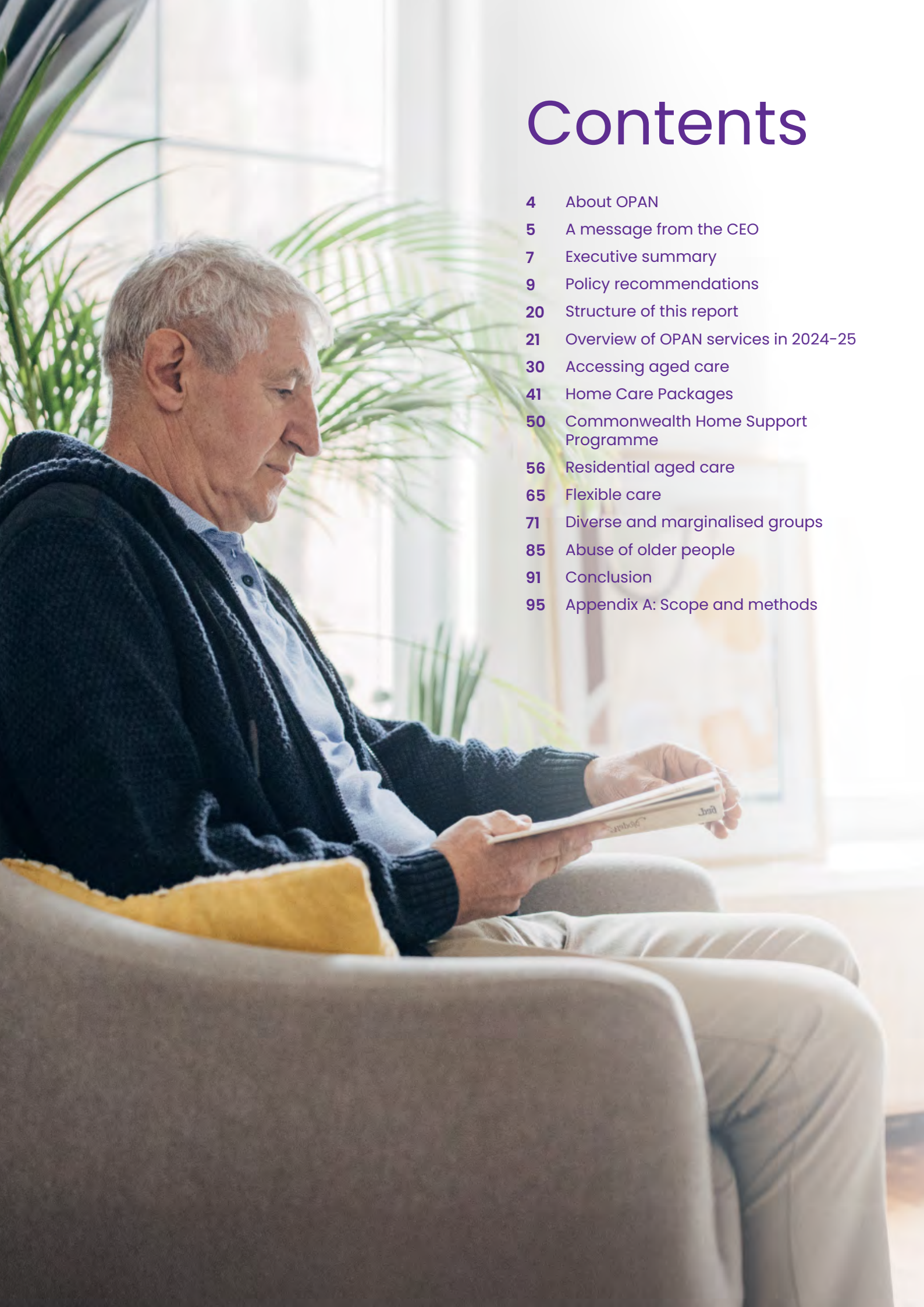
OPAN Older Persons Advocacy Network

The National Aged Care Advocacy Program Presenting Issues – Report 5

July 2024 – June 2025



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Acknowledgement of Country

OPAN acknowledges the Aboriginal and Torres Strait Islander peoples who are the traditional custodians of the lands and waterways on which we work. We pay our respects to Elders past and present. We acknowledge that sovereignty has never been ceded, that it was and always will be Aboriginal and Torres Strait Islander land.

Content warning

This report explores the negative experiences and abuse of many older people seeking to access, or receiving, aged care services in Australia during the 2024-25 financial year.

If you are impacted by the content and need some support, you can contact:

- 1300 22 4636 **beyondblue** - support for anxiety, depression and suicide prevention
- 13 11 14 **Lifeline** - crisis support and suicide prevention
- **headtohealth.gov.au** - information, resources and online mental health services
- 1800 700 600 Aged Care Advocacy Line, **Older Persons Advocacy Network (OPAN)** - connects you with the advocacy organisation in your state and territory for advocacy, information and education services
- 1800 100 500 **The National Dementia Helpline** - for emotional support and guidance, support to navigate services and programs, and information and advice
- 1800 737 732 **1800 RESPECT** - national sexual assault and domestic violence counselling service
- 1800 184 527 **Q Life** - LGBTI peer support and referral
- **Link-Up services on AIATSIS website** - the 'Where to get help' page on the AIATSIS website provides a list of contact details for state and territory Link-Up services that support people of the Stolen Generations
- 1800 779 379 **Open Place** - support service for Forgotten Australians
- 1300 656 419 or 02 9284 9888 **The Australian Human Rights Commission (AHRC)** - the AHRC National Information Service provides information and referrals about a range of human rights and discrimination issues

About OPAN

The Older Persons Advocacy Network (OPAN) is a national network comprised of 9 state and territory organisations that have been successfully delivering advocacy, information, and education services to older people across Australia for more than 35 years.

The OPAN network members are:

Australian Capital Territory:
ACT Disability, Aged and Carer Advocacy Services (ADACAS)

New South Wales:
Seniors Rights Service

Northern Territory:
Darwin Community Legal Service (DCLS)

Northern Territory Central:
Catholic Care NT (CCNT)

Queensland:
Aged and Disability Advocacy Australia (ADA Australia)

South Australia:
Aged Rights Advocacy Service (ARAS)

Tasmania:
Advocacy Tasmania

Victoria:
Elder Rights Australia (ERA)

Western Australia:
Advocare

OPAN is funded by the Australian Government Department of Health, Disability and Ageing. OPAN peak body and its members deliver the National Aged Care Advocacy Program (NACAP), supporting older people and their representatives to address issues related to Australian Government-funded aged care services.

OPAN aims to provide a national voice for individual aged care advocacy and promote excellence and national consistency in the delivery of advocacy services under the NACAP.

OPAN is an independent body that is always on the side of the older person we are supporting. This independence is a key strength both for individual advocacy and for our systemic advocacy.

ADACAS Advocacy

Seniors Rights Service

Darwin Community Legal Service

CatholicCare NT

ADA Australia
Your Aged and Disability Advocates

aras
Aged Rights Advocacy Service

Advocacy Tasmania
in your corner

ERA Elder Rights Australia
Promoting the human rights of all older people

Advocare
Empowering older people in WA

A message from the CEO

Craig Gear OAM

In the 4-and-a-half years since the Aged Care Royal Commission handed down its landmark report, successive Labor and Coalition governments have invested billions of dollars and significant political capital in large-scale reform. Unfortunately, reform can feel painstakingly slow for older seeking and receiving aged care. We are not yet at the transformed aged care system older people need and the Royal Commission called for.

OPAN's NACAP Presenting Issues Report, which examines the more than 52,000 cases of information and advocacy support our national 9-member network has provided to older people, their families and other supporters in the last financial year, is a stark reminder of how much work still needs to be done.

This in-depth analysis of the qualitative and quantitative data collected by nearly 250 aged care advocates and financial advocacy officers across every state and territory shines a light on the cracks in a system that's close to breaking point.

While we highlight the significant continuing issues for older people, our policy and reform recommendations are solution focused. We know the whole system is under significant strain and access pressure, and is seeking to change for the better. At the same time, we need to call out the continuing issues for older people – that is OPAN's systemic advocacy role.

Older people's inability to access the aged care services they were entitled to was one of the top presenting issues across all types of aged care in 2024-25. This illustrates the human cost of the 120,000-plus people on the wait list for assessment or reassessment, the 108,000-plus people on the wait list for a Home Care Package, and reports from the aged care provider peak and StewartBrown that residential aged care is effectively full, with an occupancy rate between 94% and 98%.

While access has been a recurring issue across all 5 of OPAN's Presenting Issues Reports, this year has seen the emergence of new and concerning trends.

Roadblocks in the new Single Assessment System mean too many older people are waiting too long for assessment or reassessment for the appropriate level of in-home care. According to our advocates, some assessment organisations have such a backlog of referrals, they are no longer answering or returning calls.

Following the implementation of the Single Assessment System in December 2024, OPAN's national contact centre experienced an influx of calls from older people who had been referred to us by local Members of Parliament and organisations such as My Aged Care and the Aged Care Quality and Safety Commission in an attempt to expedite the assessment process. Whilst it's our job to support older people to access the care they are entitled to, we can only do so within the limits of the system.

Once an older person has been approved for the appropriate level of in-home support, they typically wait at least another 12 months to receive it. Untenable delays such as these put older people at significant risk of adverse outcomes. No older person should have to wait for more than 30 days for these critical supports.

Decreasing numbers of providers, particularly in regional, rural and remote areas, exacerbate the trouble older people have accessing services after they have been approved for them. The Australian Institute of Health and Welfare reports a 1.97 per cent decrease in aged care service providers in 2024-25, in contrast to a 3.28 per cent increase in client population. OPAN's qualitative data suggests this is due, at least in part, to more service providers pulling out of the Commonwealth Home Support Programme (CHSP) in anticipation of upcoming changes under the new Support at Home program. Older people on the Home Care Package (HCP) waitlist frequently access CHSP as an interim measure.

The immediate release of 20,000 new HCPs followed by 20,000 new Support at Home places before 31 December 2025 will go some way to alleviating the issues outlined above – so long as there is adequate planning around workforce to match the flow of places, particularly over the summer holiday period.

