Submission made to the

Support at Home Program Inquiry

June 2026

Further Information

MND Australia welcomes the opportunity to provide further information in addition to the information contained in this submission. Please contact Clare Sullivan, CEO of MND Australia, on clare.sullivan@mndaustralia.org.au or 0415 265 262.

This submission was written with close collaboration from the MND State Associations and with the insights of the MND Lived Experience Network. MND Australia acknowledges the many people with lived experience who shared their experiences for this submission. Lead author: Dr Susan Maury.

About MND Australia

MND Australia is the national peak body of MND State Associations that support those living with, and impacted by, motor neurone disease (MND). Since 1993, we have been the voice for the MND community. MND Australia, together with the MND State Associations, form the only national network focussed on improving the lives of all Australians living with MND. Through strong national and international partnerships, we advocate for the needs of those impacted by MND and promote greater understanding of the disease. Our State Associations are:

- MND Western Australia
- MND Victoria/Tasmania
- MND Queensland
- MND New South Wales/Northern Territory/ Australian Capital Territory
- MND South Australia

There are no effective treatments for MND and there is no cure. There are no remissions and progression of MND is usually rapid and relentless, creating high levels of life-limiting disability, regardless of the age at onset. People living with MND have complex, constantly changing needs, which require a wide range of changing supports. Average life expectancy following diagnosis is a scant 27 months.

MND Australia has four key priorities, these are:

> **Advocacy** - We advocate for improvements in treatments and care to ensure people living with MND have the best quality of life possible. We seek to improve the lives of those affected by MND through improvements to federally-funded care, enhanced data infrastructure, access to new treatments and genetic testing, and investment in research.
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> **Information** - We provide resources, information and service linkage for people living with MND, their carers and family, as well as for the health professionals and service providers who support them to live well.
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> **Research** – We invest millions of dollars annually through our research grants program which supports high-quality research to discover the causes, improve care and find treatments and ultimately a cure for MND.
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> **Connection** – We are the nexus between research, services support and lived experience engagement. Our members, the State and Territory MND Associations, provide services and support to the vast majority of people with MND in Australia. Our National MND Lived Experience Network of 165 people living with or impacted by MND provide critical insights to researchers, service professionals and government, facilitating informed policy, practice and care. We are also the custodians of the MiNDAUS Registry, open to all people diagnosed with MND in Australia and with 12 participating clinics.

What is motor neurone disease (MND)?

Each day in Australia two people are diagnosed with MND and each day two people with MND die.

There is no known cure.

Disease progression is often rapid and relentless, creating a wide range of changing needs and supports.

There were approximately 2,752 Australians living with motor neurone disease (MND) in 2025 [1].

Every day in Australia, two people are diagnosed with MND and two people die from the disease.

MND is the name given to a group of neurological diseases in which motor neurons – the nerve cells that control the movement of voluntary muscles – progressively weaken and die.

With no nerves to activate muscles, people with MND lose their ability to walk, speak, swallow and ultimately breathe. MND affects each person differently. Initial symptoms, rate and pattern of progression and survival time can all vary widely.

The lifetime risk of MND is about 1 in 300 people by the age of 85.

Up to 15% of MND cases have a known genetic basis through a well-established family history. However, as we continue to better understand the complex nature of MND, it is becoming clear that genetic changes are a factor in a much higher percentage of cases. The balance of cases are considered ‘sporadic,’ meaning there is no known cause. It is thought that the onset of MND is influenced by a variety of environmental and personal factors.

It is estimated that 63% of people living with MND were diagnosed aged 65 and over [1].

There is no single medical test that can confirm diagnosis. The average time from the onset of symptoms to confirmation of diagnosis is 13 months in Australia [1]. Access to a specialised neurologist is key to timely, accurate diagnoses.

Average life expectancy for people living with MND is 27 months from diagnosis. A third of those die within one year and more than half die within two years of diagnosis. In 2024, 797 people with MND died in Australia. MND State Associations report that their case load is increasing across time, a pattern that is confirmed by recent analyses which indicate cases of MND in Australia will reach over 4,000 by 2050 [1].

Currently there are three pharmaceutical treatments available in Australia for MND. These treatments can slow disease progression, delay functional decline and extend survival times, but currently only two of these treatments are listed on the PBS. None of these treatments are a cure for MND.

Living with MND

People living with MND can experience a variety of changes in the early stages, such as stumbling or falling, changes in dexterity, slurred speech, trouble swallowing, muscle twitching, or cognitive and behavioural changes. As MND is a degenerative condition, these symptoms will worsen over time. The support and equipment needs of someone living with MND will therefore change, often rapidly.

People living with MND benefit greatly from coordinated, multidisciplinary care, as well as assistive technology [3]. This care team may include a neurologist, care coordinator, allied health assistant, occupational therapist, physiotherapist, orthotist, respiratory specialist, speech pathologist, dietitian, nurse, social worker, psychologist or counsellor, palliative care expertise, an MND association advisor, NDIS support coordinator, and community service providers. Evidence shows that those who attend a multidisciplinary clinic experience extended life expectancy [4].

A large variety of aids and equipment, usually referred to as ‘assistive technology’ (AT) are needed. Common forms of AT include power wheelchairs, hoists, hospital beds, respiratory aides, or eye-gaze technology to communicate. Many people also require home modifications, such as ramps or major bathroom modifications.

The MND State Associations provide wrap-around services and coordinated care, access to specialised equipment, assistance with system navigation and psycho-social supports.

Due to the length of time to receive an MND diagnosis, people living with MND will often have significant disability at the point of diagnosis and require immediate supports. This access to immediate supports is critical.

MND Australia strongly advocates for more equitable solutions that benefit all people living with MND in Australia. We are concerned about inadequate government funding and support for people diagnosed with MND who are aged 65 and over, as well as broader inequities related to access to specialist healthcare, geographic location, cultural and linguistic diversity, and varying levels of health literacy and capacity among people living with MND, their families and carers.

Summary of Support at Home concerns and recommendations

In consultation with the MND State Associations and the MND Lived Experience Network, MND Australia has identified the following primary concerns for the ability of the Support at Home Program to effectively support older people living with a diagnosis of MND, and the corresponding recommendations, organised by the key prompts provided by the Committee.

Term of reference 1. The ability for older Australians to access services to live safety and with dignity at home.

Concern 1. Package amounts are inadequate even at the highest levels.

Concern 2. Limiting reassessments is problematic for people living with MND.

Concern 3. The use of the Integrated Assessment Tool (IAT) coupled with the removal of clinical expertise has resulted in pecuniary rather than a person-centred approach to managing aged care.

Concern 4. There are difficulties accessing assistive technology/home modification funding, including for necessary ventilation equipment.

Recommendation 1. Support at Home package amounts must reflect the value of genuine clinical need.

