and friends and remaining at home for as long as possible (both 33%) and maintaining social connections and companionship (27%). This suggests opportunities to enhance and elevate the potential of Support at Home (as well as the intersection with the CHSP).

The recommendations in this submission build on Ageing Australia's previous recommendations to the Australian Government, the Department of Health, Disability and Ageing, Senate inquiries, Independent Health Aged Care Pricing Authority and the Exposure Draft of the Aged Care Act 2024. They are informed by community research, evidence, and engagement with providers of different sizes and specialisations throughout Australia including metropolitan, regional, rural and remote settings.

Ageing Australia members are uniquely placed to identify how implementation pressures affect older people in practice because they see both system-level implementation issues and their impact on participants. The participant examples included in this submission, as provided by members, illustrate emerging impacts on access, continuity and safety.

It is imperative that Support at Home is understood as part of a broader ageing ecosystem. Outcomes for ageing well are shaped by the interaction of aged care with health, housing, transport, technology, workforce and community services, including for people living in regional, rural, remote and thin market communities.

Key considerations for the Committee

The success of Support at Home should be evaluated against whether older people can access the right care at the right time, in order to remain safely at home and independent. Key indicators of success include reablement, independence, social and community connection, preventable hospitalisation and delaying or preventing premature entry to residential aged care.

1. Access to services to live safely and with dignity at home

Support at Home will only succeed if older people can access care when they need it, before avoidable deterioration occurs.

[3] Ageing Australia Ageing-in-Australia-Community-Expectations-Report-March-2026.pdf

The Aged Care Taskforce, chaired by the then Minister for Aged Care, the Hon Anika Wells MP, established as its first principle that:

> *The aged care system should support older people to live at home for as long as they wish and can do so safely*

Giving effect to this principle requires more than assessment and approval. Older people must be able to commence the services they have been assessed as needing within a timeframe that supports their safety, independence and preference to remain at home. Timely access is not only a safety issue. Delayed care can reduce confidence, mobility, social participation and the ability to maintain everyday routines, making reablement more difficult once services eventually commence.

Currently, delays can occur at every stage of the access pathway, including assessment, reassessment, prioritisation, funding allocation and service commencement. While people wait, their health and function may deteriorate, pressure on carers and support networks can increase, and the risk of avoidable hospitalisation or premature entry to residential aged care grows. Extended delays therefore directly undermine the Taskforce principle and the preventive purpose of Support at Home.

The Department of Health, Disability and Ageing (DHDA) has identified the need for 300,000 additional Support at Home places over the next 10 years.[4] However, a clear public methodology has not been released showing how annual supply will keep pace with growth in need, reduce existing waitlists and prevent new delays from emerging. Official performance measures also indicate allocated Support at Home places will increase from 380,000 in 2025-26 to 420,000 in 2026-27,[5] but this does not explain how release volumes will be matched to demand.

Available data shows whole-of-pathway access delays for people commencing services between 1 November 2025 and 31 March 2026. The national median elapsed time from application to service commencement was 294 days.

Ongoing Support at Home had the longest median elapsed time by service type, at 347 days. The median elapsed time for the Support at Home AT-HM and Restorative Care short term programs were each more than 100 days.[6] The Department describes these as elapsed-time measures across the access pathway, rather than pure waiting time at a single step.

At 31 March 2026, 100,191 people were waiting in the Support at Home Priority System and another 53,718 people on interim funding while waiting for their full funding.[4] The waiting list increased by 5,228 people between December 2025 and March 2026, despite the release of additional places.[7][8]

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[4] Commonwealth of Australia, Proof Committee Hansard Senate Community Affairs Legislation Committee Estimates, 2 June 2026
[5] Portfolio Budget Statements 2026–27 Paper No. 1.9
[6] Aged Care Act 2024 Wait Times Report
[7] Support at Home program data report 1 January – 31 March 2026 - AIHW Gen
[8] Support at Home program data report 1 November – 31 December 2025 - AIHW Gen

A maximum wait of one month between approval and funding allocation should be adopted as the national policy objective for ongoing Support at Home services. This objective reflects the preventive purpose of the program: once an older person has been assessed as needing support, an extended delay can allow health, function, safety and carer arrangements to deteriorate before services commence. The one-month objective should be supported by staged implementation milestones and public reporting, recognising that existing waiting lists cannot be resolved immediately.

Achieving this objective will require more than one-off releases of additional funded places. The Government should publish a quantified supply-and-demand plan showing the number and timing of funding allocations required to meet projected new demand, reduce the existing waiting list and provide full funding to people receiving a Minimum Service Offer (MSO) which is 60% of the approved classification funding. The plan should include national and regional projections, annual and quarterly allocation targets, expected wait times and the funding required to achieve the one-month objective.

Ageing Australia's member surveys indicate that providers' current capacity can be an opportunity to reduce waitlists where funded places, workforce settings, pricing, thin market supports and digital systems allow providers to scale safely. Older people should not remain waiting because funded places are released too slowly.

Once an older person has been assessed as requiring Support at Home, funding should be allocated quickly enough to prevent avoidable deterioration, carer breakdown and hospital presentation. A one-month maximum wait should therefore be established as the national access objective, supported by a funded implementation pathway, staged targets and transparent reporting on progress.

