



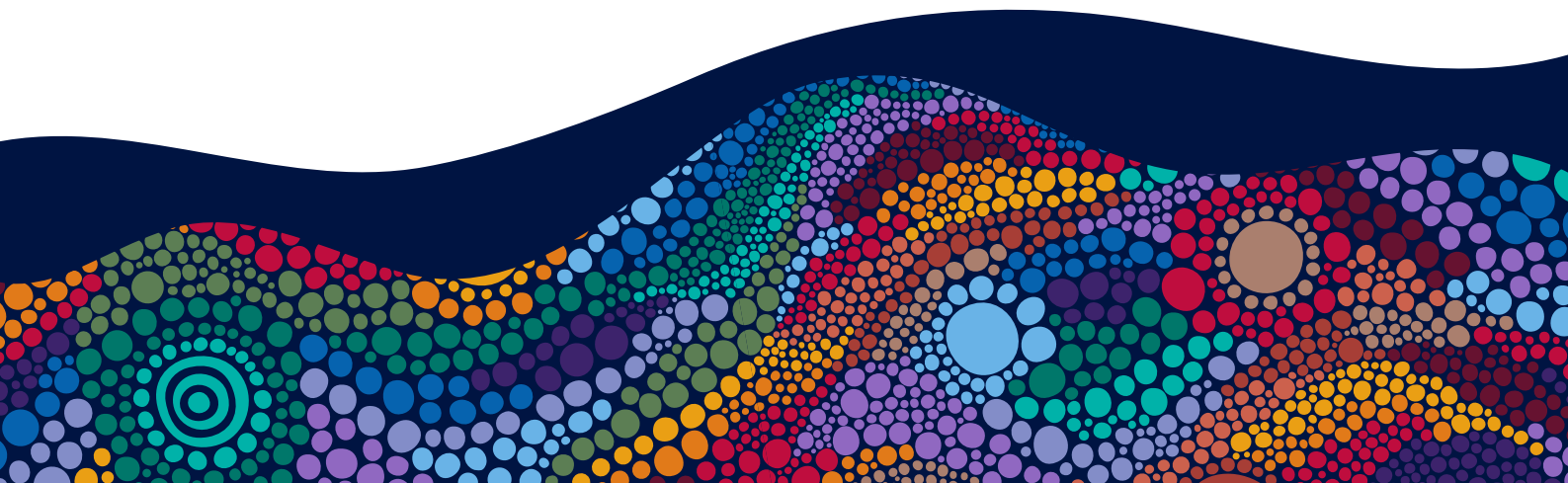
NACCHO

National Aboriginal Community
Controlled Health Organisation

Support at Home Program

Submission to the Senate Community Affairs
Reference Committee

September 2026



About NACCHO

NACCHO is the national peak body representing 148 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist several other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 149 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Recommendations

NACCHO recommends:

- 1 Aged Care programs align with the National Agreement and its four Priority Reform Areas.
- 2 The Government urgently works in partnership with the community controlled sector to develop and implement a specific Aboriginal and Torres Strait Islander aged care 10-year transformation plan in line with Priority Reform 1, and recommendations from the Aged Care Royal Commission and the Interim First Nations Aged Care Commissioner.
- 3 Continuation of the block funded Commonwealth Home Support Program for ACCHOs and ACCOs to ensure ongoing access to flexible supports for Aboriginal and Torres Strait Islander older people.
- 4 Consultation with the community controlled sector regarding CHSP and NATSIFAC, to address unmet needs in Aboriginal and Torres Strait Islander aged care.
- 5 To support all Aboriginal and Torres Strait Islander people to access culturally appropriate care, regardless of where they live, the Government funds ongoing capacity building for existing ACCHO/ACCO aged care providers and supports all ACCHO/ACCO providers to enter the market.
- 6 The Government consults with the community controlled sector to improve the functionality of the MAC Portal to better support the needs of Aboriginal and Torres Strait Islander people – particularly those in rural and remote communities.
- 7 ACCHOs delivering home care services are funded to provide everyday living services for gardening to remove risk of eviction.
- 8 ACCHOs/ACCOs are supported to deliver aged care services, Elder Care Support, and aged care assessment services. Regional and local assessors will achieve more accurate aged care assessments for Aboriginal and Torres Strait Islander people living in rural and remote communities.
- 9 Appropriate safety nets such as exemptions from co-contributions, or loadings for providers to adjust co-contribution costs for Aboriginal and Torres Strait Islander people.
- 10 There are exemptions from the need to prove financial hardship, for anyone receiving JobSeeker, or full Aged Care pension.
- 11 Broader access to employment programs such as the *Indigenous Employment Initiative* is provided to ACCHOs to support them to train and retain local staff to support aged care service delivery.