Despite its limitations, OPAN believes the Support at Home program has the potential to deliver more timely services in the community and to give older people more choice and control over their short-term and ongoing aged care. But that intended outcome can only be achieved if the Single Assessment System is unblocked.

We are also hopeful the new rights-based Act – the Aged Care Royal Commission's number 1 recommendation – will bring about the cultural shift that is needed in the sector.

In this year's report, issues related to poor communication, and a lack of information and support to make choices and decisions top the list for the third consecutive year. When the new Act comes into effect on 1 November 2025, providers who fail to support older people to make decisions about the way they want to live their lives will be in breach of their legal obligations to deliver services in line with the Statement of Rights. OPAN has developed a suite of resources to support the sector through this change process.

Our advocates will also actively raise the voices of older people with government and other sector stakeholders throughout this transition period to address issues and any unintended consequences as they arise. To this end, we are expanding our advocacy outreach to better support our vision of a society in which older people are heard, informed, and respected, and where they enjoy and exercise their human rights.

The National Aged Care Advocacy Program (NACAP) Presenting Issues Report for 2024-25 confirms that the issues in 2023-24 have not been addressed, and older people continue to face challenges and breaches of human rights when accessing and receiving aged care.

On a positive note, we are pleased by the actions taken by the department and Services Australia to streamline the hardship application process and introduce improvements in application processing time. We congratulate both agencies on this work and the commitment to a 28 day application processing time. The numerous cases outlined in this report demonstrate the need for a robust, streamlined and accessible safety net for co-contributions to be waived for those of low means. It is clearly evident in this report, that this process requires only an appropriate level of evidence and that older people should be trusted in relation to the everyday living costs they incur.

OPAN's Presenting Issues Report 5 is filled with so many cases where care, support and the system have fallen below expectations, but I am heartened by a number of case examples where aged care providers have, with the intervention of an independent aged care advocate, listened to the older person, improved communication and rectified a problem. I point you to case study 29 on page 79.

> *"The older person had spent much of their life concealing their sexual orientation due to fear of discrimination and stigma. Mardi Gras provided a unique and meaningful occasion for them to engage in an affirming and joyful celebration of their identity. In attendance was their partner of over 40 years, whose presence added deeply personal significance to the event.*
>
> *The residential aged care staff demonstrated warmth and respect, embracing the opportunity to create an inclusive environment. Both the resident and their partner expressed profound gratitude for the support and visibility offered. They shared that learning about the rights of older people and the availability of advocacy support gave them confidence and reassurance for the future. The residential aged care staff were enthusiastic about fostering a culture of inclusion and committed to ongoing learning about LGBTI ageing experiences."*

This is the aged care system we should seek for all of us, and we can get there. It is our fervent hope that the rights now enshrined in the new Act, together with increased protections of those rights, will be reflected in next year's report.

Executive summary

OPAN network members provided 52,206 instances of advocacy and information support in 2024-25, an increase of 18% since 2023-24. Demand for aged care advocacy continues to grow faster than the aged care population with this 18% increase in OPAN services in the past financial year far exceeding the 3.28% increase in the aged care population in the same period. The services provided equate to a potential reach of the 4% of people who were receiving aged care services as of 30 June 2024.

The systemic barriers combined with a lack of knowledge, ageist and ableist beliefs, and poor communication skills of aged care assessors, providers, and other services meant that the issues described throughout this report were often experienced to a greater extent by people in diverse and marginalised groups.

The proportion of OPAN advocacy and information services related to Home Care Packages (HCP) and residential aged care continues to be disproportionately high when compared to the population of older people receiving those aged care services.

On the other hand, OPAN services related to the Commonwealth Home Support Programme (CHSP) were lower than would be expected based on the number of older people receiving aged care services. However, there was a 54% increase in information provisions relating to CHSP in the 2024-25 financial year when compared to 2023-24, and a 28% increase in information provisions relating to HCPs. An analysis of the case studies and reflections provided by OPAN network members showed that many of these contacts resulted from provider actions in anticipation of the upcoming Support at Home program.

The qualitative data from Quarter 3 and Quarter 4 of 2024-25 suggested emerging issues with the new Single Assessment System, which was implemented in November 2024. Advocates had first-hand experience of new Single Assessment System service staff being unfamiliar with the aged care system and providing incorrect information to older people regarding service options that may meet their needs. This, combined with Single Assessment System staffing and service shortages, wait time for assessments and other barriers to older people participating in the assessment process meant that many older people are prevented from accessing the aged care they need.

In addition, wait-times to be allocated approved Home Care Packages continue to be an issue. This led to increased advocacy cases and information provisions as there is also a lack of available CHSP services to fill the gap in the interim. For CHSP advocacy cases, the top issues related to accessing CHSP services. The advocacy cases show an alarming decrease in the availability of CHSP services in the past year, with many CHSP services closing, being short-staffed, or no longer accepting new clients. Particular CHSP service shortages were reported for simple home maintenance (e.g. gardening and gutter cleaning), cleaning, transport and allied health services – in particular, access to Occupational Therapists.

Increasingly, advocacy cases reported difficulties for older people in securing a residential aged care place if they have high behavioural support needs (e.g. as a result of a mental illness or dementia) and complex interacting disabilities. For example, this included people with a long-term disability compounded by a series of later life traumatic health events. Advocacy casework showed that many providers are 'screening' older people with these needs and deciding not to offer them a place.

The majority of advocacy cases for Home Care Packages and residential aged care related to service delivery, which is in contrast to CHSP where the top issues related to accessing aged care.

Nonetheless, the top service delivery issue across CHSP, HCP, residential aged care and flexible care was consistent, relating to communication, decision-making and care planning. Even after direct requests from older people, aged care providers refused to provide them with the information and support they needed to make decisions and plan their aged care. Many older people who contacted OPAN network members expressed being unclear about the outcome of their engagement with My Aged Care, Services Australia and assessment teams. After receiving contradictory or unclear advice from these services, older people sought the support of an advocate. Ageist beliefs, including a lack of respect for older people's decision-making rights, were a theme underpinning many advocacy cases.

Financial issues relating to fees and charges in HCPs and residential aged care continued to be a top issue. Older people were often not given clear and transparent information about their aged care fees and charges by their provider, My Aged Care or Services Australia. In many cases, older people

had not been advised of the need for an income and means assessment or the option of a financial hardship application with Services Australia. This sometimes resulted in significant debt accruing, the older person experiencing significant stress and financial hardship, and many providers beginning debt collection proceedings.

Ageist beliefs, including a lack of respect for older people's decision-making rights was a theme underpinning many advocacy cases. The poor communication and lack of clear information in a format the older person can understand described above is an abuse of older people's right to be supported to make informed decisions about their aged care. In some cases, aged care providers enabled or even exacerbated these issues by excluding them from information and decisions about their aged care, or by following the directions of people other than the older person receiving the care.

Older people reported lengthy delays, lack of communication, and contradictory advice from service providers about the provision of assistive technology. This, combined with a lack of available Occupational Therapists for assessments, meant that many older people went without assistive technologies that were essential for their function and independence.

The 2024-25 Presenting Issues report shows that the initial stages of some key investments in aged care reform, including the Single Assessment System services and Support at Home, are unlikely to address the systemic issues in aged care which lead to persistent human rights breaches. The extent to which the new rights-based Aged Care Act impacts aged care for older people will be tested by OPAN network members' advocates in the coming year and reported in the next Presenting Issues report.

Policy recommendations

OPAN provides policy and systemic advocacy advice as part of the National Aged Care Advocacy Program (NACAP) workplan, a requirement of the Department of Health, Disability and Ageing. Based on the evidence from the lived experience of older people supported by aged care advocacy in the last year, OPAN provides 59 recommendations to improve the aged care journey for older people.

Many of the top issues in 2025 were consistent with those raised in the 2023 and 2024 Presenting Issues reports. As a result, of the 59 recommendations this year, 34 are carried over from the 2023 and 2024 reports. Recommendations are colour coded as follows:

In making these recommendations the timeline and point in the aged care reform journey has been taken into account. OPAN also recognises the role of the independent Inspector of Aged Care (IGAC) and this Presenting Issues Report, and recommendations. The IGAC plays a vital role in accountability and oversight of the system. OPAN believes the information in this report will assist the IGAC in their work but notes it was drafted at a similar time to the release of the IGAC statutory report on the implementation of the Royal Commission recommendations[1].

The first recommendation by OPAN in the 2024 Presenting Issues Report was to implement the new rights-based Aged Care Act. OPAN is hopeful that the implementation of the new Act on 1 November 2025 will result in a reduction of the breaches of human rights experienced by older people which were outlined in 2024 and continue in 2025 including, but not limited to:

- equitable access to services and timely access to culturally appropriate assessment and reassessment as each older person's physical, psychological and emotional needs change
- communication and information in the older person's preferred language or method of communication, with access to interpreters, preferred support person or aged care advocate, and communication aids as required
- exercise choice and make decisions that affect their lives and the manner of their death, have access to independent support to make those decisions where necessary, and have those decisions respected and followed, including where they involve personal risk
- have their identity, culture, spirituality and diversity valued and upheld when accessing or receiving aged care services
- make complaints without fear of reprisal, and have their complaints dealt with effectively, promptly and to their satisfaction
- an independent advocate or support person of their choice.

However, new issues arose this year due to changes to the aged care system. In particular, significantly longer wait times for assessment and access to in-home care services under both CHSP and HCP programs. There were reports of CHSP and HCP stating they were ceasing or reducing services due to the upcoming Support at Home program. There were also concerns raised in information provisions about fees and charges under the future Support at Home program.

[1] Office of the Inspector General of Aged Care, 2025. Progress Report – Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety. https://www.igac.gov.au/sites/default/files/2025-09/2025-progress-report-on-the-implementation-of-the-recommendations-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

Older people's rights

Breaches of older people's human rights across their aged care journey continued to be a dominant theme in 2025. Day-to-day breaches show that ageist and ableist attitudes persist throughout the system. Aged care assessors and providers continue to communicate with and provide information to other people and exclude the older person seeking or receiving aged care services. This occurs even when no active and relevant substitute decision-making authority is in place for the older person, and the older person is able to make decisions for themselves. Poor communication with older people by My Aged Care, aged care assessors and aged care providers continues to contribute to older people not having their right to be informed and make decisions about their care and services upheld.