Ana waited one month for an initial assessment following a decline in mobility, nutrition, medication management, and ability to manage personal care safely. After approval for Support at Home services, there was a further delay of almost eight months before Ana's funded services became available.

During this period, Ana's family members provided more informal care, which became unsustainable. Ana became more socially isolated, her risk of falls escalated, medication management became more difficult, resulting in multiple hospital presentations. By the time services became available, Ana's condition had declined to the point where she was admitted to residential aged care.[9]

Ana's experience shows why waiting-list performance should be assessed not only by the number of places released, but by whether delay leads to measurable deterioration, carer breakdown, hospital presentation or residential care entry before services commence.

[9] Ageing Australia provider case example. Names and identifying details in case examples have been changed to protect privacy.

R1 Establish a national objective that older people wait no more than one month between approval and the allocation of full Support at Home funding, supported by a funded implementation pathway to:

a) release sufficient funded places immediately to begin reducing the existing wait list and transition people from Minimum Service Offers to Full Service Offers;

b) remove the Minimum Service Offer and provide participants with their Full Service Offer from the point of funding allocation;

c) publish a quantified supply-and-demand plan that shows projected demand, supply, and investment required to meet the one month objective; and

d) invest in navigation supports, including coordination with state and territories' health and community service navigation systems, to reduce 'invisible wait lists'.

2. Access through the Single Assessment System and Integrated Assessment Tool

Human oversight must remain central to human services, with qualified professionals making the assessment decisions which determine an older person's access to care, safety and independence.

The Single Assessment System (SAS) and Integrated Assessment Tool (IAT) are intended to support nationally consistent, user-centred assessment. Ageing Australia supports this objective, including the "tell us once" principle.[10] However, consistency must not come at the expense of accuracy, professional judgement or participant safety.

Member feedback indicates that classifications, priority categories and approved service types do not always reflect an older person's observed needs and circumstances. Cognitive impairment, executive functioning, frailty, rapid deterioration, environmental and safety risks, carer stress, and the availability and sustainability of informal support may not be adequately recognised. Relevant information or required service types may also be incorrectly recorded or omitted. Previous Ageing Australia submissions also list these concerns.[11]

When an assessment outcome does not reflect need and professional judgement, the pathway for correcting it must be proportionate to the nature and urgency of the problem. Four different problems require different responses.

- Where an IAT-generated outcome is inconsistent with observed need or professional judgement, an authorised clinical decision-maker should be able to review and amend the classification and priority outcomes. Humans should

[10] Aged Care Data and Digital Strategy 2024-2029, Driving better care and leading a sustainable and productive care and support economy
[11] Senate Inquiry – Aged Care Service Delivery – Submission

remain in control of health-care systems and decisions, with appropriate transparency and accountability.[12]

- An error or omitted service should be able to be corrected promptly by assessors without requiring formal reconsideration.
- Participants must retain access to a simple and supported reconsideration process. This pathway must be accessible to people with cognitive impairment, communication barriers, limited digital capability or no informal advocate, but should not become the default mechanism for correcting assessor error or an outcome that an authorised clinician considers inappropriate.
- Circumstances involving immediate risk require a separate urgent-escalation pathway such as when there is a material risk of deterioration, carer breakdown, avoidable hospitalisation, unsafe discharge or premature entry to residential care.

The Government's decision to give older people with Motor Neurone Disease urgent priority for Support at Home recognises that some conditions and circumstances cannot be safely managed through ordinary waitlist processes. Ageing Australia supports this approach and recommends that this principle should extend to other time-critical situations where delay creates a material risk of deterioration, carer breakdown, avoidable hospitalisation, unsafe hospital discharge or premature entry to residential care. Urgent access should be determined by assessed risk and likely consequences, rather than diagnosis alone.

Betty, an older person living with dementia and multiple health conditions, was already fully using her Level 3 Home Care Package for personal care, nursing, respite and allied health. She was unable to live independently and relied heavily on both family and formal supports for daily living and safety.

Following reassessment because her needs had increased, she received a Support at Home classification only marginally above her existing funding, despite her declining capacity to live independently and significant reliance on family and formal supports. When funding was assigned, 12 months later, she received a Minimum Service Offer (MSO) and was not able to increase services.

Physiotherapy that Betty had previously used to maintain mobility was also omitted from her approved service list. The assessor could not correct the omission or obtain timely clinical amendment of the outcome, leaving Betty without appropriate mobility support while a review was pursued.

As a result, Betty's mobility and wellbeing declined and she withdrew from community engagement. Her experience demonstrates the need for prompt

[12] World Health Organization 2024, *Ethics and governance of artificial intelligence for health: guidance on large multi-modal models*

correction of omitted services and authorised clinical review where the priority or classification outcomes do not reflect the observed need.[13]

Assessment must support timely access to the right care, with human oversight where risk, complexity or urgency is not fully captured.