Acknowledgements

NACCHO welcomes the opportunity to provide a submission to the Senate Community Affairs Reference Committee on the Support at Home Program.

NACCHO acknowledges valuable input received from NACCHO's affiliates, members, and Elder Care Support ACCHOs and ACCOs in our day to day work, and specifically those from Western Australia, Northern Territory, Queensland, New South Wales, Victoria and Tasmania that have joined our consultation discussions regarding this inquiry.

NACCHO supports submissions to this consultation made by our members and our state and territory affiliates.

National Agreement on Closing the Gap

Advocating for and securing the National Agreement on Closing the Gap was an historically significant act of Aboriginal and Torres Strait Islander self-determination. The National Agreement is evidence of a new era of engagement by and with Aboriginal and Torres Strait Islander people. It commits Australia to a new direction and is a pledge from all governments to fundamentally change the way they work with Aboriginal and Torres Strait Islander communities and organisations – to support self-determination and build the capacity of the community-control sector.

The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians. Governments at all levels have committed to the implementation of the National Agreement's four Priority Reform Areas, which offer a roadmap to meaningfully impact structural drivers of poor health and social outcomes for Aboriginal and Torres Strait Islander people:

Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments, and to accelerate policy making that centres Aboriginal and Torres Strait Islander voices.

Priority Reform Area 2 – Building the community-controlled sector

Recognising that community-controlled services achieve better outcomes, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services, this Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of government organisations to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform Area 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to regional data and information to inform local decision making and support achievement of the first three Priority Reforms. This Priority Reform supports principles of

Indigenous Data Sovereignty.

Despite some progress, the need for fundamental systemic reform remains evident. In its first review of the National Agreement on Closing the Gap, the Productivity Commission found that governments are not adequately delivering on their commitments. Despite support for the Priority Reforms and some good practice, progress has been slow, uncoordinated, and piecemeal.

The Commission noted that to enable better outcomes, governments need to relinquish some control, share decision making and acknowledge that Aboriginal and Torres Strait Islander people know what is best for their communities. Aboriginal Community Controlled Organisations must be treated as critical partners rather than passive funding recipients, and trusted to design, deliver and measure government services in ways that are culturally safe and meaningful for their communities.

‘Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution’¹

NACCHO recommends aged care programs align with the National Agreement and its four Priority Reform Areas.

Aged care provision in an under-developed, and unique sector

Aboriginal and Torres Strait Islander people suffer disproportionate rates of disadvantage against all measures of socio-economic status. Stolen Generations survivors and their descendants carry higher levels of disadvantage across life outcomes when compared to other Aboriginal and Torres Strait Islander people², and their numbers are rising.

ACCHOs and ACCOs that deliver aged care services are overburdened and unable to meet the demand for services from their communities. Aboriginal and Torres Strait Islander people are calling for more ACCO/ACCHO aged care providers.

Thin markets in aged care contribute to Aboriginal and Torres Strait Islander Elders and older people going without essential care to stay on Country or having to move away from Country and their family, at the time they are most needed.

Providers delivering care in urban, rural and remote locations and those operating small facilities face a range of issues when trying to recruit and retain staff such as the high costs of recruitment and/or relocation and a lack of access to suitable accommodation. Remote services often need to provide expensive incentives such as remote allowances, free/subsidised accommodation, travel allowances and additional leave. There is a high turnover of staff in rural and remote locations due to a range of factors including isolation, culture shock and the complex and sometimes confronting nature of the work.