Recommendation 2. The IAT should be a component of a holistic decision-making process that is led by clinical expertise. Use of the IAT should also make clear:

- What aspects of the assessment process are impacted
- What the guidelines are for automated decisions
- Whether the automated decision can be overturned and by whom, and
- What the appeals process is.

Recommendation 3. Ready access to reassessments as needed would save government money by increasing package amounts at the point in time when it is needed, while responding flexibly to changing needs.

Recommendation 4. CHSP should better integrate into Support at Home, removing barriers to continuity of care, particularly for AT/HM needs. Equipment rentals should be billable to keep costs affordable.

Recommendation 5. AT/HM funding should be assessed at ‘High’ priority to align with the recently-created priority pathway for people living with MND.

Recommendation 6. AT funding should explicitly cover respiratory equipment and text-to-speech aides.

Term of reference 2. The impact of the co-payment contributions for independent services and everyday living services on the financial security and wellbeing of older Australians.

Concern 5. There are multiple avenues through which older Australians living with MND are struggling to afford their care through My Aged Care, including:

- The co-pay structure, which places a financial burden on older Australians to afford their care.
- The unregulated costs of aged care providers, who have raised their prices for key services between 35-50% since 1 November 2025.
- The administrative fee that is added by providers when processing claims.
- Low package amounts and under-funding of care.
- Long wait times were also creating financial pressures; we are thankful that this stressor has been removed for people living with MND.

Recommendation 7. A comprehensive analysis on the household financial impact of the Support at Home program should be conducted.

Recommendation 8. The risks associated with accessing care and support privately should be considered if the co-pay structure is maintained.

Term of reference 3. Trends and impact of pricing mechanisms on consumers.

Concern 6. MND Australia has undertaken an informal analysis of aged care provider fee structures, and have found that costs have risen approximately 35-50% since the introduction of the reforms on 1 November 2025. They are also 24-94% higher than NDIS costs for comparable services.

Recommendation 9. Support at Home packages need to accommodate reasonable fees charged for services by providers. Provider fees need to be regulated.

Term of reference 4. The adequacy of the financial hardship assistance for older Australians facing financial difficulty.

Concern 7. The difficulty of filing for financial hardship assistance precludes people from accessing this option.

Recommendation 10. A viable, accessible process should be established to request hardship assistance.

Term of reference 5. The impact on the residential aged care system, and hospitals.

Concern 8. The government commitment to provide more residential aged care beds is nearly meaningless for people diagnosed with MND because they are ‘clinically declined’ from most residential facilities. This leads to unnecessarily long hospitalisations and in some cases early use of voluntary assisted dying.

Recommendation 11. The government should commit to upskilling the aged care workforce to deliver complex clinical care needs as well as providing adequate funding to care for older Australians with complex, intensive clinical needs in residential care settings.

Term of reference 6. The impact on older Australians transitioning from the Home Care Packages Program.

Concern 9. MND Australia documented the difficulties of the transition from the Home Care Packages to Support at Home in a submission to the Committee in January 2026. Key concerns and recommendations are provided in the body of this report.

Term of reference 7. Thin markets including those affected by geographic remoteness and population size.

Concern 10. Finding a provider and accessing needed services has been challenging for many clients of the MND State Associations. This is true for Support at Home and a widespread problem for people relying on CHSP, and is not solely experienced by people in rural, regional or remote areas.

Recommendation 12. Access to services needs to be improved across Australia. CHSP should be maintained with proper investment. Providers need to be held accountable for timely, appropriate service provision.

Term of reference 1. The ability for older Australians to access services to live safely and with dignity at home.

MND Australia is deeply concerned that the Support at Home program is not designed to support older Australians living with a diagnosis of MND to live safely and with dignity at home. Specifically, our concerns are:

Concern 1. Package amounts are inadequate even at the highest levels.

Concern 2. The use of the Integrated Assessment Tool (IAT) coupled with the removal of clinical expertise has resulted in a pecuniary rather than a person-centred approach to managing aged care.

Concern 3. Limiting reassessments is problematic for people living with MND.

Concern 4. There are difficulties accessing assistive technology/home modification funding, including for necessary ventilation equipment.

We provide further information on each of these issues below as they are a critical component of how the Support at Home program is failing to achieve the stated goals of the program.

Concern 1. Package amounts are inadequate even at the highest levels.

Motor neurone disease is generally very fast-progressing, and this is the most common experience for older people. Research finds that (older) age is the single primary predictor of fast-progressing MND [5]. While the average life expectancy from diagnosis is 27 months, for older people it is most likely to be much shorter than this. The lived reality for most people living with MND and their carers who rely on the aged care system is that they very quickly require intensive, clinical supports. This may include nursing supports, a range of allied health care services, home modifications (e.g., bathroom remodels, grab bars, ramps or platform lifts), and assistive technologies (e.g., power wheelchair, eye gaze technology, feeding tube, ventilator/BiPAP machine).

Prior to the announcement by The Hon Mark Butler's office on 2 June 2026, the low package amounts and the long wait times to receive funding packages were intertwined problems for people living with MND. People with a diagnosis of MND were experiencing wait times of 9 months or longer at 'medium' priority; since the reforms were implemented on 1 November 2025, almost none of the MND State Association clients with an initial assessment had received Support at Home funding. The announced change to prioritise people living with MND as 'urgent,' with a commitment to delivering funding within 30 days of package approval, represents a long-sought step forward in creating an aged care system that is flexible and responsive to the reality of need. MND Australia, the State Associations and the entire MND community are grateful for this change, which goes a long way to relieving the caring and financial pressures that people reliant on the aged care system have been experiencing.

In order to truly meet people's needs, rather than subsidise their care, package amounts also need to increase.

Data collected from the MND State Associations between November 2025 – April 2026 (N=71) reveals that less than 20% of all aged care clients with an MND diagnoses receive Level 8 (the highest tier) funding of approximately $78,000 per annum, while approximately 15% receive Level 7 funding, valued at approximately $58,000 per annum. This means 70% of people are assigned package amounts ranging between levels 1-6. (Note: This data is explored in more detail in the section on the Integrated Assessment Tool.)

Currently, the expense of having MND is quantifiable by looking at the average NDIS funding for the identical disease but for a younger cohort. Data shows that the average NDIS package amount for someone diagnosed with MND, and who has been assessed by someone who is knowledgeable of MND and its progression trajectory, is $300,000 per year [1]. A package amount of $78,000, which only a very few qualify for, falls woefully short of this amount. The lower package amounts that most older people with MND receive are even less adequate.