R2 Strengthen assessment accuracy, clinical oversight and urgent access under the Single Assessment System and Integrated Assessment Tool by:

- **a)** establishing an authorised clinical pathway to correct errors, omissions, missing service types, and amend classifications and priority outcomes that do not reflect need, risk or professional judgement, supported by specialist clinical advice where required;
- **b)** revising classification and priority criteria to better recognise clinical complexity, cognition, medication and safeguarding risks, environmental factors, emergency capacity and the availability of sustainable informal support, including where risks cannot be observed through a phone assessment;
- **c)** broadening the clinical urgent-access framework established for Motor Neurone Disease to include other time-critical circumstances, with priority based on deterioration, risk of hospitalisation, residential care or carer breakdown, and the maximum safe waiting period; and
- **d)** providing a simple, timely and supported reconsideration process for participants and their representatives, including assistance for people experiencing cognitive, communication, cultural, digital or other barriers.

3. Access to sufficient funded support for care continuity

Support at Home will reduce pressure on hospitals and residential aged care if older people can access enough funded support, before their needs escalate.

Responding to complex and exceptional needs

Support at Home should ensure people with complex, changing or deteriorating needs receive enough funded support to remain safe at home where this is clinically appropriate. Some participants require more intensive support than the current highest ongoing Classification 8 because of clinical complexity, rapid functional decline, cognitive impairment, carer breakdown or other significant changes in circumstances. For these participants, a higher ongoing classification should be available so their assessed needs

[13] Ageing Australia provider case example. Names and identifying details in case examples have been changed to protect privacy

can be safely met at home, potentially preventing avoidable hospital admissions or premature entry to residential care.

In addition, Ageing Australia recommends an exceptional-needs pathway that provides supplementary funding, for a defined period and on clinical advice, where assessed needs cannot be safely met within the participant's classification. This would respond to episodic, urgent and rapidly changing needs without requiring an additional permanent classification.

The need for a higher funding pathway is highlighted by the experience of people living with Motor Neurone Disease (MND). MND Australia reports that the average NDIS package for a person with MND exceeded $300,000 in 2024 – substantially more than the maximum funding available under Support at Home.[14] [15]While the NDIS and Support at Home are not directly comparable, this comparison shows that some older people have clinical and functional needs that exceed the current Support at Home funding and the amount of funding can be determined by a person's age.

Ageing Australia welcomes urgent priority access for older people with MND. However, faster priority alone is not sufficient, and older people must also have adequate funding for services to meet their needs. The same principle should apply to other time-critical and rapidly deteriorating circumstances, that is, priority access and sufficient funding must be made available.

Pricing transparency and access

Ageing Australia supports transparency and reasonable pricing that gives participants confidence in what they are paying, and ensuring providers can set and adjust prices to enable delivery of safe, high-quality care.

Reasonable prices must reflect the actual cost of delivering care, including workforce, travel, subcontracting, administration, compliance, digital systems, reforms implementation, innovation, and the additional resources required to support people with complex needs.

Ageing Australia's June 2026 survey indicates that current pricing settings do not always adequately reflecting these costs. Sixty-two of 100 providers reported that their Support at Home prices were insufficient to cover all the service delivery costs, while only 18 considered them adequate. Among rural and remote providers, only 12 percent reported that pricing settings and thin market grants adequately covered the additional costs of delivering services. Providers identified travel, workforce availability, subcontractor pricing, transport expenses and limited local service availability as key pressures.

In this context, binding price caps should not be implemented where they risk reducing service availability or continuity, particularly in rural, remote and thin markets. The NDIS Review found that regulated price limits can become the default price charged across the market, rather than acting only as the upper limit. This can reduce price variation and

[14] NDIS - National Disability Insurance Scheme
[15] MND Australia 2025, *Every moment matters*

participant and may affect service supply and sector growth and innovation. Support at Home should avoid reproducing these effects.[16]

A better approach would be for Government to publish evidence-based reference price ranges, informed by independent pricing advice and contemporary cost data. The ranges should help participants compare services while enabling providers to set prices that reflect service complexity and different models of care that meet local need. This would support choice without creating de facto price regulation that could undermine service viability or access.

R3 Ensure assessed need is matched by sufficient funding and viable pricing by:

- **a)** establishing an exceptional needs pathway or higher classification for participants whose needs exceed the current highest classification;
- **b)** reassessing Support at Home subsidies and thin market funding against the real cost of service delivery, including travel and digital requirements; and
- **c)** supporting transparent and reasonable pricing through clear participant information, contemporary pricing evidence and informed consumer choice, enabling sustainable price setting.

4. Affordable access, social connection and quality of life

Older people need access to affordable everyday supports that help them to remain independent and socially connected at home. Contribution settings and affordability should be assessed by whether older people accept the services they need, or whether costs lead to reduced, delayed or declined support.

Impact of contributions on independent and everyday living services

Ageing Australia welcomes the Government's decision that, from 1 October 2026, personal care services will be fully funded where they are approved in a participant's support plan.[17] However, affordability remains an access issue for independence and everyday living services.

Affordability cannot be assessed only by income and assets thresholds. A contribution that appears affordable under program rules may not be affordable in the context of an older person's lived experience, financial commitments and daily pressures.