Services in urban areas also operate in economically and culturally thin markets. Across the sector, there is a lack of access to staff who can provide culturally safe care for Aboriginal and Torres Strait Islander people. Analysis from the Institute for Urban Indigenous Health (IUIH) showed that the rate of access to aged care for older Aboriginal and Torres Strait Islander people is 10% below the national average. However, the rates of access in many remote and very remote communities attained or exceeded the national average. This

¹ Productivity Commission, Review of the National Agreement on Closing the Gap, Study Report, Canberra, 7 Feb 2024
<https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report>.

² <https://www.aihw.gov.au/getmedia/d7a0f2d9-c965-471c-86a7-919edcb3458f/aihw-ihw-257.pdf?v=20230605181817&inline=true>
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accessed 2 Sept 2025

demonstrated that to address these access barriers and close the parity gap, investments to improve access must also focus on older Aboriginal and Torres Strait Islander people living in cities and towns.³

To ensure more equitable access to high quality, culturally safe and inclusive aged care services for older Aboriginal and Torres Strait Islander people, NACCHO supports the Interim First Nations Aged Care Commissioner's call for Government to develop a 10-year transformation plan, co-designed in genuine partnership with Aboriginal and Torres Strait Islander people.⁴

NACCHO recommends the Government urgently works in partnership with the community controlled sector to develop and implement a specific Aboriginal and Torres Strait Islander aged care 10-year transformation plan in line with Priority Reform 1, and recommendations from the Aged Care Royal Commission and the Interim First Nations Aged Care Commissioner.

Specialist aged care programs for Aboriginal and Torres Strait Islander people

“Since the changes introduced on 1 November 2025, there has been increased reluctance to access aged care services. Some clients assessed through My Aged Care are not taking up services due to fees and often return to us as a trusted provider. Although we have NATSIFAC funding, we have not opened to SAH, as the model is not fit for purpose for ACCHOs or community members.”

ACCHO Aged care provider

There is considerable anxiety about the Commonwealth Home Support Program (CHSP) transitioning to Support at Home (SAH). We welcome the recent announcement to delay this until 1 July 2029 at earliest and look forward to genuine consultation around the limitations of fee-for-service models for the community controlled sector.

The CHSP block funded model gives ACCHOs flexibility to support their clients according to their individual and collective needs and priorities. It supports ACCHOs to plan for community level needs, for example, to support social programs for Elders to bring them to a community day centre for needed social and emotional support, as well as health care checks and meals.

Funding is not sufficient, however, and it limits provision of care to lower level needs.

CHSP has much simpler administration and reporting requirements and could eliminate some of the administrative burden placed on providers who are not set up to manage the complexities of Support at Home.

We understand that the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) is to remain as a separate, specialised program⁵, however the Department of Health, Disability and Ageing is silent on its future, and if, when or how aged care providers who do not currently access NATSIFAC will have the opportunity to do so. We understand that there is a review underway, however the timeline for this is continually being pushed back.

NACCHO recommends continuation of the block funded Commonwealth Home Support Program for ACCHOs and ACCOs to ensure ongoing access to flexible supports for Aboriginal and Torres Strait Islander older people.

³ Transforming aged care for Aboriginal and Torres Strait Islander people, First Nations Aged Care Commissioner

⁴ Transforming aged care for Aboriginal and Torres Strait Islander people, First Nations Aged Care Commissioner

⁵ Department of Health, Disability and Ageing, Submission 31, Senate Inquiry into Aged care service delivery, p. 4. (accessed via Aged care service delivery final report)

NACCHO recommends consultation with the community controlled sector regarding CHSP and NATSIFAC, to address unmet needs in Aboriginal and Torres Strait Islander aged care.

ACCHO/ACCO aged care providers and their workforce

Programs managed by the Aboriginal community controlled sector, such as NACCHO's Elder Care Support program, are successfully addressing issues around access to aged care services. Other workforce initiatives that could be funded and managed by the community controlled sector to address issues of aged care service access include Aboriginal and Torres Strait Islander Aged Care Assessors and embedding Aboriginal Health Practitioners into aged care service delivery.