OPAN looks forward to the supported decision-making provisions under the new Aged Care Act which will help drive culture change by requiring providers and registered supporters to respect and uphold the older persons rights to privacy and sharing of information in the manner they have directed, with care delivered in line with their preferences.

While training for frontline aged care staff in human rights has begun, it must continue to be a priority and requirement for all.

Recommendation 1	**Continue to prioritise information, education and training on older people's rights and how the intent of the Aged Care Act can be implemented for older people and aged care providers from 1 November 2025.**
Recommendation 2	**Invest in aged care provider cultural change initiatives through compulsory participation in human rights training. Make access to aged care subsidies subject to documented training completion by a set date, similar to child-safe organisation training requirements.**
Recommendation 3	**Compel residential aged care providers to allow independent advocates to deliver a minimum of one Statement or Rights-based NACAP education session to aged care residents and staff on an annual basis.**
Recommendation 4	**Apply learnings from the disability sector's progress to the aged care system to ensure the rights of all older people are upheld, particularly in relation to recognising dignity of risk when supporting older people to make decisions.**
Recommendation 5	**Collaboration between the Australian government and state and territory substitute decision-making entities (e.g. public advocates) to ensure all aged care providers have access to training on understanding the application of supported decision-making principles and substitute decision-making instruments, including when it is appropriate to seek a decision from a formally appointed substitute decision-maker and for which types of decisions.**
Recommendation 6	**Provide clear guidance to older people and their supporters on how to lodge complaints about breaches of their rights by aged care services, including My Aged Care, assessors and providers.**
Recommendation 7	**Develop and require targeted education for aged care providers on understanding older people's decision-making rights, including their rights to be supported to make decisions and their rights when they have an active substitute decision-maker.**

Workforce

While much work has been done to address aged care workforce issues in the past year, all of the recommendations relating to the aged care workforce made in 2023 still apply.

Recommendation 8	**Continue to invest in growing the aged care workforce by supporting providers to attract, recruit and retain appropriately skilled aged care workers.**
Recommendation 9	**Immediately enhance older people's access to high-demand and lower-risk services - such as cleaning and gardening - through increased funding for the Commonwealth Home Support Programme (CHSP) and Support at Home services. Bring forward regulatory reforms that enable sole traders to become registered aged care providers for the delivery of lower-risk services, with required adherence to the Statement of Rights, and Aged Care Code of Conduct.**
Recommendation 10	**Address workforce shortages in thin markets - such as the provision of culturally safe, bilingual and bicultural care, or in regional, rural and remote Australia - through regulatory reforms that enable older people to employ trusted family or friends to provide care at home.**
Recommendation 11	**Continue to invest in, and expand, the rollout of OPAN diversity education to build the capacity of providers to plan for improved access and care for priority population groups.**
Recommendation 12	**Mandate allied health professional care minutes in residential aged care and ensure Support at Home Assistive Technology and Home Modifications (AT-HM) funding and service list price caps do not create barriers to older people's access to the allied health care they need.**

Accessing aged care

There continue to be significant barriers to accessing aged care within the complex ecosystem of eligibility, assessment and service delivery. The Inspector-General of Aged Care found '…there is a clear case for the department to review and make enhancements to My Aged Care to ensure it is meeting consumers' needs as the one-stop-shop for aged care information and support. The Inspector-General's upcoming review of My Aged Care will explore these issues in greater detail.'[2].

The new Single Assessment System presented new barriers to older people in accessing aged care this year, which must be monitored closely to see if there are persistent flaws in the system or transition issues that will resolve with time.

Complexity and a lack of combined processes and consistent messaging between Services Australia, assessors, My Aged Care, and providers leaves older people unable to navigate their aged care journey and falling through the gaps with associated financial implications.

OPAN acknowledges and welcomes the significant work in the past financial year in streamlining and improving Services Australia processes, including reducing 18 pieces of evidence required for a financial hardship application to 4. OPAN looks forward to further reform in this area.

[2] p.83. Office of the Inspector General of Aged Care, 2025. Progress Report – Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety. https://www.igac.gov.au/sites/default/files/2025-09/2025-progress-report-on-the-implementation-of-the-recommendations-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

Recommendation 13	**Continue to invest in information and education services for the general public about My Aged Care and the range and scope of aged care services available.**
Recommendation 14	**Review My Aged Care communications in consultation with older people from diverse and marginalised groups and incorporate principles from the United Nations Disability-Inclusive Communications Guidelines and the National Standards for Disability Services.**
Recommendation 15	**Develop and produce accessible aged care information in plain English and in a range of other languages and accessible formats.**
Recommendation 16	**Continue to invest in face-to-face supports for older people accessing aged care services with Aged Care Specialist Officers at every Services Australia centre across Australia. Enable a 'no wrong door approach' across the NACAP, the care finder program and the Elder Care Support program.**
Recommendation 17	**Ensure the diverse needs of older people drive implementation of the Single Assessment System and that assessment services:** • are underpinned by a knowledgeable and skilled workforce • are appropriately resourced to provide timely face-to-face aged care assessment and referral • are transparent about aged care assessment wait times and benchmarking data • use video communication technology to shorten wait times when this does not negatively impact the efficacy or outcomes of assessments. For example, where an older person provides their consent, has access to an appropriately trained and experienced support person in person during the assessment, and up-to-date technology with a good internet connection • use enhanced client management technology to address service access blocks and resolve communication issues between My Aged Care and the aged care assessment workforce • improve communication processes between assessors, older people, their families and supporters, • provide streamlined access to timely support plan reviews and re-assessment.
Recommendation 18	**Ensure key performance indicators within the Single Assessment System account for the additional time required for aged care assessors to engage with older people with disabilities, from diverse and marginalised groups and people living in rural, regional and remote areas.**
Recommendation 19	**Ensure all My Aged Care staff are appropriately trained and competent in:** • identifying what stage an older person is at in their aged care access journey • communicating effectively and identifying the caller's needs • engaging in difficult conversations • problem solving • dealing with angry or frustrated callers.

Recommendation 20	Improve My Aged Care communications to older people after completion of assessment to ensure older people understand which services they have been approved for and what the next steps are to secure and commence services.
Recommendation 21	Clarify the responsible agency for supporting veterans and their widows/widowers to access aged care and clarify processes to support them in navigating the system, including completion of income and assets assessments.
Recommendation 22	Improve My Aged Care communication and provide a clear resolution pathway for older people when a provider cannot deliver some or all services after they have accepted a referral.
Recommendation 23	Create combined and consistent plain-English materials for older people, aged care provider staff, Services Australia staff, needs assessors, and My Aged Care on the Support at Home program and associated income and assets testing and participant contributions.
Recommendation 24	Monitor delays in clinical assessments under the Single Assessment System and implement measures to ensure timely access to clinical assessments and reassessments.
Recommendation 25	Create combined My Aged Care and Single Assessment Services processes for identifying older people who have been waiting for an assessment for more than a month and responding to these wait times.
Recommendation 26	Create My Aged Care processes for identifying older people who have had referral codes assigned, but the services are yet to be provided, and for following up and offering support to connect them with services.
Recommendation 27	Create priority aged care access pathways for people who are unnecessarily in hospital due to a lack of available aged care services. If aged care services are not available, the Commonwealth government should pay the relevant aged care subsidy to the health service to provide aged care type services for 'Nursing Home Type Patients' who have been in hospital for more than 35 days and are not receiving acute treatment.
Recommendation 28	Ensure funding and service gaps are addressed to allow older Aboriginal and Torres Strait Islander peoples to realise their right to opportunities, and assistance, to stay connected (if the individual so chooses) with community, Country and Island Home.

Service availability

Many of these recommendations relate to ensuring that older people receive the support they need to remain living at home. As the majority of older people now stay at home for much longer prior to entering residential aged care (if at all), it is important that we get the new Support at Home program right.

With the new Support at Home program due to incorporate Home Care Packages on 1 November 2025 and Commonwealth Home Support Programme (CHSP) services no earlier than July 2027, the 2022–23 recommendations relating to this new program still apply.

The call for the urgent release of additional Home Care Packages before 1 November 2025 was made by OPAN prior to the decision to delay the commencement of the Aged Care Act 2024. The Royal Commission recommended a continued flow of demand driven packages rather than a capped system. The urgency of this request is highlighted by the advocacy support sought in 2025 by older people who are in urgent need of services at home, and where CHSP services are not available to fill the gap.

Recommendation 29	**The Australian Government must ensure appropriate and sustainable funding of the new Support at Home program so that older people have timely access to the services they need and are not forced into residential aged care due to lack of access to appropriate supports and services at home.**
Recommendation 30	**Retain a consumer-directed care approach to choice and decision-making, with flexibility to meet individual needs in the new Support at Home program. The government must ensure thin market grants to address unique service access challenges and maintain service viability and access for older people living in regional, rural and remote areas, older people with disability, and some diverse and marginalised groups.**
Recommendation 31	**Ensure older people are not displaced from their community. The government must develop measures to support residential aged care providers considering closure to stay open or to rebuild within the same area.**
Recommendation 32	**Clarify responsibility of providers and My Aged Care in proactively contacting older people and informing them of the steps they need to undertake following the sudden closure or exit of a Home Care Package provider.**
Recommendation 33	**There must be increased funding for the CHSP between now and 2027, when the CHSP may be incorporated into the Support at Home program, to ensure that older people's lower-level service needs are met and they do not unnecessarily transition to a Home Care Package or Support at Home program prior to 2027.**
Recommendation 34	**Ensure older people can remain living at home and not unnecessarily enter residential aged care. The government must develop measures to support CHSP and Home Care Package and Support at Home providers to remain open and delivering services where there are no other providers available to fill the gap if they exit.**

Recommendation 35	**Create cross-sectoral registration processes for aged care workers and providers across aged care, NDIS and veterans' care, in line with Draft Recommendation 1.1 of the Productivity Commission's Interim Report 'Delivering quality care more efficiently'[3].**
Recommendation 36	**Lift the lifetime cap on home modification funding and adopt an equitable, culturally responsive and flexible funding model that enables all older people - including Aboriginal and Torres Strait Islander older people - to age safely in place, regardless of tenure, location or socioeconomic status.**

Service delivery

Older people continue to have their human rights breached in the delivery of aged care services across the system. Providers fail to communicate directly with older people and in a format that they can understand, which leads to older people not having control over the aged care services they receive.