The June 2026 member survey indicates that participant contributions are already influencing service choices, with over 80 percent of providers reporting that contributions influenced participant decisions and nearly three quarters of providers reporting that

[16] Australian Government, NDIS review Webpage

[17] Department of Health, Disability and Ageing, Support at Home participant contributions Updated May 2026

budget constraints limit the mix or volume of services needed.[18] Providers reported decreases in domestic assistance, social support, transport, personal care and meals. These supports may be low complexity, but they help people to maintain routine, relationships and independence at home.

If older people decline supports to meet these basic needs because of cost, Support at Home may be less effective in preventing deterioration, carer strain and breakdown in support networks. It may also reduce confidence, mobility, social participation and the person's ability to remain connected to everyday life. Contribution settings should therefore be reviewed where they are leading older people to reduce or decline services that support independence, prevention and quality of life.

Social connections and wellbeing

Social connection and participation should be considered integral to independence, prevention and reablement. However, engagement and connection should not be treated as transactional services. They require time to understand a person's experiences, interests, strengths and barriers to participation – supporting them to build confidence, autonomy and meaningful connections.

Support at Home and the Commonwealth Home Support Program should incorporate social connection models that support older people to maintain relationships and purpose in their local communities. The model should be informed by older people, providers, evidence, and the broader sector.

Respite should be treated as a preventive support, not only as a carer service. Cottage respite can give carers a meaningful overnight break while helping older people maintain connection outside their home. However, current Support at Home guidance excludes cottage respite from Support at Home funding, meaning access depends on CHSP availability rather than assessed need creating a barrier to service access. Ageing Australia recommends that government enable cottage respite to be funded under Support at Home to ensure access to this valuable service.

Contribution settings for social support, group activities and cottage respite should be considered carefully. If contributions are too high, older people may prioritise essential living expenses, reducing access to supports that help prevent isolation, carer strain and deterioration.

Financial hardship assistance and affordability protections

Ageing Australia welcomes the move to an electronic hardship format, as it should improve access, streamline submissions and make the process easier for people seeking support. However, broader hardship settings should be reviewed to ensure they keep pace with cost-of-living pressures and reflect the financial circumstances of older people who need aged care support.

[18] Ageing Australia February 2026 Member Survey found similar results, indicating a sustained change in service access

Hardship arrangements must therefore be simple, accessible and responsive enough to protect access before a person reduces essential supports.

Cam, an older person living alone on a full pension, was approved for social support, transport and domestic assistance to help maintain independence and community connection. However, they were already financially stretched by cost-of-living pressures and became worried about the out-of-pocket costs associated with continuing services.

Although a hardship application was available, Cam found the process too stressful and burdensome to pursue. Instead, they chose to attend fewer social support and transport services to limit costs.

Over time, Cam became increasingly isolated, stopped attending community activities and appointments as regularly, and showed a decline in confidence, mood and physical wellbeing. As informal checks reduced, the provider observed increasing care needs and greater risk of deterioration. This highlights how participant contributions can lead older people to reduce preventive supports, even when those services are essential to remaining safe and independent at home.[19]

R4 Advance affordability, social connection and strengthen quality of life under Support at Home, and its intersection with the Commonwealth Home Support Program by:

- **a)** reforming contribution settings, hardship arrangements or other protections where participant contributions are resulting in older people reducing, delaying or declining services they need to live safely and independently at home;
- **b)** developing and integrating a community connection and participation social support model across Support at Home and Commonwealth Home Support Program;
- **c)** strengthening coordination between aged care, primary care, housing, local government and community organisations to identify and respond to social isolation, and to support community engagement as part of prevention, independence and reablement; and
- **d)** funding cottage respite through the Support at Home program.

5. Workforce and digital capacity for better service access

High-quality home care depends on a workforce and digital infrastructure that are properly resourced to deliver care, not consumed by administration and red tape.

[19] Ageing Australia provider case example. Names and identifying details in case examples have been changed to protect privacy

Workforce capacity and administrative burden

Australia's aged care workforce continues to experience shortages in some occupations, service types and geographic areas. However, Support at Home is not constrained by a universal lack of provider capacity. Ageing Australia's February and June 2026 member survey found that over 60 percent of providers have capacity to increase service delivery and accept additional participants, while others face workforce shortages in particular services, including care workers, registered nurses, allied health and care management.[20] This demonstrates strong underlying capacity across much of the sector to take on additional Support at Home packages, with targeted responses needed only where constraints are linked to service types, geographic areas or the higher costs of thin-market delivery.

Support at Home is placing significant additional workload on a sector already experiencing workforce pressures. In the 2026 member surveys, 80 percent of providers reported the need to expand corporate teams such as quality, finance, education and training to deliver the Support at Home program. Many also reported the need to increase resources in procurement, coordination or management, clinical governance, operations and care delivery. Only 5 percent of providers reported that no additional resourcing was required. [21]

Australia's aged care workforce is finite, and future service growth cannot rely solely on recruiting additional workers. Every additional hour spent on duplicated administration, manual claiming, reconciliation, correcting system errors or navigating multiple digital platforms is an hour not available for direct care. Improving workforce productivity through better system design must complement workforce growth, particularly in areas where shortages are already affecting access.