> **Case study 1: Level 7 funding creates hardship**
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> Graham is 80 years old, and was transitioned over from a Level 4 Home Care Package, which was valued at approximately $61,500 per annum. While it was inadequate to cover all of his needs, it did pay for 14 hours of in-home care per week, that provided his wife and primary carer Gaynor, aged 79, with daily help to get him out of bed daily. When he was reassessed for the Support at Home program, he was placed on Level 7 funding. While this is just below the highest level of funding (Level 8), at $58,000 per annum it is a reduction from his previous funding. With increases in provider costs, it is now only covering 9 ½ hours/week. This means Gaynor no longer has the help she requires to get Graham out of bed daily. This is a health hazard for both Graham and Gaynor. The funding model does not appear to consider the age and capability of the carer. The Crossans recently heard their request for a reassessment was disallowed by the Department of Health, Disability and Ageing because his status had not changed since the initial assessment in November. The inability to challenge a poor decision made by the Integrated Assessment Tool is another barrier to justice. [6]

Concern 2. The use of the Integrated Assessment Tool (IAT) coupled with the removal of clinical expertise has resulted in a pecuniary rather than a person-centred approach to managed care.

Concern 3. Limiting reassessments is problematic for people living with MND.

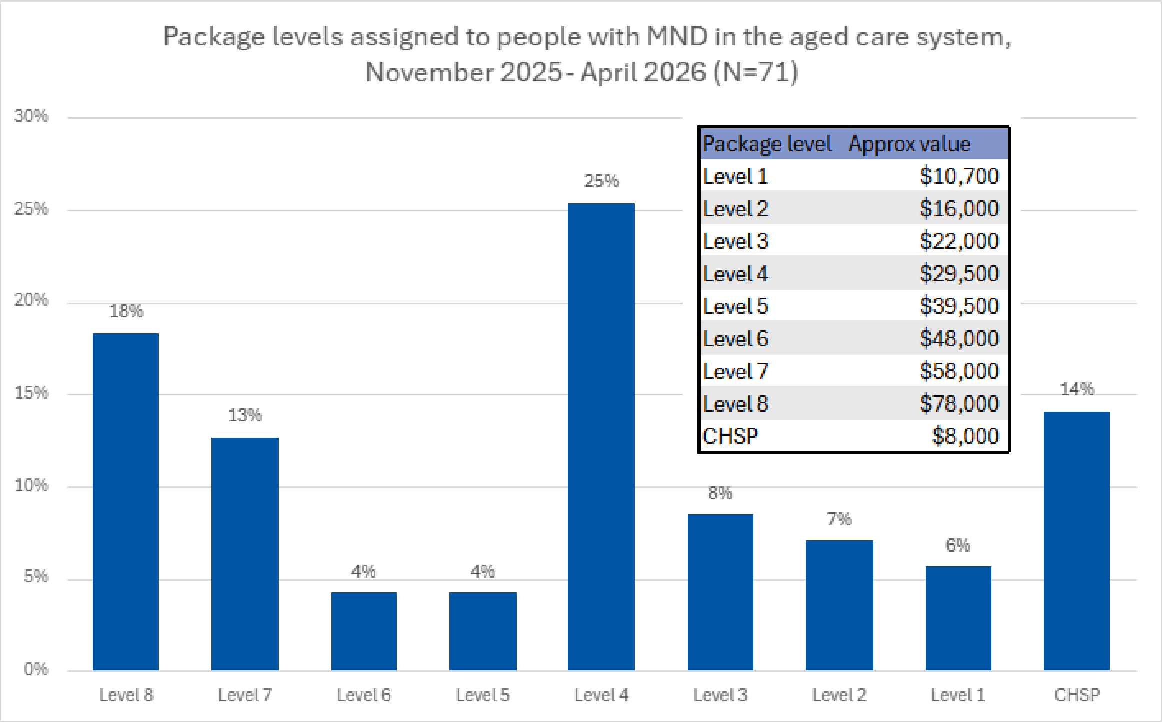
Accurate assessments and ready access to reassessments are both critical for managing the rapid rate of MND progression. If assessments are done with proper clinical input and reassessments are readily available, funding amounts can be adjusted at the point in time when they are needed. This would allow for targeted, flexible funding that keeps pace with the needs of people living with MND, rather than needing to approve larger funding amounts in anticipation of imminent need.

The stated intention of introducing the Integrated Assessment Tool (IAT) was to ensure assessments reflect “fairness, accuracy and efficiency” [9]. However, this is not how the assessments performed by the IAT are being experienced on the ground.

The MND State Associations shared data on how the IAT was assessing people with MND. Across 71 assessments between November 2025 and April 2026, the IAT assigned every level of package, from CHSP and Level 1 up to Level 8; see Image 1. While there is of course some variation in individual need and capability, the wide range of package assignments is surprising for the same disease which has a largely predictable trajectory and corresponding need. Of note:

- Only about 20% of all clients received the highest level package (Level 8).
- Only 31% of clients received Level 7 or Level 8 package assignments.
- 60% were assessed at a Level 4 or below.

Image 1: Spread of IAT assigned package levels for people with MND, November 2025 – April 2026



Package level	Approx value
Level 1	$10,700
Level 2	$16,000
Level 3	$22,000
Level 4	$29,500
Level 5	$39,500
Level 6	$48,000
Level 7	$58,000
Level 8	$78,000
CHSP	$8,000

MND Australia and the State Associations suggest that, for people living with MND aged 65 or older, outcomes should be much more consistent, and much more skewed towards the higher package amounts.

> **Case study 2: Inexplicable low Level 1 funding for at-risk client**
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> A 75-year-old living in South Australia with a diagnosis of MND was assessed at Level 1 package funding (approximately $10,700 per annum). Living alone, they had a fall which required a paramedic visit. They now stay with a family member. Despite the Level 1 'light touch' funding, they are unable to prepare meals, clean the home, drive, shop or attend appointments without assistance. There continues to be a high risk of falls and injury. There is no explanation or accountability for why the package amount is at the lowest level. The government has not provided a matrix of the various levels and how they correlate to need. [7]

Ready access to reassessments would mitigate some of the difficulties of low package amounts. However, requesting and receiving a reassessment can be a very lengthy process. This has been particularly true when people living with MND were being assessed as 'standard' priority, since a reassessment could not be requested until the funding was received – often 9 months or longer.

Even where reassessments are performed, they are still at times returning inappropriately low package amounts. Assessors point to the Integrated Assessment Tool as the problem.