Access to appropriate assistive technology and home modification assessments and funding arose as a dominant issue for people receiving aged care services at home. While the new Support at Home Assistive Technology and Home Modifications (AT-HM) funding is hoped to partially address these concerns, it remains to be seen if the funding tiers and caps will be sufficient to meet the costs of assessment, purchase and installation, and wrap-around supports for the majority of older people.

Recommendation 37	**Ensure that provider's responsibilities to develop care plans jointly with older people, uphold their right to choice and decision-making, and provide plans on request to older people or their registered supporters (if requested by the older person) are clarified and enforced by the Aged Care Quality and Safety Commission.**
Recommendation 38	**Strengthen provider obligations and Aged Care Quality and Safety Commission actions to ensure providers communicate efficiently, transparently and professionally with older people about service changes and closures.**
Recommendation 39	**Explore innovative options for integrated aged care and disability services to ensure older people with long-term disability acquired earlier in life receive the services they need within the aged care system.**
Recommendation 40	**Provide rights-based guidance to providers on navigating inclusions and exclusions of the service list and AT-HM list for Support at Home to ensure that older people receive the goods and services they require.**
Recommendation 41	**Ensure older people have equivalent access to Goods, Equipment and Assistive Technology (GEAT) and home modifications under the CHSP, to prevent unnecessary transition to Support at Home from July 2027 purely for this purpose. This should include providing CHSP clients with immediate access to the AT-HM loans scheme while waiting either for GEAT funding or a Support at Home place and expedited access to home modifications for older people unable to be discharged from hospital without them.**

[3] Productivity Commission, 2025. Interim report – Delivering quality care more efficiently. Australian Government. Available at: https://www.pc.gov.au/inquiries/current/quality-care/interim

Recommendation 42	**Create an expedited referral process for AT-HM as per the end-of-life pathway so people can receive necessary assistive technology and home modifications while a recipient of services under the Transition Care Program or Short-Term Restorative Care (STRC) pathway.**
Recommendation 43	**Monitor whether people's care management needs are being appropriately addressed under Support at Home, noting the 10% budget deduction for care management activities, limited access to the care management supplement and guidance on approved care management activities in the Support at Home program handbook. If not, consider prioritising the rollout of a multi-provider model to enable access to a care partner with clinical qualifications who is independent to the service provider or an equivalent interim measure.**
Recommendation 44	**Ensure the restorative care pathway under Support at Home program addresses current issues in the STRC programme and supports smoother transitions between hospital and home. This includes improved guidance on use of restorative care funding and AT-HM funding to remove barriers to appropriate care and support.**
Recommendation 45	**In line with the Interim First Nations Aged Care Commissioner's recommendation[4] mainstream approaches to aged care information and service provision need to be transformed and co-designed in genuine partnership with Aboriginal and Torres Strait Islander older peoples.**

[4] Interim First Nations Aged Care Commissioner, 2024. Transforming Aged Care for Aboriginal and Torres Strait Islander people. Available from Transforming Aged Care for Aboriginal and Torres Strait Islander people | Australian Government Department of Health, Disability and Ageing

Financial issues

Continuing from 2023 and 2024 is the need to improve older people's ability to understand, query and make decisions about fees and charges so they can better utilise their often limited funds.

The numerous cases related to fees and charges issues throughout this report highlight the need for revised and streamlined financial hardship processes and for these to require only an appropriate level of evidence, and that older people are trusted in relation to reporting their everyday living costs. OPAN is hopeful the new Aged Care Act Higher Everyday Living Fees and Agreements legislative requirements and Rules will stamp out residential aged care provider practices around inappropriate 'additional services' fees and provide greater consumer protections for older people.

Recommendations have also been made to address the significant increase in contacts to OPAN network members in the last quarter of 2024-25 due to older people's concerns about consumer co-contributions under the new Support at Home program. The 2024 recommendations to invest in education for frontline staff on fees and charges in aged care became even more urgent in 2025 as there were many reports of misinformation by providers about the upcoming Support at Home program.

Recommendation 46	**Invest in provider education, especially frontline staff, on fees and charges in aged care so that everyone can explain to older people how the aged care funding system works on a basic level, including grandfathering and new entrants.**
Recommendation 47	**Establish effective and targeted information and education for older people and service providers about changes to income and assets assessment, and fees and charges, under the new Act and Support at Home.**
Recommendation 48	**Increase access to affordable transport and social support to attend activities and appointments where required for older people. This could be addressed by allowing people living in residential aged care and with a Support at Home place access to Commonwealth Home Support Programme (CHSP) community transport and social support services.**
Recommendation 49	**Following the implementation of Support at Home, monitor the transfer of funds issues that are so prominent under the Home Care Packages program so that no older person goes without essential services and assistive technology after transferring to a new provider under the Support at Home program. This includes issues relating to the 56-day plus 28-day extension period to engage a new provider, the 70-day period for transfer of funds, and transparency around unspent funds transfers.**
Recommendation 50	**Monitor the effectiveness of the introduction of consumer protections for Higher Everyday Living Fees in the new Aged Care Act and monitor existing Extra/Additional Service Fee arrangements that continue until 31 October 2026 for people who agreed before 1 November 2025.**
Recommendation 51	**Establish a priority pathway to request a reconsideration or resubmission of an income and assets test if the older person suspects that Services Australia has made an error or someone else (for example a substitute decision-maker) has not submitted all relevant information.**

Recommendation 52	**Continued investment in face-to-face supports for older people accessing aged care services including Aged Care Specialist Officers at all Services Australia centres and increased resources in the Services Australia team assessing aged care financial hardship applications to reduce wait times for an assessment to no longer than 28 days.**
Recommendation 53	**Automatically flag any older person eligible for both Commonwealth Rent Assistance and Support at Home program by Services Australia as potentially eligible for financial hardship assistance and provide them with information on eligibility criteria and sources of assistance to apply.**
Recommendation 54	**Implement changes to the processes used to assess an older person's financial position, to ensure the level of debt experienced by the older person is taken into consideration. Debt accrues over time and can have a significant impact on the amount of money people have to spend on necessary items like food, medicines and health care.**
Recommendation 55	**Improve communication and education to registered providers regarding the need to clearly explain to older people how to apply for financial hardship fee reductions or waivers.**
Recommendation 56	**Improve regulation of provider debt collection practices, particularly their use of external debt recovery agencies.**

Aged care advocacy

There was a significant increase in information provision by network members in the final quarter of 2024-25 under the existing National Aged Care Advocacy Program (NACAP), due largely to concerns and queries about the new Support at Home program. This highlights the ability of network members to manage workflow and address a broad range of older people's issues. It also highlights the likely continued increase in demand for NACAP services due to the implementation of the new Act and Support at Home.

Recommendation 57	**Promote and refer to the NACAP throughout the aged care journey as an independent source of information and support. This will help improve older people's experience of aged care, address aged care concerns and build the capacity of aged care providers to resolve issues.**
Recommendation 58	**Continue to educate staff working in My Aged Care, the care finder program, Elder Care Support program, aged care providers and aged care assessors on the role of independent aged care advocates in enabling older people to have a voice and exercise choice in addressing and resolving issues with their current provider or in choosing a new provider.**
Recommendation 59	**Provide independent aged care advocates with a Services Australia provider number so they can access the aged care provider phone line, or other pathways for fast tracking calls, to deliver timely support for older people in resolving their issues.**

Structure of this report

This report analyses the quantitative data on information provisions and advocacy cases reported by OPAN network members as well as the hundreds of de-identified case studies and reflections on presenting issues provided by network members[5].

The report begins with an overview of the number of information provisions and advocacy cases, with explorations of who the contact people were and comparisons across aged care programs in the frequency of contacts. An overview of the top issues by aged care program in 2024-25 is also provided in this section.

The remainder of the report then focuses on an in-depth exploration of the network member advocacy cases only (i.e. not information provisions), as only advocacy cases deliver an in-depth understanding of the issues faced by older people and allow presenting issues to be defined and recorded by the network member.

Each in-depth chapter begins with an overview of the most common presenting issues, drawn from advocacy case data. This is followed by an examination of the underlying causes and impacts of these issues, based on qualitative analysis of 413 advocacy case examples provided by OPAN network members, which reflect the top and emerging issues in 2024-25.

The issues faced by older people in accessing aged care are considered first. Key issues and emerging trends are then outlined by aged care program, in order of how commonly issues related to these programs were raised in advocacy cases; Home Care Packages, Commonwealth Home Support Programme (CHSP), residential aged care, and flexible care[6].

Service delivery and financial issues are presented together as they are the responsibility of aged care providers. However, the financial issues section also considers, where relevant, the role of other entities - such as Services Australia - in compounding issues resulting from poor provider financial management.

Access and service delivery issues experienced by older people in diverse and marginalised groups are then examined. The final chapter reviews trends in network member data and case examples related to abuse of older people by individuals and institutions other than waged care providers.

[5] This report refers to counts of cases and counts of issues. For a detailed explanation of methodology please refer to Appendix A - Scope and methods.

[6] Flexible care includes respite care, Innovative Care, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC), Multi-Purpose Services, respite care, the Short-Term Restorative Care (STRC) pathway and the Transition Care Programme (TCP).

Overview of OPAN services in 2024-25

Figure 1. Total number of National Aged Care Advocacy Program (NACAP) services vs total aged care client population.

OPAN network members provided 52,206 instances of advocacy and information support in 2024-25, an increase of 18% since 2023-24. This 17.57% increase in OPAN services in the past financial year far exceeds the 3.28% increase in the aged care population in the same period (from 1,267,660 in 2023-24 to 1,309,203 in 2024-25). (Figure 1)

Figure 2. Potential reach of aged care client population by OPAN services.