These pressures are occurring after several years of aged care reform and are contributing to burnout and retention risks. Providers report fatigue among care workers, care managers and registered nurses, whose roles are necessary for safe and continuous home care. Reducing unnecessary administrative burden would allow providers with existing workforce capacity to deliver more services, while supporting retention in areas where shortages are already affecting access. Workforce fatigue is therefore a direct access and quality risk.

ASSOCIATED PROVIDERS AND RED TAPE

Ageing Australia supports the accountability objectives of the Associated Provider framework, but its implementation is creating unnecessary red tape, duplication and cost. Allied health organisations working across multiple registered providers will need to meet different contractual requirements and share workers private information with each contract. In one example, a non-registered Associated Provider with more than 1,100 allied health staff delivers services through over 500 registered providers. Each

[20] Ageing Australia Support at Home design and transition survey 2026 – unpublished

[21] The Catalyst Report Provider Pulse Survey March 2026 also found reports of increased administration under Support at Home Program: 'Two in five respondents raised concerns about the increased administrative requirements of Support at Home'.

registered provider is required to 'keep' the worker screening records for each allied health worker's screening records creating duplication, administrative burden and privacy concerns. This diverts resources from service delivery, delays access to allied health and increases costs that may flow through to price schedules and participant contributions.

DIGITAL SYSTEMS AND EFFICIENCY

Reliable digital infrastructure is fundamental to Support at Home and workforce efficiency. Government digital reform frameworks recognise digital maturity, interoperability, secure data sharing, digital foundations and workforce digital capability as essential to safe and sustainable service delivery.[22] However, providers continue to report data mismatches and digital issues across My Aged Care, Services Australia, PRODA/B2G software and provider systems, which affect efficiency, provider payment, participant statements and consumer confidence.

Participant statements are often lengthy - exceeding 10 pages of data and description listing transactions and balances from several accounts. They are complex and focused on past activity. However, providers report that many participants would prefer clearer visibility of their current budget account balances, remaining funds and what this means for future services. Care partners are spending significant time helping participants and families interpret information on past service use.

Future reforms should treat workforce capacity and digital infrastructure as core requirements for safe, high-quality care. This should include workforce impact and readiness assessments, realistic lead times, simplified administration, reduced duplication, interoperable digital systems, timely error-resolution pathways, clearer claiming and payment rules, and simpler participant statements.

R5 Strengthen workforce and digital capability to ensure Support at Home can be delivered safely, efficiently and at scale by:

- **a)** establishing a 'Digital Capability Fund' to support software updates, interoperability, automation, and innovation that reduces administrative burden and improves care outcomes;
- **b)** requiring the System Governor to publish readiness criteria before major policy, digital, claiming or reporting changes commence;
- **c)** reviewing workforce and service availability by service type and location, and providing targeted additional funding where shortages are linked to service type, geography or thin market delivery costs;
- **d)** amending the Aged Care Rules 2025 so associated provider and aged care worker record keeping do not require unnecessary duplication;

[22] Aged Care Data and Digital Strategy 2024-2029, Driving better care and leading a sustainable and productive care and support economy, Australian Government; Australian Digital Health Capability Framework 2024, Australian Government.

e) implementing a national single-entry database for associated provider records and national worker screening records; and

f) aligning My Aged Care and Services Australia and provider-facing systems so claiming, payment and reconciliation are timely and accurate. This will enable participants to access clear and current information.

6. Care management and navigation for informed access

Care management is not an administrative add-on; it is a core service that enables participants to understand, coordinate and safely use their supports.

It brings together the participant, their family and carers, workers and clinicians to ensure care is practical, coordinated and responsive to changing needs, risks, goals and preferences. It is also a key mechanism through which participants exercise choice, understand their rights, manage risk and maintain continuity of care across multiple services and providers.

The amount of care management required is not uniform. It varies according to participant complexity, cognitive and communication needs, the availability of informal support, the number of services and providers involved, and changes in health or personal circumstances. A quarterly pooled allocation may give providers some flexibility across their cohort, but it does not reliably reflect when and where intensive care management is needed. Funding can be exhausted at precisely the point when participants require the most support.

Funding arrangements must therefore be capable of responding to individual need, rather than relying solely on a fixed pooled allocation. A higher baseline cap, supported by supplementary funding for participants with more intensive needs, is necessary to protect safe and continuous care.

This role is particularly critical for those with cognitive impairment, limited support networks, complex needs, language barriers, housing insecurity or other circumstances that make the aged care system harder to traverse. Ageing Australia's Community Expectations Report found low knowledge of the aged care system, including among older Australians.[23] For these participants, care management is important to reduce avoidable escalation into crisis, hospital or residential care.

Under Support at Home, care management workloads have increased significantly and are likely to remain higher than under previous arrangements. The program requires more detailed participant communication, budget explanation, service coordination, reassessment activity, documentation, registered supporter engagement, complaint resolution, and support for participants to exercise rights and make informed decisions. These activities reflect the added complexity of the program and the stronger rights-

[23] Ageing Australia, Ageing-in-Australia-Community-Expectations-Report-March-2026.pdf

based obligations on providers to ensure participants understand their options, contributions, service arrangements, risks and choices.