Aboriginal and Torres Strait Islander people have a clear preference to access community-controlled services, many bypassing mainstream services to access an ACCHO, where they are confident their cultural safety is guaranteed.⁶

Feedback from our members over the last few years is consistent – more community controlled aged care services are needed, particularly on-Country residential and palliative care services. Many ACCHOs are deeply committed to ensuring that Elders in their community are well cared for, in culturally appropriate settings, and that they can stay on Country and close to family in their own communities. However, there are simply not enough culturally appropriate places for people to live in their later years.

NACCHO's member services are well placed to meet this need and have clearly expressed an interest in growing to ensure they can look after their elders in their own communities. As such, transition to the provision of aged care services will be essential for many ACCHOs, particularly in the thin market context of rural and remote areas which are not considered viable markets by larger providers and culturally thin markets many urban ACCHOs have identified. For many ACCHOs, the move into aged care will require a complex expansion from primary health care into a service delivery model requiring organisational capacity building, as well as workforce expansion and development.

NACCHO recommends that to support all Aboriginal and Torres Strait Islander people to access culturally appropriate care, regardless of where they live, the Government funds ongoing capacity building for existing ACCHO/ACCO aged care providers and supports all ACCHO/ACCO providers to enter the market.

Barriers to supporting Aboriginal and Torres Strait Islander Elders and older people to live safely and with dignity at home

The Royal Commission into Aged Care Quality and Safety highlighted the opportunity to design a national aged care system with capacity and flexibility to respond to Aboriginal and Torres Strait Islander people's needs and aspirations. It recommended that Aboriginal and Torres Strait Islander people receive culturally respectful and safe, high quality, trauma-informed, needs-based and flexible aged care services regardless of where they live.

The Royal Commission determined that priority be given to support Aboriginal and Torres Strait Islander providers to become aged care providers. It determined that place-based and integrated service delivery models, and a focus on providing services within, or close to, Aboriginal and Torres Strait Islander populations would ensure people can maintain connection with their Country and communities.

⁶ Kathryn S Panaretto, Mark Wenitong, Selwyn Button and Ian T Ring, Aboriginal community controlled health services: leading the way in primary care, *Med J Aust* 2014; 200 (11): 649-652. | doi: 10.5694/mja13.00005

The Aged Care Act 2024 offered much hope of person-centred care. However, the reform implementation does not recognise Aboriginal and Torres Strait Islander aged care. Rather than focusing on care and improving equity of access to culturally safe care, SAH seems to be centred around monetising relationships with clients which is resulting in harm. It is impacting the ability of ACCHOs and ACCOs to sustainably deliver the aged care services needed in their communities. Many Aboriginal and Torres Strait Islander Elders and older people are suffering, because SAH providers are struggling to keep up with changes. This is not what was envisaged by the Royal Commission.

NACCHO reiterates its support for the Aged Care Royal Commission recommendations relating to Aboriginal and Torres Strait Islander people and aged care service providers.

Support at Home

SAH limits choice and control and does not allow flexibility for providers to deliver services the client needs in the way the client wants. In remote areas there are not enough service providers to service all the people with packages. This is exacerbated by the fact that some service providers won't travel to small towns or communities.

Reduced flexibility, when compared with CHSP, results in people who are aged, who may be experiencing cognitive decline, and may not have social or family support, having to endure long wait times of three to twelve months or more for assessment and approval, with no flexibility to receive urgent care, or any services in the interim.

SAH and the aged care system's complex and often culturally unsafe processes have created significant anxiety and confusion, leading many older people to disengage from services. This has been particularly evident in relation to the introduction of co-contributions and hardship paperwork, where fear and misunderstanding have resulted in people declining approved packages. These barriers affect Elders' access to the essential support and services they need.