The OPAN services provided equate to a potential reach of the 4% of people who were receiving aged care services as of 30 June 2024[7] (Figure 2).

Advocacy accounted for 26% of services provided by network members (13,486 cases), with information provisions accounting for the remaining 74% (38,720 instances).

The amount of information provisions per financial year has almost doubled since 2022-23 (20,064 provisions in 2022-23), increasing by a further 30% in the last financial year (30,185 provisions in 2023-24). Advocacy cases have remained relatively stable since last financial year (14,219 cases in 2023-24).

[7] Source: Aged care data snapshot-2024. AIHW GEN Aged Care Data, 8 October 2024. https://www.gen-agedcaredata.gov.au/resources/access-data/2024/october/aged-care-data-snapshot-2024

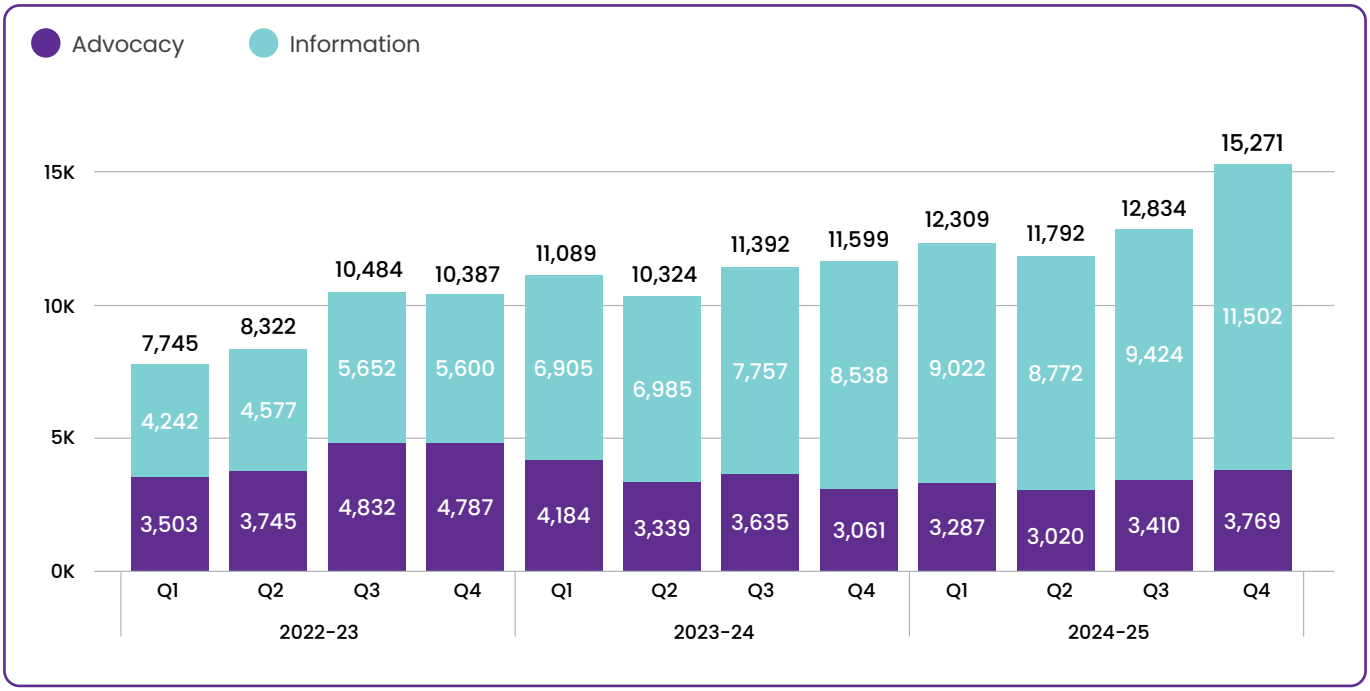

Figure 3. Number of services by type since July 2022.

There was a significant increase in the number of information provisions in Quarter 4 of the 2024-25 Financial Year (Figure 3).

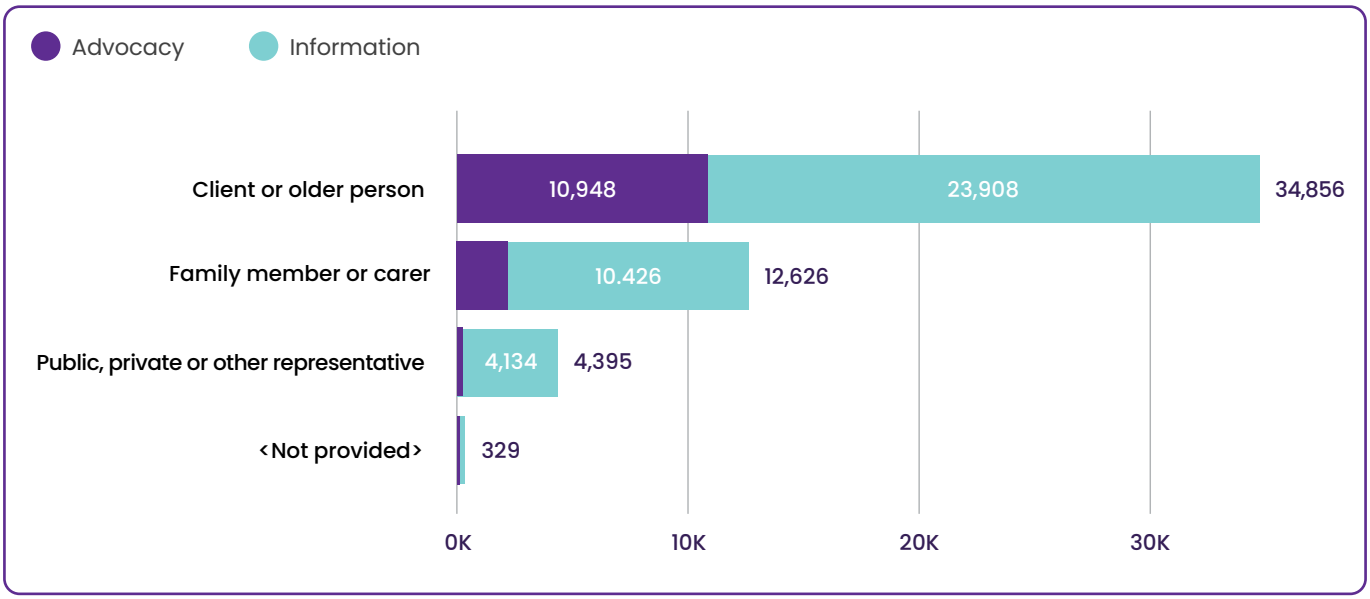

Figure 4. Number of services by primary contact and service type.

The primary contact with OPAN was most often the older person themselves (67% of services, 10,948 advocacy cases and 23,908 information provisions). The older person's family member or carer was the primary contact in 24% of cases (2,200 advocacy cases and 10,426 information provisions). In 8% of cases, the primary contact was the older person's public, private or other representative (e.g. a privately appointed or public substitute[8]) (261 advocacy cases and 4,134 information provisions). (Figure 4)

[8] A substitute decision-maker is a person permitted under the law to make decisions on behalf of someone who does not have decision-making ability. Depending on the state or territory, a privately appointed substitute decision-maker may be called an enduring guardian, an attorney, an agent, a person responsible or a decision-maker. Public substitute decision-makers are often called Guardians or Administrators).

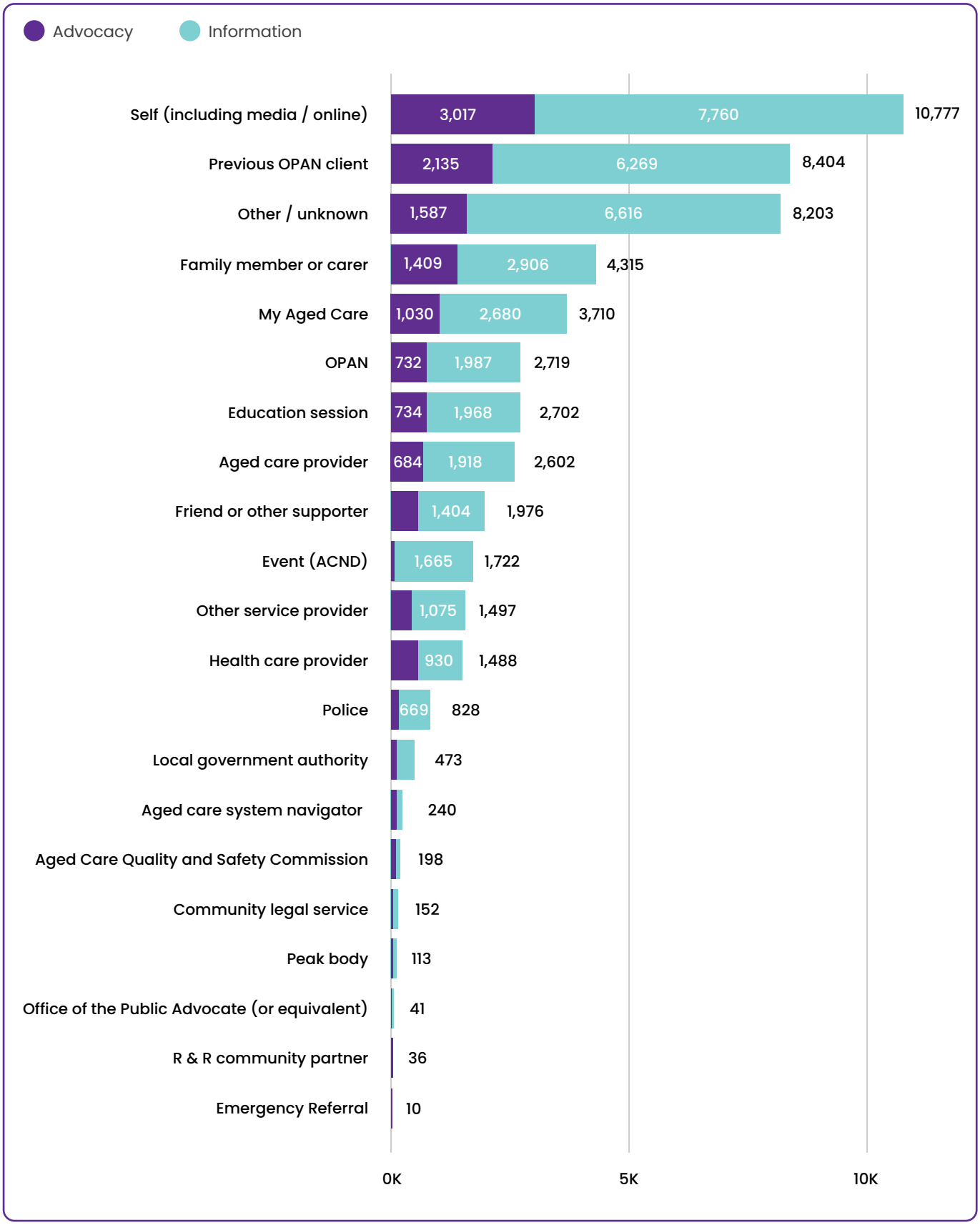

Figure 5. Number of services by referral source and service type.