The service list should therefore recognise care management as a broad participant-facing function, rather than confining it to a narrow task list. Claimable activity must include partnering with participants, managing risks, coordinating services, developing knowledge to support individual needs and arranging aids, equipment and home modifications where these are necessary to deliver safe and effective support.

The current pooled care-management limit does not reliably reflect the amount or distribution of care management required to support participants safely. Although pooling gives providers some flexibility to direct care management across their participant cohort, the total funding available remains constrained and is not sufficiently responsive to participants with complex needs or periods of intensive activity.

This creates a structural mismatch - participants do not require an equal amount of care management, and individual demand does not arise evenly throughout a quarter. Some participants may require relatively little support, while others need intensive coordination because of cognitive impairment, clinical complexity, limited informal support, safeguarding concerns, hospital discharge, deterioration or significant changes in services. A fixed pooled limit may be exhausted even where the additional care-management activity is necessary to maintain safe and continuous care.

Ageing Australia's June 2026 member survey indicates that the current funding limit is already constraining access to care management. Approximately half of respondents reported successfully recording and claiming all available pooled care-management funding. More significantly, approximately a third of providers reported delivering hours of care management that could not be claimed because the available pooled funding had been exhausted. In addition, care management demand is highest at commencement, particularly for participants receiving a Minimum Service Offer who require support to establish and coordinate services, and during changes leading to reassessment, yet care management is not funded in the first quarter of service delivery.[24] This indicates that the current funding settings can leave care management work unfunded impacting the participant interact ability and provider sustainability.

Margaret is a care manager supporting a caseload of approximately 65 participants, including people with cognitive impairment, limited informal supports and reduced capacity to communicate, understand changes or coordinate their own care.

Since the implementation of Support at Home, Margaret's workload has increased significantly. This includes explaining ongoing program changes to participants and families, developing Minimum Service Offer budgets and then redoing budgets when the Full Service Offer is issued, managing review requests

[24] Parliament of Australia, Senate estimates Hansard 2026 June 2. Minimum Service Offer is more than 90 percent of SAH allocated packages

where funding is insufficient or where AT-HM supports have been missed, assisting participants through reconsideration processes, checking service lists, responding to contribution queries, and managing additional documentation and system workarounds.

Her role is increasingly focused on reform administration rather than proactive care management. As more time is absorbed by these tasks, Margaret has less capacity to monitor participants, identify deterioration early, coordinate services or explain changes in a way participants can understand.

The flow-on impact is delayed access, reduced continuity, confusion about available supports and greater risk of missed changes in need, isolation and avoidable deterioration.[25]

R6 Strengthen care management as a core service that safeguards participant rights by:

- **a)** setting care management pooled funding at a level that reflects actual care management demand, with an increase to 15 percent as an immediate measure;
- **b)** enabling supplementary funding for onboarding participants and for participants with intensive and complex needs; and
- **c)** broadening the care management definition to ensure it recognises the full range of participant-facing activities required to support safe, rights-based care.

7. Equitable access across communities

Equitable access requires program flexibility to respond to local conditions, jurisdictional contexts and individual need so older people are not prevented from receiving care by avoidable system barriers.

Equity is not achieved by applying the same program rules in every community. Older people's access to care depends on local circumstances, including delivery costs, workforce supply and skill, and housing availability, travel distances and the number of services operating locally. In thin markets, where there are few providers or limited workforce capacity, service availability can be particularly fragile. If pricing, grants and assessment settings do not reflect local delivery conditions, older people may experience longer waits, fewer service options and reduced continuity of care. However, pricing reforms alone cannot overcome structural barriers such as workforce shortages,

[25] Ageing Australia provider case example. Names and identifying details in case examples have been changed to protect privacy.

specialist skill gaps and limited housing. These require coordinated workforce, housing and regional development policies.

Ageing Australia's provider surveys demonstrate that provider capacity is not uniform across locations or service types. In both February and June 2026, approximately 54 percent of respondents reported capacity to accept referrals and commence services across all areas in which they operated. Another 10 percent of providers showed some capacity to take on participants in at least part of the areas they already serve.

As Support at Home increasingly supports people with higher acuity and more complex needs, maintaining equitable access will depend on developing multidisciplinary workforce capability alongside service availability.

Maintaining equitable access in thin markets will require both viable service funding and investment in multidisciplinary workforce capability. Rural and remote providers face higher costs for travel time, fuel, vehicle wear, accommodation, freight, scheduling inefficiencies, subcontracting and workforce attraction and retention and lost staff time caused by long travel distances or gaps between visits. These costs determine whether an older person can receive services at home, particularly where there are few or no alternative providers.

Equity concerns also extend to First Nations people, culturally and linguistically diverse communities, people experiencing or at risk of homelessness, people with cognitive impairment, and people with limited family or advocacy support. These participants may require more time for communication, trust-building, supported decision-making, cultural safety, help to understand and apply for hardship assistance and coordination with housing, health, disability or community services. Standardised assessment, pricing, contribution and hardship settings may not be sufficient where they do not recognise these additional access barriers. People without secure housing may also need more intensive navigation and flexible service models before mainstream home care supports can be effective.