> **Case study 3: From avid sportswoman to in a wheelchair, but reassessments were inaccurate**
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> Annette (name changed) was an active retiree in NSW after a career as an executive in the health industry, enjoying golf, yoga, surfing and community volunteering. In February 2025, while volunteering with a sports program for children with disabilities, she had a fall, which was her first symptom of MND. She was assessed for a Home Care Package in July 2025, only needing a few supports at that time, and received CHSP funding which covered her occupational therapy and physiotherapy expenses. While her CHSP funding also included in-home supports, Annette was unable to find a provider who would accept her referrals.
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> She was reassessed in December 2025 as she had declined considerably since July, and was approved for a Support at Home Level 2 package (the second-lowest tier, approximately $16,000) with an estimated 10-month wait. She noted to the assessor that much of the information had not been updated from her first assessment; it still listed her as active in the community, able to do her own shopping and to manage stairs, none of which was true any longer. The assessor responded that they were unable to override the algorithm decision.
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> In April 2026 Annette had a fall resulting from her weakened leg as her MND symptoms escalated, which landed her in hospital. When she returned to her home,

> where she lives alone, she required a stair lift, grab bars and a wheelchair, as well as help with activities such as showering. She tried to update her information with My Aged Care but without success; the person she spoke to was offhand and dismissive. With the advocacy of a new provider, the hospital social worker and her federal member, she was finally approved for an urgent reassessment. This was done in May 2026 and she was approved for a Level 7 package (approximately $58,000). Her priority level did not change and she was told it would be at least another eight to nine months to wait before she received any funds.
>
> Of her disappointing interactions with My Aged Care, Annette says, “They don’t know how dysfunctional the system is. It is broken… If they are aware of the despair and distress it is causing they don’t care. Something has to change.”
>
> As a partial pensioner Annette has had to take a loan through the Home Equity Access Scheme to pay privately for the allied health and care help she required, while MND NSW assisted her with equipment loans. With the announcement that all MND cases would be prioritised as ‘urgent’ was wonderful news and within a week Annette was advised that her package funding had been allocated.

Concern 4. There are difficulties accessing assistive technology/home modification funding, including for necessary ventilation equipment.

There have been many instances in which individuals are unable to access assistive technology/home modification (AT/HM) funding. This is due to a few key issues, including:

- the lack of access and/or coordination with CHSP funding,
- the inability to bill equipment rentals through CHSP;
- the exclusion of AT/HM funding in the ‘priority pathway’ legislation change;
- the refusal of providers to provide AT/HM without the accompanying package; and
- an exclusion for ventilation equipment.

Each of these issues is explained in the following section.

The **CHSP program has been filling critical service gaps** for people diagnosed with MND who are awaiting aged care funding packages. Since the transition to Support at Home on 1 November 2025, however, it has become increasingly difficult to find a CHSP provider. This has impacted on accessing all service supports, but of particular concern is the inability to access AT/HM. In some cases this is due to a shrinking CHSP market. In others, it is due to the poor interface between CHSP and Support at Home.

The MND State Associations have been told that once a person is approved for Support at Home funding, they cannot access AT/HM funding or supports via the CHSP program. While the intention of this is apparently to limit ‘double dipping,’ in practice it means people living with MND have been approved for AT/HM funding but are unable to access it.

> **Case study 4: Unnecessary delays to access AT/HM**
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> A client of MND South Australia received an initial comprehensive and complex assessment from My Aged Care. The Support Coordinator requested a referral to Goods and Equipment via CHSP funding but was told it is no longer possible to access this program once approved for Support at Home. The Support at Home AT/HM funding, however, could not be immediately requested, but needed to be included in a support plan review request. Requesting a support plan review takes time, and then there is the additional wait for approved AT/HM funding to be made available. This policy change means the client is unable to get the immediate AT/HM support that they need. The Support Coordinator was informed that the only way to sidestep this problem would be to request a simple assessment for CHSP funding in the first instance, then request a comprehensive reassessment. While this may resolve the issue, it is administratively repetitive and unnecessarily complex.

The State Associations have equipment libraries that allow for rental of expensive AT needs, including specialised wheelchairs, eye gaze technology, BiPAP machines and similar. Currently, **the CHSP program will not compensate for equipment rental**. This is creating yet another barrier for many older people to receive the equipment they need. It should be noted that equipment rental is allowed under NDIS and saves that program an estimated 85% the cost of purchasing new equipment.

Many clients of the MND State Associations have received their Support at Home funding package within 30 days of approval, but are now finding that **their AT/HM funding, while approved for the highest level of $15,000, is a ‘standard’ priority** with a wait time of approximately 9 months. It is hoped that this is merely an oversight, as the separate funding pools require two changes to the legislation. It is highly problematic to not have both funding pools assessed as urgent priority, since older people living with MND need assistive technology and home modifications very soon after diagnosis.

The MND State Associations also report that when AT/HM funding is approved and assigned prior to receiving Support at Home funding, clients face barriers accessing the funding. This is because billing must go through an aged care provider, and **many providers are refusing to process AT/HM expenses without also having access to the approved Support at Home package** due to the limited administrative costs they can charge back on the AT/HM funding.

The **exclusion on respiratory equipment** is deeply concerning to MND Australia and the State Associations. It is the only known intervention that extends life for people living with MND. We are also concerned about unclear wording concerning speech-to-text technology. We repeat here our comments from earlier in the year [10].

It is extremely concerning the respiratory equipment has an exclusion from AT funding [11, p. 26]. The reason given for exclusion is because it is “Currently funded by others” [Ibid.] MND Australia is unaware of where someone reliant on My Aged Care would access other funding for respiratory equipment.

Such equipment is critical for people living with MND. The muscles involved in breathing are weakened by MND, which leads to difficulties in speaking, swallowing and coughing; regular breathing also becomes disrupted, leading to very shallow breathing. Such changes lead to less oxygen absorbed into the bloodstream and more difficulty exhaling carbon dioxide; these two physiological changes have profound impacts on overall health and functioning. During sleep these problems are exacerbated, when breathing becomes extremely shallow and disrupted [12].

Many people living with MND choose to utilise non-invasive ventilation (NIV), most often using a bi-level positive airway pressure (bi-PAP) machine. A bi-PAP machine is often initially utilised at night but this can progress to using breathing assistance around the clock. This involves wearing a mask over the nose and/or mouth that is connected to a pump that provides breathing assistance. This is far less invasive than a tracheotomy and also much safer from complications such as infection. The use of NIV/bi-PAP is associated with a significant extension of life for people living with MND, with better outcomes associated with earlier adoption. Researchers reported that bi-PAP users live on average 21 months, compared to 13.8 months for people who did not use a bi-PAP machine, and using a bi-PAP machine for more than 8 hours/day is associated with even better outcomes. Life expectancy was longer using the bi-PAP machine when compared to the use of Riluzole, one of a few pharmaceutical treatments for MND that is available in Australia [13].

This simple intervention can be life-changing for people living with MND and their families. In addition to extended life expectancy, the bi-PAP machine helps with better sleep, increased energy levels, fewer headaches, better cough and speech capability, and overall improved quality of life [14].