Most commonly, older people found out about and contacted network members themselves (i.e. a self-referral), including after searching online and hearing about OPAN in the media (21% of advocacy and information services). Other common referral pathways included being a previous client of OPAN (16%) or referral by a family member or carer (8%). My Aged Care staff and aged care provider staff referred older people to network members in 7% and 5% of OPAN service instances, respectively. (Figure 5)

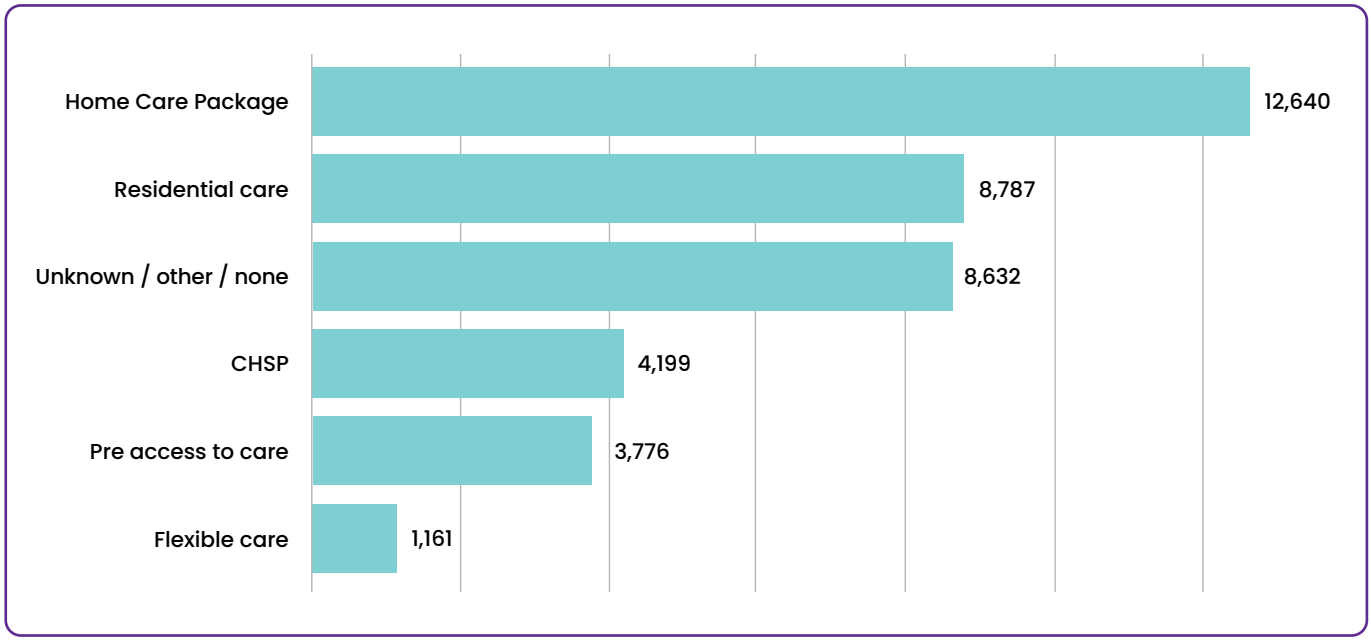

Figure 6. Number of information provisions by current aged care type(s) of client.

Of the 38,720 information provisions in 2024-25, Home Care Packages (HCPs) were the most common self-identified current aged care type[9] of older people in information provisions (33% (12,640) of information provisions). This was followed by residential aged care (23%, 8,787 provisions), Commonwealth Home Support Programme (CHSP) (11%, 4,199 provisions), and flexible care[10] (3%, 1,161 provisions). People who had not yet accessed aged care services accounted for 10% (3,766) of information provisions. Given the nature of the contacts and limited information provided by the caller, it is unsurprising that 22% (8,632) of information provision cases in 2024-25 were reported as an 'other/ unknown/none' aged care type. (Figure 6)

As shown in Figure 3 and explored above, there was a significant increase in information provisions in the last quarter of 2024-25. Comparing the count of information provisions by current aged care type(s) of clients in Figure 6 to the 2023-24 data shows that there was a 54% increase in information provisions relating to CHSP in the 2024-25 financial year when compared to 2023-24 (from 2,730 provisions in 2023-24 to 4,199 provisions in 2024-25). There was also a 28% increase in information provisions relating to HCPs (9,899 in 2023-24 to 12,640 in 2024-25) and 20% increase in information provisions relating to residential aged care (7,339 in 2023-24 to 8,787 in 2024-25).

[9] 'Current aged care type(s) of client' is what is reported by the client during their contact with OPAN. Once advocates have gained an in-depth understanding of the issues during an advocacy case it may be revealed that the issues raised actually relate to another type of service. For the majority of this report where the focus is on advocacy casework, the 'aged care type' identified by advocates is therefore used.

[10] 'Flexible care includes respite care, Disability Support for Older Australians (DSOA), Innovative Care, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC), Multi-Purpose Services, respite care, the Short-Term Restorative Care (STRC) pathway and the Transition Care Programme (TCP).

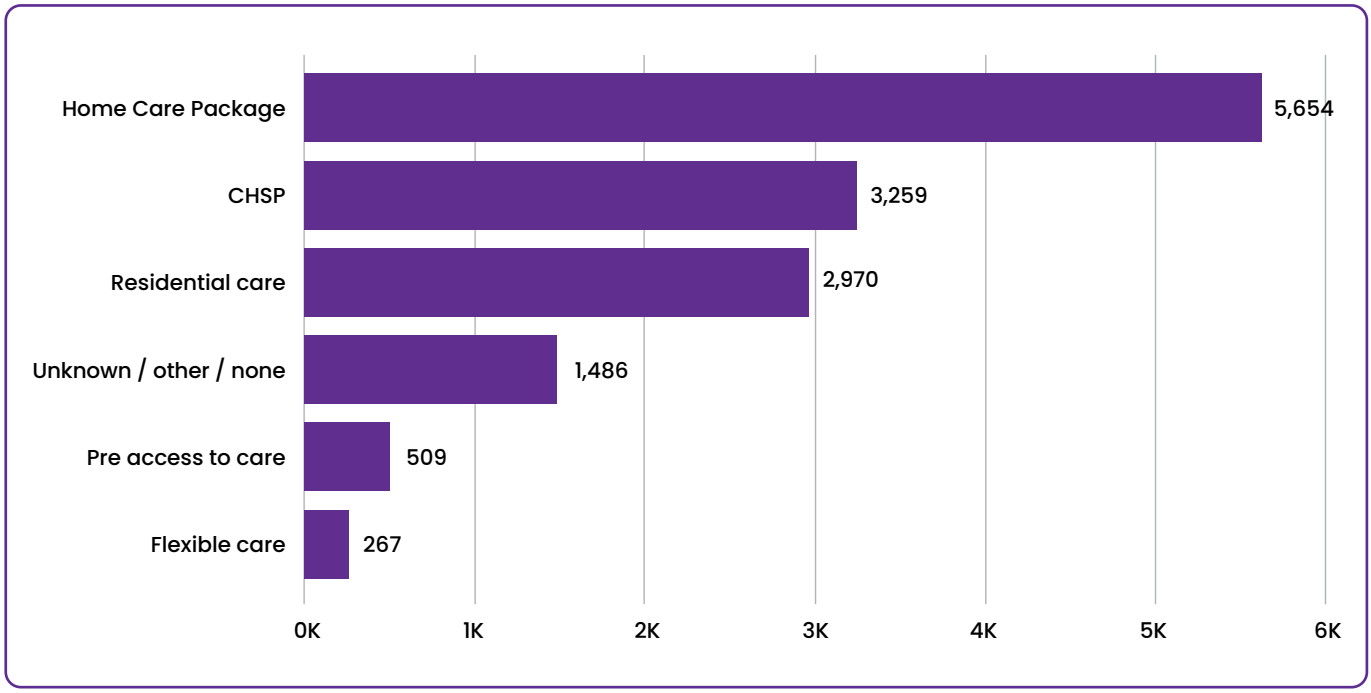

Figure 7. Number of advocacy cases by aged care type relating to client's issue.

Following a similar pattern to information provisions, HCPs were the most common type of aged care type related to issues raised in the 13,486 advocacy cases in 2024-25 (42% (5,654) of advocacy cases). However, in contrast to information provisions, CHSP was the next most common aged care type (24%, 3,259 cases), followed by residential aged care (22%, 2,970 cases) and flexible care (2%, 267 cases). Older people who were yet to access aged care services accounted for 4% of advocacy cases (509 cases). The aged care type was recorded as 'other/unknown/none' in 11% of advocacy cases (1,486 cases). Qualitative analysis showed that often the 'other/unknown' service type related to issues with My Aged Care or Services Australia, including Aged Care Specialist Officers, Regional Assessment Services (RASs), Aged Care Assessment Teams (ACATs)[11], and/or the Single Assessment System services that replaced RAS' and ACATs in December 2024. (Figure 7)

[11] In Victoria, the Aged Care Assessment Team (ACAT) function is known as the Aged Care Assessment Service (ACAS). For simplicity, ACAT is used throughout this report.