Some Elder Care Support workers have brought many Elders out of isolation and assisted them to get Support at Home packages. However, the program is not delivering as anticipated for Aboriginal and Torres Strait Islander people. There is widespread uncertainty about SAH rules and the potential need to pay for services. This, together with the rise in costs for services following increases in mainstream provider charges since 1 November 2025, is causing added stress instead of care and support.

"The rollout of the Support at Home Program, replacing the existing Home Care Packages Program and Short-Term Restorative Care, has created concerns, confusion, and anxiety among the Aboriginal and Torres Strait Islander people supported by our Elder Care Connectors. Changes to co-contribution fees have led some clients to decline their Support at Home Packages, as the associated costs create significant financial hardship for the Elders and older people we support. As a result, many in our community are unable to access critical aged care services that enable them to live independently at home, maintain personal hygiene, and remain culturally connected to their community."

ACCHO Elder Care Support program feedback

Culturally unsafe assessment, communications and systems

SAH assessments do not align with findings from previous CHSP assessments, and people are assessed as needing a lower level of care. Home Care Package clients have been grandfathered into SAH, under the *no client worse off* condition. This has caused some concern amongst Elders and older people in community where the perception is that all are not treated equally.

Clients who have waited months for their assessment, miss calls from assessors who call from a private number to book an assessment, as some clients will not answer a private number.

There have been occasions where, despite requests, the assessor has not included the ECS Coordinator or the local ACCHO when distributing the client's Support Plan. Instead, the client's home address has been listed as the 'recipient'. This can create a significant risk that the client may not receive or understand the outcome of their assessment within the required timeframe. In some cases, this can result in the client being

unaware that they have been approved for an SAH Package and subsequently losing access to the funding because the acceptance timeframe has expired. This ultimately impacts the client's ability to access the support and care they require. This is especially so, for transient populations.

Where appropriate and with the client's consent, it would be beneficial for the relevant ECS Coordinator and/or Health Clinic to also receive a copy of the Support Plan so that they can assist the client to understand the outcome, respond within the required timeframe and access their approved supports.

There is a need to improve the MAC Portal, as currently, providers are experiencing several challenges. Relevant staff are not receiving alerts and notifications needed to support their clients in their journey through assessment, approval and access to services. They must manually open individual client profiles to check whether referral codes or other updates have become available. For small teams managing many clients, particularly in remote communities, this is time-consuming and increases the risk of important updates being missed.

CASE STUDY

One ACCHO has clients who have had urgent need for gardening, and who are about to become homeless because they've been unable to keep their garden in a 'liveable state'. However, MAC determines that gardening is not urgent, and so priority for this service for their clients is downgraded.

*"It would be good to have access to a flexible code we can use for our ECS clients while they are awaiting assessment. Being referred to ECS should be enough to warrant a code.
A lot of the time, a hospital or a GP will email us. "*

ACCHO Elder Care Support provider

CASE STUDY

One ACCHO client was assigned a gardening code instead of a cleaning code – even though they lived in an assisted living facility which had no garden, and the notes on file indicated that they needed cleaning services. It took the ACCHO two months to get the code changed in MAC. In the meantime, the ACCHO took on the cleaning work for their client, unpaid, as it was an urgent need for them.

Improving the registration and consent process, strengthening cultural awareness in assessments, ensuring appropriate local health services are included in communication to Elders, and improving the functionality of the MAC Portal would significantly support both staff and clients, particularly those living in remote and regional communities.

NACCHO recommends that the Government consults with the community controlled sector to improve the functionality of the MAC Portal to better support the needs of Aboriginal and Torres Strait Islander people – particularly those in rural and remote communities.

NACCHO recommends ACCHOs delivering home care services are funded to provide everyday living services for gardening to remove risk of eviction.

Remote communities

There are several systemic barriers within the Aged Care process that fail to consider the needs and circumstances of older people living in rural and remote communities.

The challenges experienced by clients in these locations can be very different from those encountered in urban settings, particularly in relation to communication, access to phones, cultural considerations, and the availability of local support. These factors need to be considered when developing and implementing

processes to ensure that clients living in rural and remote areas are not disadvantaged in accessing the assessment, funding, care and support they require.