The program should also recognise people at risk of homelessness, not only people experiencing homelessness. People without secure housing may need more intensive navigation, trust-building, coordination with housing and health systems, and flexible service models before mainstream homecare supports can be effective.

Variability in service availability, particularly across Modified Monash Model locations, can limit access to supports allowed under program rules. Where relevant state, territory or local programs are unavailable, older people may face greater risk simply because of where they live. Support at Home settings should therefore be sufficiently flexible to allow participants to access clinically necessary services, including diabetes education, pharmacist-prepared Dose Administration Aids and orthotic services, where an assessed need cannot be met through existing or available programs in their area.

The June 2026 survey reflects this geographic variability. Of the 37 percent of respondents reporting constraints in some areas, 59 percent identified at least one Modified Monash Model (MMM) area where they were unable to accept new participants. The most frequently reported constraints were in MMM 5 small rural towns, identified 23 percent respondents; MMM 4 medium rural towns, identified 21 percent of respondents; and MMM 2 regional centres, identified 19 percent respondents. Respondents could identify constraints in more than one area.

Support at Home should be designed to make culturally safe, locally available and relationship-based care possible. This includes differentiated funding for thin markets, practical hardship pathways, culturally appropriate assessment and communication, and support for specialist providers working with people whose needs are not well met by mainstream service models.

R7 Improve equitable access to services by:

- **a)** funding specialist assessment, culturally safe and relationship-based care for older people who are poorly served by mainstream models, including First Nations people, culturally and linguistically diverse communities, people experiencing homelessness and people in thin markets;
- **b)** introducing differentiated thin market funding that reflects the real cost of delivering care where distance, workforce shortages, housing constraints and limited local services make standard pricing unworkable; and
- **c)** allowing Support at Home funding to cover clinically necessary services and equipment when state, territory or local programs are unavailable, delayed or inaccessible, including in regional, rural and remote communities.

8. Access to Assistive Technology and Home Modification (AT-HM)

AT-HM delivered quickly can prevent major deterioration, support end of life care provide confidence for people to live independently and avoid unnecessary hospitalisation and early admission to residential care.

The effectiveness of early intervention through short-term programs should be evaluated. Reduced access risks increasing deterioration, hospital presentation and premature entry to residential care.

AT-HM is a key prevention pathway. Low-cost and timely equipment or modifications can reduce falls risk, support independence and help people remain safely at home. However, providers report concerns across the participant journey, including inconsistent practice or errors in assessment and approval. Providers also report operational concerns about funding notifications, care management, claiming and reconciliation.

Low-cost and urgent safety items should not be delayed by processes designed for higher-risk or more complex supports. Care management should be funded within AT-

HM, as safe delivery requires coordination with assessors, suppliers, trades, clinicians, participants and families.

These issues are especially acute for End-of-Life Pathway participants, where delays in assessment, prescription or funding allocation can mean equipment arrives too late to support safe care at home. AT processes should include urgent end-of-life pathways and access to high tier AT that recognise foreseeable decline and avoid repeated reassessment for predictable equipment needs.

Although AT-HM funding is generally approved much sooner than an ongoing Support at Home budget, this creates another challenge. Many participants receive AT-HM funding before they have an ongoing provider to coordinate. Therefore, direct care management funding for AT-HM program.

This funding should also be extended to cover maintenance costs for Support at Home providers and AT-HM services delivered under CHSP.

The approval process is unnecessarily complex for low-cost, high impact assistive products, like shower chairs, and anti-slip mats. In her recent Press Club address, the Inspector-General of Aged Care recounted the story of an older woman whose GP urgently prescribed a pair of $50 crutches so she could stay safe, mobile, and at home. However, to access the funding through AT-HM, she required an in-home OT assessment. This turned a $50 item into an $1,800 taxpayer cost with a three-month wait.

During that wait, her fall risk rose, her confidence declined, and her world grew smaller. Had she fallen, she could have faced hospitalisation and a fast track into residential care — at roughly $123,000 a year to the taxpayer — all because a simple, timely $50 intervention got tangled in unnecessary process.

We recommend allowing participants to use Tier 1 funds on a range of approved products that are ARTG registered without requiring an in-home OT assessment. This would reduce the wait time for an OT for more significant assessments, simplify the process for participants and providers, and likely limit deterioration during the waiting period.

Another issue for providers is that they do not receive a notification when a participant they care for has their AT-HM package approved. We recommend a notification be added for providers on the participants My Aged Care portal profile.

There are a range of improvements to AT-HM. We recommend that the program has its own review in the near future.

R8 Improve access to assistive technology and home modifications by streamlining delivery arrangements and enabling flexible funding that:

- **a)** simplifies and expedites approval for low-risk and urgent safety items;
- **b)** ensures care management is funded throughout the AT-HM pathway, including before ongoing Support at Home funding commences;

c) enables ongoing Support at Home program budget funds to be used for equipment subscriptions, maintenance and repairs where this supports safe and effective use;

d) increases access to include high tier assistive technology to be used in conjunction with EOL pathway; and

e) expand the scope of the AT-HM program to include essential health and safety supports, such as CPAP machines, as well as equipment maintenance and repairs, and ensure the program remains flexible enough to respond when state and territory health service settings change.