Case study 5: Administrative run-around forces self-funded ventilation support

Jayne cares for her mother Julie-Ann, who has MND. Julie-Ann’s MND has progressed to a point where she needs assistance with breathing. Ventilation equipment is specifically excluded from Support at Home funding because it is ‘funded elsewhere’, Jayne approached EnableNSW at the direction of My Aged Care to request access to a bi-PAP machine. EnableNSW informed Jayne that they were unable to assist because Julie-Ann was in receipt of a Federal Government Aged Care Package, and they have been directed to reject all such applicants.

Jayne has submitted complaints to both the Commonwealth Ombudsman and the Aged Care Quality Complaints Commission about her inability to access funding through either My Aged Care or EnableNSW. The Aged Care Quality Complaints Commission told her there was nothing they could do to rectify the issue. In consequence, Jayne and Julie-Ann have purchased a BiPAP machine at their own expense for $4,800.[15]

We urge My Aged Care to include ventilation in the list of approved AT. It is the single-most effective intervention available to people living with MND that is medially non-invasive, low-risk, and provides extensive benefits for health, wellbeing and improved life expectancy.

MND Australia is also concerned about the wording regarding assistive technology for communication. We note that “text to speech devices and software” are allowed by prescription [11, p. 21]. However, there are exclusions for “voice generation” and “speech flow devices” [11, p. 31]. Many people living with MND are dependent on text to speech devices to communicate in the latter stages of disease progression. MND Australia would like to see clearer wording concerning the funding of such devices to ensure ease of access for clients.

Recommendation 1. Support at Home package amounts must reflect the value of genuine clinical need.

Recommendation 2. The IAT should be a component of a holistic decision-making process that is led by clinical expertise. Use of the IAT should also make clear:

- What aspects of the assessment process are impacted
- What the guidelines are for automated decisions
- Whether the automated decision can be overturned and by whom, and
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Recommendation 5. AT/HM funding should be assessed at ‘High’ priority to align with the recently-created priority pathway for people living with MND.

Recommendation 6. AT funding should explicitly cover respiratory equipment and text-to-speech aides.

Term of reference 2. The impact of the co-payment contributions for independent services and everyday living services on the financial security and wellbeing of older Australians.

The impact of the co-pay structure cannot be understood independent of the many other ways that the Support at Home program creates financial stress for older Australians. MND Australia and the State Associations are concerned that:

Concern 5. There are multiple avenues through which older Australians living with MND are struggling to afford their care through My Aged Care, including:

- The co-pay structure, which places a financial burden on older Australians to afford their care.
- The unregulated costs of aged care providers, who have raised their prices for key services between 35-50% since 1 November 2025.
- The administrative fee that is added by providers when processing claims.
- Low package amounts and under-funding of care.
- Long wait times were also creating financial pressures; we are thankful that this stressor has been removed for people living with MND.

The way that these various factors interact and intensify financial stress and insecurity should be scrutinized. It is difficult to isolate the impact of the co-pay structure independent of the other factors.

With that caveat, the MND State Associations see the co-pay structure creating significant financial stress and hardship. The announcement by the Hon Mark Butler that showers and other essential services will be provided without a co-pay was very welcome news, as many older Australians living with MND were foregoing such critical services due to their inability to afford the co-pay.

While the ‘Everyday Living” category of service has the highest co-pay, items on this list such as gardening, shopping and domestic assistance can be accessed at lower rates privately. However, there is risk when accessing services independent of My Aged Care, which provides a level of oversight and accountability for providers. MND Australia and the State Associations are concerned that the co-pay model may unintentionally place some older Australians at risk by encouraging the access of private, potentially unregulated, service providers.

The co-pay structure must also be understood as particularly burdensome for older people living with MND. The inadequate package amounts, even at the highest level, means **there is already a co-pay structure built into Support at Home,** with adequate care costing people over $2 in private funding for every $1 received by the Australian government, prior to the co-pay calculation.[16]

> **Case study 6: Highest package amount inadequately subsidises care**
>
> Glenn was diagnosed with MND 4 years ago, at the age of 71. He receives the highest-level package amount through Support at Home, approximately $78,000 per year. Glenn recently wrote a letter to the Governor General outlining the age-based differential support amounts that older people receive compared to younger people with MND who are on the NDIS – a difference of over $200,000 per annum. While he says that the package amounts were adequate until paralysis set in, Glenn reports that he is currently spending $8,000 per week on his care. Glenn's receipt of the most generous package amount available through aged care covers just $1,500 of this cost, while he and his family are paying $6,500 per week out of pocket. In addition to living with advanced MND, Glenn also suffers from the guilt of the high financial burden his care is placing on the family; for this reason he is considering accessing voluntary assisted dying (VAD) at an earlier stage than he would otherwise choose, to lessen the financial impact on the household. [17]

Recommendation 7. A comprehensive analysis on the household financial impact of the Support at Home program should be conducted.

Recommendation 8. The risks associated with accessing care and support privately should be considered if the co-pay structure is maintained.

Term of reference 3. Trends and impact of pricing mechanisms on consumers.

MND Australia and the State Associations are extremely concerned about the amounts that older Australians are currently paying for their care.

Concern 6. MND Australia has undertaken an informal analysis of aged care provider fee structures, and have found that costs have risen approximately 35-50% since the introduction of the reforms on 1 November 2025. They are also 24-94% higher than NDIS costs for comparable services.

In this analysis, we examined the published pricing guides for five large aged care providers, providing services to every state and territory excepting the NT. (Note that this analysis was constrained by the availability of pricing sheets for the time period just prior to the reforms.) We examined six categories of care that are commonly accessed by older people living with MND: In-home nursing, allied health assistant, personal care, respite in the home, domestic assistance, and allied health (defaulting to occupational therapy where it was specified). We used the weekday standard rate for comparison. The individual price changes from each provider was then averaged for each service area.

We found that prices increased significantly across all six service areas pre- to post- aged care reform. Allied health services/OT had the lowest average increase of 35%, while the highest average increase was for in-home respite services, at 51%. See Table 1 for full list.

Table 1: *Average percent increase of costs pre- to post-aged care reform (1 November 2025)*

Item (day, in home, by the hour)	Average % increase
In-home nursing	**38%**
Allied Health Assistant	**38%**
Personal care	**42%**
Respite in home	**51%**
Domestic assistance	**38%**
Allied health/OT	**35%**

We also examined how costs for identical services compared to the NDIS pricing guides. For this analysis, we were able to include eleven service providers which covered of all geographic locations across Australia. However, to ensure we were comparing services like-for-like, we limited the analysis to just four services: In-home nursing, personal care, domestic assistance and allied health (again, selecting occupational therapy where it was specified).

This analysis revealed that older Australians are paying between 24% - 94% more for the same services that are provided via the NDIS. Once again, allied health/OT had the lowest difference, at 24%, while domestic assistance had the highest increase with older Australians paying an average of 94% more than participants on the NDIS. See Table 2 for the full list. We have provided a full report of the analysis in Appendix A.