In remote areas, we have heard that older people are receiving inappropriate assessments for a range of reasons, including language barriers – where they don't understand questions, and inadequate assessments because they are putting their best foot forward when the assessor comes – so the assessor is not able to accurately ascertain their actual level of need.

Of significant concern is the use of interstate assessors who may have limited familiarity with local communities, cultural practices, and the ways in which clients may communicate or respond during assessments.

Some Elders will often downplay their needs, due to shame or fear – a limited understanding of this behaviour from an interstate assessor can impact the accuracy of assessments and the assessor's ability to establish a client's actual level of need.

CASE STUDY

An Elder was sitting, having a drink with family members at the time of their assessment. When the assessor asked questions regarding alcohol and other drug (AOD) use, the client advised that she did not drink and had given up. The client also downplayed her mobility issues; indicating that her mobility was fine.

Following the assessment, the Elder Care Support worker had to inform the assessor that the client had been drinking kava during the assessment.

After receiving the assessment report which had determined that the client was a suitable candidate for CHSP supports, the local ACCHO AOD Coordinator, who supports the client on a regular basis, contacted the Elder Care Support worker. They noted that due to the client's health-related decline, her needs were more appropriately aligned with Support at Home (SAH) and advocated for reassessment. A reassessment was undertaken, and the client was assigned SAH Classification 5, which better reflected her level of need.

The case above highlights the potential impact that cultural context, communication styles, local knowledge, and an understanding of community practices can have on the accuracy of an assessment and the resulting support recommendations. It also demonstrates the importance of ensuring that assessors have appropriate cultural awareness and, where possible, access to local knowledge when assessing clients in remote communities.

Since this occurrence, the agency has advised that they have now employed an assessor who lives and works locally. That community is hopeful that having an assessor based locally will help address some of these concerns and support a greater understanding of the communities, cultural considerations, and circumstances for clients in their jurisdiction.

Other SAH concerns

We are hearing that there are some mainstream SAH providers that are recovering money for services that have not been delivered. This is especially so for personal care services, where our members have reported incidents where Elders have gone up to two weeks without personal care.

Some mainstream providers lack cultural awareness. They will walk out and not deliver service because they've seen a mattress on the floor. Some areas only have access to Fly-In-Fly-Out (FIFO) services delivered by non-culturally aware, non-Indigenous providers. MAC random-assignment of referral codes for assessment services is seeing assessment services assigned to very distant, interstate assessors who achieve two half-days of assessments in a four-day round trip, when other, local and more culturally aware assessors could be used.

A lot of providers and even MAC are contacting Elders and older people and putting pressure on them to use their SAH funding. They are being told that if they don't use their funding immediately, they will lose all the services they have been provided. They are being contacted by My Aged Care staff and receiving cold calls from service providers who are scaring people into signing service agreements.

NACCHO recommends that ACCHOs/ACCOs are supported to deliver aged care services, Elder Care Support, and aged care assessment services. Regional and local assessors will achieve more accurate aged care assessments for Aboriginal and Torres Strait Islander people living in rural and remote communities.

Impact of co-payment contributions for independent services and everyday living services

SAH co-payment contributions, the associated administrative burdens and costs of associated hardship applications and approval processes, limit access to essential basic care needs for vulnerable Elders. They also have a negative impact on Aboriginal community controlled aged care providers who prioritise their respect for and cultural obligations to Elders and bear these financial burdens rather than pass them on to vulnerable Elders. This is not sustainable in the longer term, puts continued access to aged care services delivery at risk in culturally and economically thin markets.

Fees and co-contributions are a significant barrier and deterrent to older Aboriginal and Torres Strait Islander people accessing the aged care support they need. Many have ongoing caring responsibilities for family members and have kinship obligations to share their resources within extended family and community. Those with limited means will often choose to keep their money to support family and community rather than spend it on their own care needs.

Not accessing care to support independence, such as support for mobility, medication management, hygiene, showering or continence management will increase risk of falls, hospitalisation and declining health.