9. Restorative Care Program

Restorative care should be a core prevention pathway that helps older people regain function, confidence and independence.

Restorative care and reablement should be strengthened as core prevention pathways within Support at Home. They provide time-limited, goal-focused support to help older people regain or maintain function, confidence and independence after decline, illness, hospitalisation or changes in circumstance. However, providers report that some participants who appear eligible for the Restorative Care Program are not being approved for this service.

The interface between Support at Home, CHSP, restorative care and hospital discharge pathways must be clear. Older people can be left waiting in hospital when they could be discharged home with Restorative Care Program.

Restorative care should be available as a step-down and prevention pathway for people who can safely return home with time-limited support, even if they do not need ongoing Support at Home. This would strengthen the program's role in reducing hospital discharge delays and avoiding premature residential care entry.

Restorative care should also support place-based and pooled approaches where appropriate, including in small towns, retirement villages and thin markets. Shared reablement, allied health, nursing, transport or social support models may be more efficient and responsive where workforce supply is limited.

R9 Strengthen integration and flexibility across aged care programs to support timely access to preventive, restorative and independence-supporting services by:

a) strengthening interfaces between Support at Home, CHSP, restorative care, short-term supports and hospital discharge pathways so people can move seamlessly between supports as their needs change; and

b) enabling pooled or place-based prevention models in thin markets, small towns and retirement villages where shared delivery would improve access to restorative care, allied health, nursing, transport and social support.

10. End-of-Life Program

End-of-life care at home depends on rapid approval, flexible services, timely equipment and adequate funding, because delays at this stage cannot be recovered.

Effective end-of-life care at home depends on rapid and flexible service access. Under the End-of-Life Pathway, participants can access around $25,000 for up to 16 weeks. We welcome the Government's decision to extend access to further program funding and duration from early 2027 for participants who live beyond the initial funding period.[26] These are important settings, but the pathway will only be effective if services and equipment can be activated quickly.

Members have reported that participants are not always approved for the equipment and services needed for end-of-life at home. Manual service selection creates an avoidable risk of error, and people with acute end-of-life needs do not have time to wait for those errors to be corrected. Service approval should therefore include the full range of allied health, clinical, personal care, social support and equipment that may be required at the time of assessment and in the following weeks of palliation.

A dedicated end-of-life assistive technology approach is also needed. This should include pre-approval of an essential equipment bundle for predictable needs such as skin integrity and transfers. Participants should have access to the assistive technology from the date their End-of-Life Pathway funding commences.

Once a person is approved for the End-of-Life Pathway, they should be automatically approved as eligible to access all ongoing service types on the Support at Home Service List. This would give the participant, their registered supporter or appointed decision-maker, and their provider the flexibility to agree on a care plan that reflects the person's needs, preferences and likely trajectory of decline.

The pathway also shares known challenges with prognosis-based eligibility, including difficulty predicting life expectancy and the risk that rigid criteria delay access. Providers view the dedicated End-of-Life Pathway as offering more timely and intensive support, and a better chance for people to remain at home at the end of life. Its effectiveness, however, depends on rapid approval and flexible implementation. Approval and activation within 48-72 hours should be built into the program design.

Demand for palliative care at home will increase, and the sector needs to be skilled and supported to deliver this specialist care. Targeted education for the aged care assessment workforce, registered nurses, care managers and frontline workers would support more consistent assessment, better anticipation of decline and safer care planning. This is an important opportunity to build the foundation for more people to palliate at home safely, with dignity and with the supports they need.

A successful end of life program should be measured by whether the person can exercise choice, remain connected to family and community, and experience home as a place of

[26] Department of Health, Disability and Ageing, End-of-Life Pathway Updated May 2026

dignity, comfort and belonging. Program settings should enable care to adapt quickly as needs and preferences change.

R10 Redesign and fix the End-of-Life Pathway so that:

- **a)** approval automatically gives participants access to the full range of approved Support at Home services and all assistive technology funding tiers;
- **b)** services are activated within 48-72 hours and extended according to clinical need rather than fixed time limits; and
- **c)** providers are supported by clear operational and clinical guidance to deliver safe, consistent end-of-life care at home.

Conclusion

Support at Home will be judged not only by whether services are assessed, approved and delivered, but by whether older people receive the right support early enough to remain safe, independent and connected at home. The program's success will be reflected in whether people can retain or regain function, exercise choice, sustain relationships and continue participating in everyday and community life.

Delayed funding, unaffordable contributions, inaccurate assessments, unavailable services, insufficient care management and administrative burden all weaken these outcomes. They also increase the risk that older people will deteriorate, present to hospital or enter residential care earlier than necessary.

Ageing Australia recommends targeted adjustments to support improved access, including shorter waits for full funding, stronger assessment oversight, sufficient funding for complex needs, sustainable pricing, affordable contribution settings, properly funded care management, less administrative duplication, and flexible access to specialist, restorative, assistive technology, home modification and end-of-life supports. These changes would help Support at Home better respond to local circumstances and enable older people to live meaningful, connected lives at home where this is clinically appropriate and reflects their choice.