Table 2: *Average percent difference between NDIS and aged care pricing. Aged care costs were consistently higher across all services compared.*

Item (day, in home, by the hour)	Average % increase over NDIS: all providers
In-home nursing	**42%**
Personal care	**69%**
Domestic assistance	**94%**
Allied health/OT	**24%**

MND Australia and the State Associations argue that it is unjust for older Australians living on fixed incomes to be paying a premium for the services required to care for their health and welfare. The dramatic increase in cost since 1 November 2025 means that even in instances where support packages have increased, the value has reduced.

The MND State Associations also report that **the administration fee that aged care providers attach to bills that they are processing for payment appear excessive** at times. For example, MND Queensland reports that they provide equipment bundles to older people living with MND for a reduced and subsidised rate of $5,000 per year. One provider added an additional fee of $3,000 merely for processing the bill, bringing the cost to the older person to a total of $8,000. This negates the discount that MND Queensland was providing. Similarly, MND Queensland bill allied health visits at a discounted rate of $180 but the provider charged it through at $260. This subsidised rate is not sustainable for the State Associations; they make up the difference through donations. To have the intention of the reduced rate erased by a provider who is merely processing the bill is not well received by older people living with MND who are already struggling with severe underfunding of their care.

It is not the intention of this analysis to imply that provider costs are unreasonable. We are aware that aged care service providers face many challenges in maintaining viability. Our point, however, is that the package amounts are capped, unlike NDIS funding, while the fees that older Australians are paying for services are not capped. The system needs to work for both older Australians and providers.

Recommendation 9. Support at Home packages need to accommodate reasonable fees charged for services by providers. Provider fees need to be regulated.

Term of reference 4. The adequacy of the financial hardship assistance for older Australians facing financial difficulty.

The MND State Associations report that the difficulty of filing for financial hardship assistance precludes people from accessing this option.

Concern 7. The difficulty of filing for financial hardship assistance precludes people from accessing this option.

Recommendation 10. A viable, accessible process should be established to request hardship assistance.

Term of reference 5. The impact on the residential aged care system, and hospitals.

The impact of the shortcomings of My Aged Care have a significant impact on hospital stays and over-stays, resulting from the inability of most people living with MND to access residential aged care.

Concern 8. The government commitment to provide more residential aged care beds is nearly meaningless for people diagnosed with MND because they are ‘clinically declined’ from most residential facilities. This leads to unnecessarily long hospitalisations and in some cases early use of voluntary assisted dying.

We support the commitment of the government in the budget to provide more residential aged care beds. However, this investment is nearly meaningless for people diagnosed with MND because they are ‘clinically declined’ from most residential facilities. There needs to be a commitment to providing both a skilled workforce and adequate financial resources for aged care facilities to provide intensive clinical care.

When aged care packages are delayed or inadequate, as they nearly always are, and/or when carers, themselves often older, can no longer manage, people with MND end up in hospital. It is difficult to discharge them without access to residential aged care, and the care they receive in hospital is often uninformed. Hospital stays are often terrifying for people living with MND as clinicians, nurses and doctors are so unfamiliar with the unique aspects of the disease that they are unable to provide appropriate support. As reflected in many of the case studies in this submission, a number of people turn to voluntary assisted dying at an earlier point than they would have otherwise chosen, due to the lack of care supports and the pressures placed on family members and carers.

Recommendation 11. The government should commit to upskilling the aged care workforce to deliver complex clinical care needs as well as providing adequate funding to care for older Australians with complex, intensive clinical needs in residential care settings.

Term of reference 6. The impact on older Australians transitioning from the Home Care Packages Program.

There were many problems experienced with the transition to the Support at Home program, some of which have been since rectified, while others are ongoing.

Concern 9. MND Australia documented the difficulties of the transition from the Home Care Packages to Support at Home in a submission to the Committee in January 2026. Key concerns and recommendations are provided in summary below, with a link to the full submission in the footnotes.

Key concerns raised:

1. Several people supported by MND State Associations are worse off under the new packages.
2. People diagnosed with MND are inconsistently treated regarding urgency [Rectified] and funding, with little hope for a timely reassessment.
3. The assessment algorithm is not sensitive to the realities of MND.
4. Prices charged by aged care providers have skyrocketed.
5. The co-pay for the 'Independence' category of expenses is inappropriate. [Rectified]
6. Accessing assistive technology, particularly communications devices and respiratory equipment, is problematic.

Our **key recommendations** for immediate action were as follows:

1. The value of Home Care packages should be transferred over to the Support at Home packages.
2. MND should be automatically assessed as urgent priority [Rectified] and at levels of funding that anticipate rapidly-changing needs.
3. The reassessment process should immediately review and rectify inappropriate assessments.
4. Any algorithm used in the assessment process should be adjusted to:
    a. Provide transparency about how criteria are applied in the assessment process;
    b. Recognise MND and other degenerative diseases as a rapidly progressing disease that requires predictive needs assessment; and
    c. Provide a recommendation that can be adjusted by a human assessor.
5. The fees charged by aged care providers should be regulated.

6. The purchasing power of Support at Home packages should be tracked and adjusted as needed.
7. The co-pay framework should be analysed to understand the financial burden it may be placing on individuals and households.
8. ‘Independence’ support services should not have a co-pay. [Rectified]
9. AT/HM funding should be available to people who have been unable to secure an aged care provider.
10. AT funding should explicitly cover respiratory equipment and text-to-speech aides.

Term of reference 7. Thin markets including those affected by geographic remoteness and population size.

MND Australia and the State Associations are very concerned about the inability of many people living with MND to access services.

Concern 10. Finding a provider and accessing needed services has been challenging for many clients of the MND State Associations. This is true for Support at Home and a widespread problem for people relying on CHSP, and is not solely experienced by people in rural, regional or remote areas.

The MND State Associations report that accessing CHSP services has become particularly difficult, often impossible, despite the ease with which codes can be accessed. Anecdotally there are fewer CHSP providers, and many of those that remain cannot handle the volume of requests and have long waiting lists.

Support at Home services can also be very difficult to access. This is true in rural, regional and remote areas but can also be true in urban and peri-urban settings. It can be difficult getting access to allied health professionals but some providers are also unresponsive to even basic needs.

Case study 7: NDIS support readily available but aged care providers scarce

An older woman in regional South Australia with quickly-progressing MND was hospitalised while awaiting her package funding. When the funding was received the options for an aged care provider were very few, and many said they could not manage her complex care (e.g., hoists, slings, suction unit, BiPAP and similar). A provider was finally engaged but when the support worker arrived she was only able to do basic house cleaning rather than provide clinical care. At this point one of the daughters, a nurse by training, stopped working to support her mother full-time while other family members were rostered on to help. The client chose voluntary assisted dying due to the difficulties with accessing appropriate support, and her concern about the high burden that was placed on her family. This devastating outcome is not solely due to thin markets in a regional location, as in the same community there are many support workers who care for NDIS clients with complex needs.