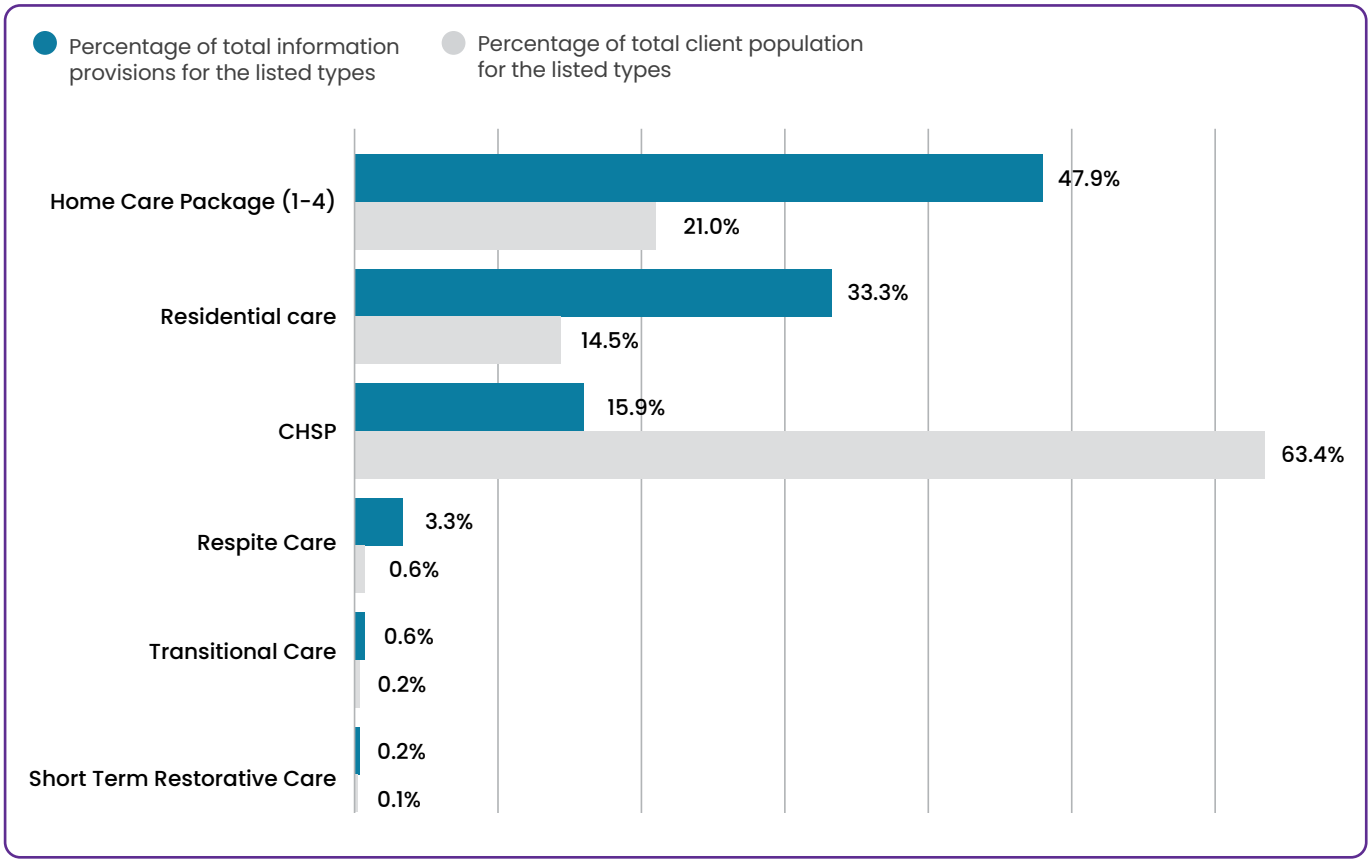

Figure 8. Comparison of aged care types by proportion of information provisions for clients and proportion of client population.

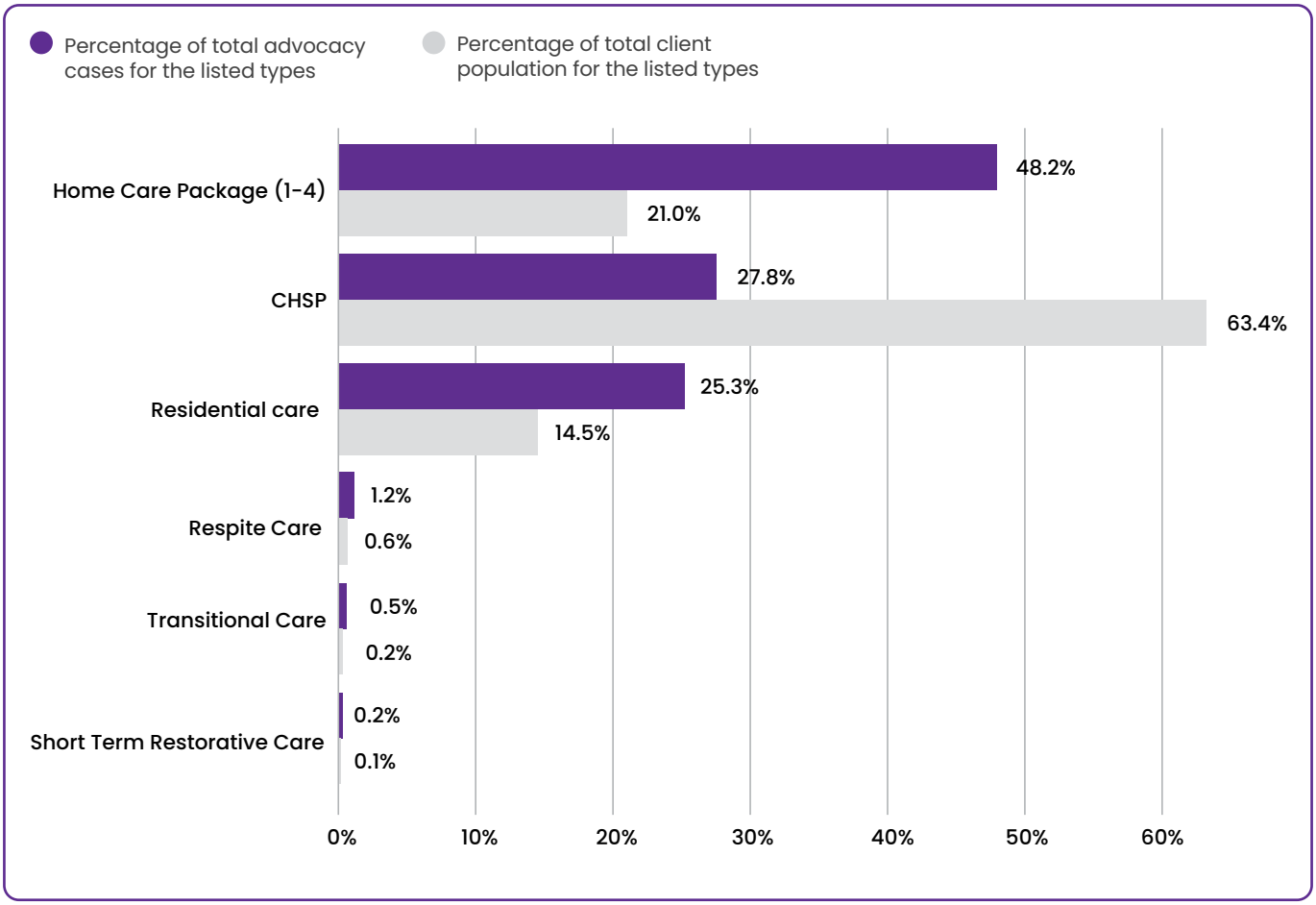

Figure 9. Comparison of aged care types by proportion related to issues in advocacy and proportion of client population.

The proportion of information provisions and advocacy cases relating to HCPs and residential aged care is disproportionately high. This is demonstrated in Figures 8 and 9 by comparing the aged care population data[12] to the equivalent numbers[13] for information provisions (self-identified aged care type of client) and advocacy cases (aged care type issues related to).

There were 2 times more advocacy cases (Figure 9) and 1.5 times more information provisions (Figure 8) related to HCPs than would be expected by the size of the aged care population for this aged care type.

There were 1.5 times more advocacy cases (Figure 9) and information provisions (Figure 8) related to residential aged care than would be expected by the size of the aged care population for this aged care type.

On the other hand, there were 5.9 times fewer advocacy cases (Figure 9) and 2.6 times fewer information provisions (Figure 8) related to CHSP than would be expected by the size of the aged care population for this aged care type.

[12] Source: AIHW Aged care data snapshot - third release, October 2024. https://www.gen-agedcaredata.gov.au/resources/access-data/2024/october/aged-care-data-snapshot-2024

[13] For the purposes of this comparison, the OPAN data is presented by the service type groupings used in the GEN "Aged care data snapshot - 2024" release. It is noted that one person may have more than one aged service type at the time of their contact with OPAN so percentages may add to over 100%.

Top issues arising across all advocacy casework

The in-depth understanding gained from advocacy cases allows key issues to be identified and reported by network members, which is not possible through information provisions. The remainder of this chapter therefore examines issues identified through advocacy cases only (i.e. not information provisions).

Table 1. Number of advocacy cases by issue category.

Issue category	Total cases
Service delivery	5,501
Accessing aged care	5,299
Financial	2,422
Abuse of older person	645
Out of scope	512
<Category not provided>	448
EPOA / guardian info (not abuse)	207
Other - in scope (NACAP)	203
COVID related	5
Total	**13,486**

The most common issues in advocacy cases related to service delivery (41% of advocacy cases) and accessing aged care (39% of advocacy cases) (5,501 and 5,299 of the 13,486 advocacy cases, respectively) (Table 1). These were also the top two issue categories across advocacy casework in 2023-24, however the proportion of advocacy cases relating to accessing aged care increased by 23% (32% of advocacy cases in 2023-24 related to accessing aged care, compared to 39% in 2024-25).