Accessing support for social and community engagement, particularly to engage in cultural activities is integral to maintaining good health. Losing this, due to limited financial means, would be detrimental.

Not accessing services provided with Everyday Living (home maintenance, domestic assistance etc.) could potentially see more older people at risk of losing their tenancies if they cannot afford to co-contribute to keep their homes in a 'liveable state' due to impacts of their age and declining health. Not being able to access healthy meals will impact diet and general health issues.

Whilst Aboriginal and Torres Strait Islander people can access aged care services from age 50, they are disproportionately affected financially, because unlike older non-Indigenous Australians receiving aged care services, they cannot access the Age Pension or their superannuation from that younger age, and so those aged under 65 years who rely on lower income support payments, are financially worse off.⁷

Self-funded, retired Elders can often not afford the 80% co-contribution fee and may feel pressure to choose between services, and food and other essentials.

Elders currently receiving CHSP services are reluctant to undergo further assessment because they fear receiving less funding under Support at Home, and that co-contribution costs will increase over time.

Without intergenerational wealth or ability for Elders and the next generation to build wealth, targeting them for co-contributions for care that they need and were receiving previously without the need for co-contributions, demonstrates that Government is not taking into account the social and cultural context Aboriginal and Torres Strait Islander people live in, or the complexities associated with the locations in which they live.

The requirement for fees and co-contributions where none previously existed constitutes structural disadvantage and undermines the intended equity provided by early access to aged care. It is also at odds with Royal Commission recommendations to support and improve access for Aboriginal and Torres Strait

⁷ Transforming aged care for Aboriginal and Torres Strait Islander people, First Nations Aged Care Commissioner

Islander people. ACCHO services have advised that collecting payments from Elders and older people is not the Aboriginal and Torres Strait Islander way.

With the Support at Home Program, care providers are now responsible for educating their care recipients a complex system of fees and exception forms. For ACCHO service providers, explaining to care recipients who did not previously pay for services that they will now have to contribute is very difficult and risks undermining trust in their service. In contrast, the Commonwealth Home Support Program does not require service providers to have complex conversations about budgets and co-contributions. One ACCHO noted:

“The only thing we should be educating people on is what quality service they should expect and that if a provider provides you a service or a worker comes and you don't get the service that you want, how to make a complaint.”

NACCHO supports recommendations from the Interim First Nations Aged Care Commissioner that DoHDA develops tailored pathways for Aboriginal and Torres Strait Islander people that acknowledge historic and ongoing economic disadvantage and provide safety net settings in response to the proposed introduction of increased co-contributions for Aged Care services.

Access to aged care will not be equitable until appropriate exemptions and or safety nets are in place to support those who are financially disadvantaged.

NACCHO recommends there are appropriate safety nets such as exemptions from co-contributions, or loadings for providers to adjust or eliminate co-contribution costs for Aboriginal and Torres Strait Islander people.

Hardship

Ironically, the need to apply for hardship assistance, is itself, causing harm. Hardship is seen, culturally, as ‘shame’ – and so people are declining service rather than applying.

The process for financial hardship is complex and can be overwhelming for older Aboriginal and Torres Strait Islander people. The questions are intrusive and not culturally appropriate, for example, not recognising cultural obligations, such as grandparents needing to care for grandchildren in school holidays.

We have heard from services, that many are refusing to apply for hardship because it's too overwhelming and takes several months. They wait for their package, then if they can't afford the support they need, they either decline services or don't accept the package when it's offered.

The application form is only available on the MAC portal, and the language used is difficult to understand. Those without online access are having to navigate a 70-80+ page application form.

In some communities, many Elders don't have phones so can't phone for help. It is a lot to ask of an older person to tell their whole financial story, even when they have an ECS worker to help them.

Hardship is putting pressure on ACCHO resources. Elder Care Support workers try to assist, but often find a social worker is needed. It appears to our members that Services Australia does not have adequate resources to process the volume of hardship applications. Some applications have been pending for at least three months with no response. Services Australia should be supporting Elders with the process, but instead it is falling to ACCHOs/ACCOS.