Case study 8: Thin markets in a 'major city' (MM 1 classification)

Tony and Gill live an hour outside of Brisbane, in a community that is classified as MM 1 – a major city. When Tony was diagnosed with MND 2 years ago, they were therefore not expecting trouble accessing services. Tony was initially put on CHSP funding. While they were provided with codes for various needed supports, they were unable to access any. They therefore self-funded much of Tony's initial needs. Minor home modifications, including grab rails and a ramp, were fashioned by a community support group that only charges for the cost of materials and made the items using volunteer labour. Tony had codes to pay for a speech pathologist but they were unable to find anyone via a CHSP provider, so organised and paid for that privately. As Tony's health deteriorated rapidly, after a long delay he was reassessed and approved for a Support at Home package, valued at approximately $63,000. Services can only be accessed via a provider, and their provider had no sense of urgency or understanding of Tony's situation. Gill found that working through MND Queensland was more efficient, because they understand MND and could anticipate Tony's needs. Through them she was able to organise a physiotherapist, a dietician and some speech pathology, which then had to be billed through the provider. Other, basic items were very slow; for example, Tony desperately needed a pressure cushion, a toilet seat raiser and a shower base. All of these minor but necessary items were wrapped up in red tape, and after long delays Gill sometimes purchased the items herself and submitted for reimbursement, but not always successfully. After waiting for the shower base, which had been prescribed as necessary by an occupational therapist, Gill purchased one herself; however, the provider refused to pay for it because she hadn't gotten multiple quotes.

Because of the struggles to access and pay for the care he needed, Tony chose voluntary assisted dying. Gill is still receiving bills for items that carry a co-pay. She estimates they spent at least $10,000 out of pocket, and wonders how people without savings would manage. Gill had a long career as a registered nurse, and she knows how the health system should work. “I didn't know how My Aged Care works though.” She found everything was a fight that takes an emotional toll on carers like herself who just want to focus on spending time with their loved one. Her assessment is that for the providers it is all about the money, which creates an unethical dynamic in providing needed services and care for older Australians, which would never be tolerated in the health care system. She felt the overarching message was, “Go away and die, we're not interested in you.” [19]

Recommendation 12. Access to services needs to be improved across Australia. CHSP should be maintained with proper investment. Providers need to be held accountable for timely, appropriate service provision.

References and notes

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Appendix A

Aged care price increases: Summary

April 2026

MND Australia has analysed the price lists of major aged care providers to confirm whether prices have increased, and if so by how much, since the aged care reforms were enacted on 1 November 2025. We also wanted to understand whether costs are equitable between people living with a disability under the age of 65 and those aged 65 plus.

Question 1: Have consumer prices increased in the last 12 months, and if so by how much?

First, we examined online pricing guides from prior to 1 November and compared them to price guides after the reforms took place. Limited by access to older price guides, this analysis was confined to five major carers: BlueCare, BaptCare, ECH, Silverchain and Anglicare. These providers covered every state and territory excepting the NT; see Table one for geographic information.

Table 1: *List of providers and their geographic locations for comparison of pre- to post-reform pricing guides*

Providers assessed for price increases, 2024 – 2025/26	
Provider	**Geographic location**
BlueCare (Uniting Care Queensland)	Queensland and Northern NSW
BaptCare	NSW, ACT, Victoria, Tasmania, SA, WA
ECH	South Australia
Silverchain	WA, NSW, Victoria, SA, Queensland, ACT
Anglicare	NSW, ACT

All prices examined were the hourly rate for weekday services (standard charge) provided in the home. In two instances there was no matching data; BlueCare did not have provide an hourly rate for allied health/OT pre-reform, and ECH did not provide an hourly rate for in-home respite care pre-reform. In these instances the data was removed from the analyses. Silverchain prices pre-reform were based on Victorian prices, while post-reform prices were standardized for all states and territories except the NT. NT costs were therefore not represented in these analyses.

Five comparable items were considered: In-home nursing, allied health assistant, personal care, in-home respite care, domestic assistance and allied health professional. Note that the allied health professional price was a general listing for some price sheets (e.g., "allied health"), while for others a range of allied health specialities was listed. When this was the case, we used the listing for an occupational therapist (OT).

Findings

We found that, on average, prices increased between 35 - 51% across these categories, see Table 2. In-home respite care had the highest average cost increase, at 51%, while allied health/OT rates were the lowest at 35%. Appendix A provides all published costs and their increases pre- to post-reform.

Table 2: *Average percent increase of costs pre-to post-aged care reform (1 November 2025)*

Item (day, in home, by the hour)	Average % increase
In-home nursing	**38.4**
Allied Health Assistant	**37.8**
Personal care	**42**
Respite in home	**51**
Domestic assistance	**38.4**
Allied health/OT	**34.8**

For **in-home nursing**, the average cost increase was 38%. ECH had the lowest price increase of just 4%, from $153/hour to $160/hour. The largest increase in this category was Silverchain, rising from $140/hour to $220/hour – an increase of 57%.

Allied health/OT prices rose on average 35%. ECH again had the lowest increase of 18%, from $189/hour to $230/hour. Silverchain had the greatest increase of 46% ($175/hour to $255/hour).

Allied health assistant costs rose an average of 38% across the five providers. Silverchain had the lowest price increase of 7% ($175 to $188), while the greatest increase was BlueCare at 84% ($106 to $195).

Personal care costs rose an average of 42%. ECH had the lowest rise at 27% ($87 to $119). Silverchain had the greatest cost increase at 56% ($82 to $127), followed closely by Anglicare at 52% ($85 to $129).

In-home respite care had the highest rate of average cost increase, at 51%. Silverchain had the highest rates of increase at 56% ($82 to $127), while BaptCare had the lowest, at 44% ($83 to $119).

Hourly rates for **domestic assistance** rose an average of 38%. ECH and Anglicare had the lowest increases of 27% ($87 to $119) and 28% ($85 to $109) respectively. The highest rate increase was BlueCare, at 51% ($89 to $135).

Question 2: Are older Australians being charged at comparable rates to NDIS participants?

The second question we wanted to answer was how aged care prices compare to NDIS pricing caps. This is relevant because in many instances the services being delivered are identical; the only difference is the age of the recipient. The NDIS also closely regulates the amount it will reimburse for services.

We were able to include a much broader range of aged care providers for this question, because we needed only their current price sheets which they are required by law to publish. We could then compare this to the current NDIS price guide. See Table 2 for the list of eleven included aged care providers for this analysis. All states and territories are covered in this analysis, including the NT. However, it should be noted that for some providers there were NT-specific pricing sheets which tended to be higher than for the other states. In these situations we reported on the lower prices.