Some members are having good outcomes with hardship forms through help from Services Australia Aboriginal Liaison Officers, including help populating the forms using existing data they currently hold for clients. Other members tell us that they prefer to engage face to face, but there are no local liaison officers.

Some have indicated that hardship applications, as complex and arduous as they are, only result in a co-contribution discount. It seems there is no recognition that clients who are already on JobSeeker (noting that aged care access for Aboriginal and Torres Strait Islander people is from age 50) or receiving rental assistance from Services Australia, have limited means. They must still apply for and navigate the complex processes associated with accessing hardship.

We hear that some people who own a car but have no substantial cash are exceeding the allowable asset limits to claim hardship, and that the allowable assets limits are not adjusting in line with inflation.

CASE STUDY

A mother had been providing small amounts of financial support to her son to support him while he was dealing with addiction. Over the course of a year this amounted to more than \$10,000 and had left her with nothing in her bank account. Because she had 'gifted' \$10,000, she was assessed as not in financial hardship.

We understand that the 'gifting' rules are intended to stop fraud, but for Aboriginal and Torres Strait Islander people, kinship obligations constitute a different type of relationship to gifting, that is not considered under the current rules.

"Applications for financial hardship are a complete joke. They are culturally inappropriate, they are invasive... it is so long, and I am still yet to hear of someone being approved."

ACCHO aged care provider

NACCHO recommends there are exemptions from the need to prove financial hardship for anyone receiving JobSeeker or the full aged care pension.

Impact transitioning from the Home Care Packages Program

With the introduction of the SAH requirement for clients to contribute via a means-tested co-payment, many clients have become increasingly reluctant to apply for support fearing they will be presented with a co-contribution invoice.

The SAH model has increased complexity and has become more challenging for many clients to understand. This has created additional barriers to access and informed decision-making.

Delays in My Aged Care review processes and approval of updated SAH Plans continue to affect older peoples' ability to receive timely support. Extended wait times for reassessments, plan updates, and service endorsements mean Elders and older people may go without essential support—such as personal care, domestic assistance, or equipment—while their needs increase.

Elders transitioning from Home Care Packages (HCP) are being grandfathered in at Level 4 without consideration of previous assessments.

Three-monthly budgets have a disproportionate impact on older people who live in areas of no or low access to services and shops. Once exhausted, the wait for the next quarter's allocation has a detrimental impact. Paperwork to have budgets rolled over is lengthy and overly complicated.

As co-payments are individually means tested, it is difficult to provide clients with clear and accurate information about the expected cost of their care. This uncertainty contributes to hesitancy from Elders and older people to engage with programs.

ACCHOs are reporting a high administrative burden with the transition from the HCP, especially when their staff are mostly clinical, with no, or few, administrative staff. Some clients, who have never had large amounts of money can be overwhelmed by the need to budget.

We are hearing from members who are aged care providers, that they are unsure about the new SAH program. Guidelines are unclear, the "call centre" is unhelpful, the service list is too restrictive, and reporting requirements are overly burdensome. Services are battling with increasing complexities and are having difficulty keeping up the changes. They tell us that their clients, Aboriginal and Torres Strait Islander Elders and older people, are the ones suffering the most.

NACCHO recommends broader access to employment programs such as the Indigenous Employment Initiative is provided to ACCHOs to support them to train and retain local staff to support aged care service delivery.

Impact on residential aged care and hospitals

Factors impacting residential aged care and hospitals include:

- Ageing populations in rural and remote communities
- Distances for providers to travel – which can be one to two hours away – which often results in mainstream service providers refusing to travel
- Failing of aged care programs and systems to support people to live well and maintain function at home (through a variety of factors mentioned elsewhere in this submission).
- Workforce capacity issues cause by difficulty retaining staff needed to service the needs well and maintain function at home then there will be a flow on effect for hospitals and Residential Aged Care
- The process of assessment, approval and activation is sometimes taking 18+ months, and is resulting in Elders moving off Country, and prematurely, into aged care facilities.