Table 3: *List of providers and their geographic locations for comparison of pricing guides to NDIS published prices*

Providers compared to NDIS pricing, 2025/26	
Provider	**Geographic location**
BlueCare (Uniting Care Queensland)	Queensland and Northern NSW
BaptCare	NSW, ACT, Victoria, Tasmania, SA, WA
ECH	South Australia
Silverchain	WA, NSW, Victoria, SA, Queensland, ACT
Anglicare	NSW, ACT
Bolton Clarke	Queensland, NSW, Victoria, SA
Helping Hand	SA
Australian Unity	Victoria, NSW, Queensland
Uniting	National
Regis	Tasmania, NT, Victoria, Queensland, WA
Care Connect	Victoria, NSW, Queensland

All prices examined were the hourly rate for weekday services (standard charge) provided in the home. To ensure a comparison of like with like, we limited this analysis to four services: in-home nursing, personal care, domestic assistance and allied health/OT.

The Regis price list did not include a cost for personal care services; they were therefore excluded from this category. Care Connect's published price list included three costs for each service: the highest possible cost, the lowest possible cost, and the median cost. The analyses here used the published median costs. Silverchain prices used here reflect their standard national prices which is consistent across all states and territories except the NT.

Findings

All costs that were compared in this analysis were higher for people reliant on aged care than for NDIS participants. Domestic assistance reflected the greatest difference at 94% more expensive in the aged care sector than in the disability sector. Personal care averaged 69% higher prices charged for older people, in-home nursing was 42% higher for aged care, while allied health/OT was the closest in cost, but still averaged 24% higher than NDIS pricing guidelines. See Table 4.

Table 4: *Average percent difference between NDIS and aged care pricing. Aged care costs were consistently higher across all services compared.*

Item (day, in home, by the hour)	Average % increase over NDIS: all providers
In-home nursing	**42%**
Personal care	**69%**
Domestic assistance	**94%**
Allied health/OT	**24%**

In-home nursing is reimbursed at $136 per hour by the NDIS for a registered nurse. BlueCare reflected the highest increases in comparison, at $224/hour, representing 65% cost difference. The lowest price difference was ECH, at 18% higher (at $160/hour).

Personal care costs $70/hour on the NDIS. BlueCare again had the highest comparative price, at $135, representing a 93% difference in cost structures. Bolton Clarke had the closest prices to the NDIS for personal care services, at $99/hour, representing a 41% difference.

Domestic assistance through the NDIS is reimbursed at $59/hour. BlueCare had the highest prices compared to the NDIS, charging $135/hour for domestic assistance, a difference of 129%. The closest to NDIS pricing were $99/hour for Bolton Clarke (68% difference) and $100 for Helping Hand (69% difference).

Allied health/OT services are reimbursed by the NDIS at $194/hour. Regis had the greatest discrepancy to the NDIS price at $293/hour (a difference of 51%), followed closely by BlueCare, at $290/hour (40%). Helping Hand were closest to NDIS pricing, at $210/hour, a difference of only 8%.

The full analyses can be found in Appendix B.

Why does this matter?

We were interested in conducting this analysis because we have received many reports that the per-hour cost of Support at Home aged care provision has risen dramatically since the introduction of the reforms on 1 November 2026. We have therefore attempted to include as many major aged care providers as possible in this analysis.

While the analysis was hampered by the inability to source pricing guides for 2024/25 (pre-reform), we were able to include five major aged care providers in our analyses that reflected nearly all the geography of Australia. What we found is that prices have increased significantly – ranging between 38 – 51% across six different services.

This matters because, while in some (but not all) instances funding package amounts have risen, the value of the packages has decreased in real terms. Combined with the introduction of a co-pay for many non-clinical services, many older people who are reliant on aged care can no longer afford some services.

There is also the matter of intergenerational equity. The government is carefully controlling the cost of services for people with a disability who are NDIS participants, most of whom are under the age of 65 since those 65+ do not qualify for the scheme. It is hard to understand why older Australians, many on fixed incomes, are expected to pay significantly more, in some cases double, than younger people who require the same service.

MND Australia does not assume that the prices charged by aged care providers is ‘unfair.’ Maintaining financial viability as an aged care provider can be difficult. However, the issue is that these costs are passed directly on to older people while package amounts are fixed and do not cater for the true cost of care.

Appendix A.a: Cost increases for age care providers, pre- to post- 1 November 2025.

Item	BlueCare 12/24	BlueCare 11/25	% diff	BaptCare 01/5	BaptCare 11/25	% diff	ECH 08/25	ECH 11/25	% diff	Silverchain 2024	Silverchain 2025	% diff
In-home nursing	157	224	43%	138	198	43%	153	160	4%	140	220	57%
Allied Health Assistant	105.75	195	84%	130	186	43%	121	140	14%	175	188	7%
Personal care	102.75	135	31%	82.5	119	44%	87	119	27%	81.5	127	56%
Respite in home	88.75	135	52%	82.5	119	44%		119	0%	81.5	127	56%
Domestic assistance	89.25	135	51%	82.5	116	41%	87	119	27%	79.5	115	45%
Allied health/OT	--	290		170	226	33%	189	230	18%	175	255	46%

Item	Anglicare 07/25	Anglicare 11/25	% diff	Average % increase: all providers
In-home nursing	148	214	45%	**38.4**
Allied Health Assistant	117	165	41%	**37.8**
Personal care	85	129	52%	**42**
Respite in home	85	129	52%	**51.0**
Domestic assistance	85	109	28%	**38.4**
Allied health/OT	169	240	42%	**34.8**

Appendix A.b: Cost differentials between ten aged care providers compared to NDIS 2025/26 pricing guides.

Item (day, in home, by the hour)	NDIS	BlueCare, Nov 25	% diff	BaptCare, Nov 2025	% diff	Bolton Clarke 2025	% diff	ECH Nov 2025	% diff	Helping Hand 2025	% diff
In-home nursing	136	224	65%	198	46%	169	24%	160	18%	180	32%
Personal care	70	135	93%	119	70%	99	41%	119	70%	110	57%
Domestic assistance	59	135	129%	116	97%	99	68%	119	102%	100	69%
Allied health/OT	194	290	49%	226	16%	229	18%	230	19%	210	8%

Item (day, in home, by the hour)	Australian Unity 2025	% diff	Anglicare Nov 2025	% diff	Uniting 2026	% diff	Regis 2026	% diff	Care Connect 2026	% diff	Average % increase over NDIS: all providers
In-home nursing	214	57%	214	57%	180	32%	189	39%	197	45%	**42%**
Personal care	124	77%	129	84%	110	57%			122	74%	**69%**
Domestic assistance	117	98%	109	85%	110	86%	121	105%	116	97%	**94%**
Allied health/OT	235	21%	240	24%	220	13%	293	51%	232	20%	**24%**