Financial issues were the next most common category in advocacy cases, comprising 18% of advocacy cases in 2024-25 (2,428 cases) (Table 1).

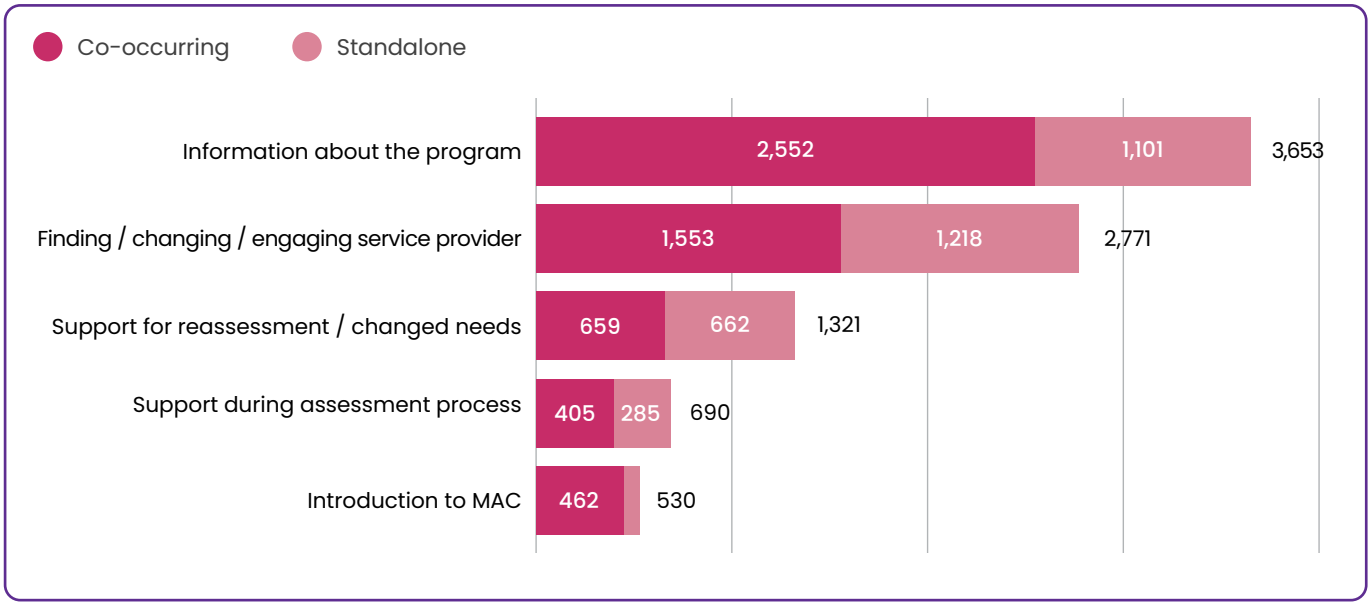

Figure 10. Top five accessing aged care issues by category (count of issues).

Advocacy related to accessing aged care occurred in 5,299 cases in 2024-25 (Table 1). The most common issues were information about the program and finding and engaging a service provider, followed by support for reassessments and support for assessments (Figure 10).

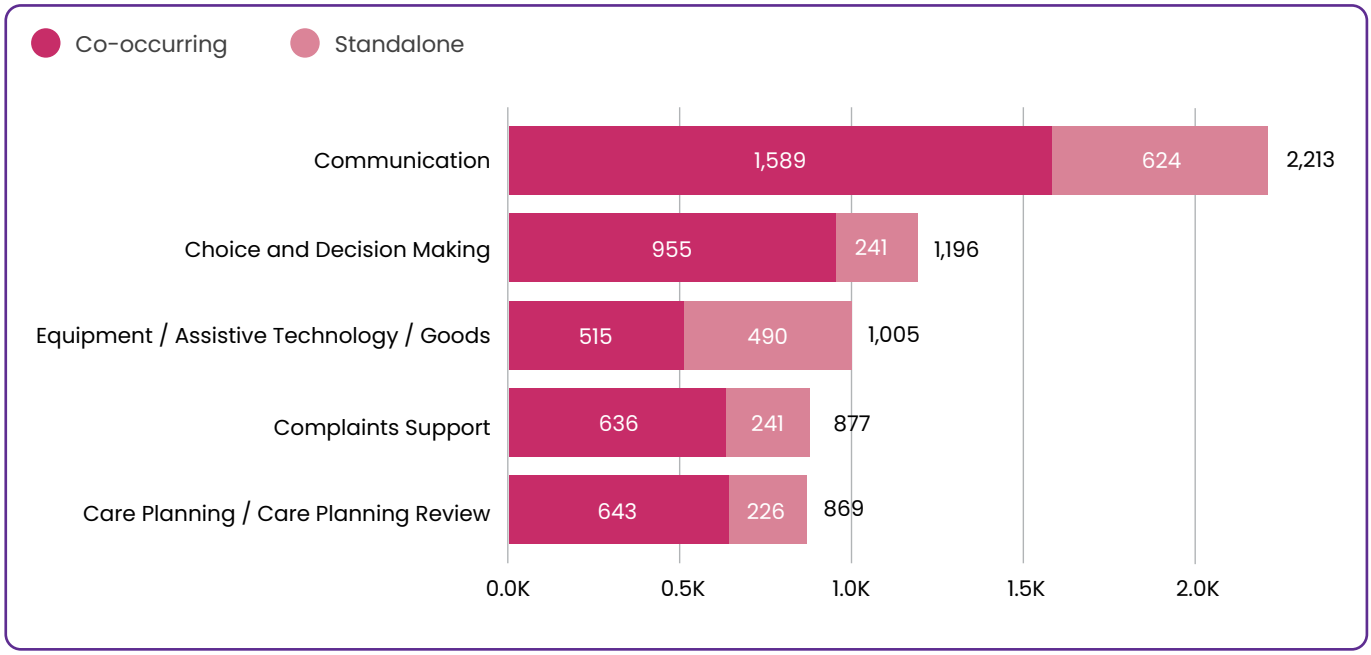

Figure 11. Top five service delivery issues by category (count of issues).

Service delivery issues were the top category in advocacy cases, being raised in 5,501 cases (Table 1). The most common issue in service delivery advocacy cases was poor communication by providers, followed by issues relating to decision-making, assistive technology, complaints support and care planning (Figure 11).

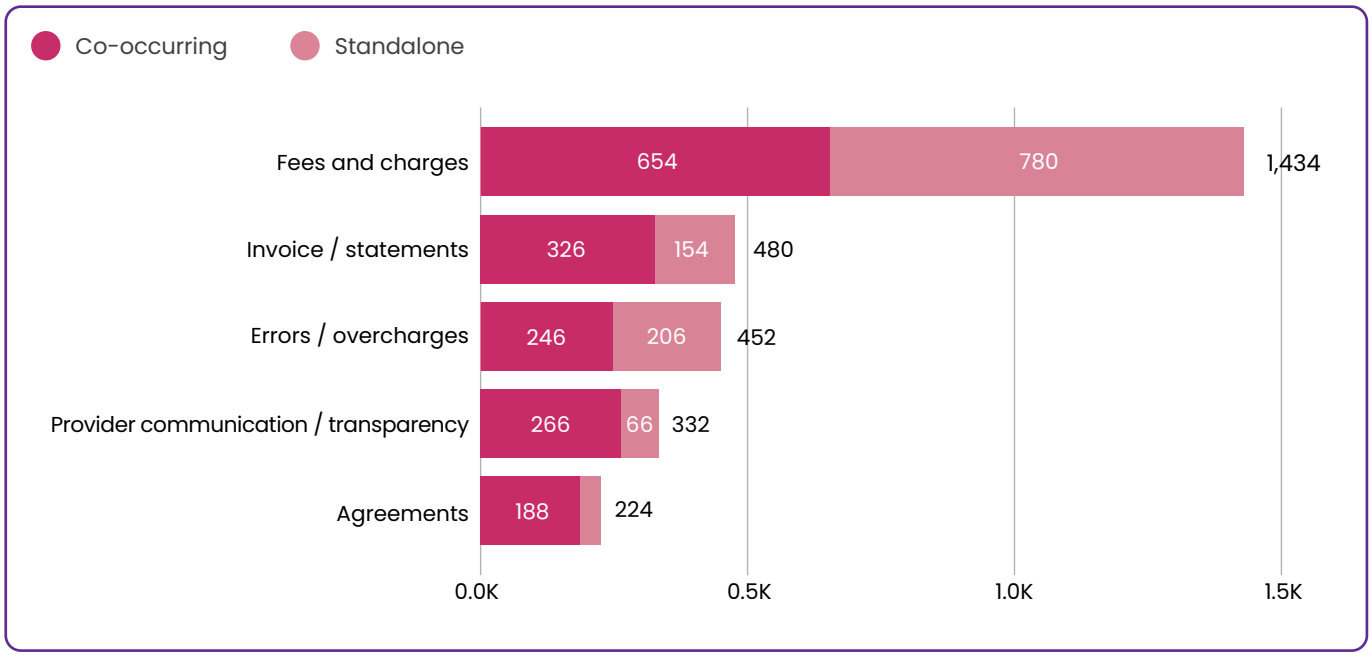

Figure 12. Top five financial issues by category (count of issues).

Financial issues were raised in 2,422 advocacy cases in 2024-25 (Table 1). The most common issues concerned fees and charges, followed by invoices and statements, errors and overcharges, poor provider communication and transparency, and agreements (Figure 12).

Accessing aged care

Table 2. Top five accessing aged care issues by category (count of issues).

Issue category	Co-occurring	Standalone	Total
Information about the program	2,552	1,101	**3,653**
Finding / changing / engaging service provider	1,553	1,218	**2,771**
Support for reassessment / changing needs	659	662	**1,321**
Support during assessment process	405	285	**690**
Introduction to MAC	462	68	**530**
Total	**2,825**	**3,334**	**6,159**

Issues accessing aged care accounted for 39% of all advocacy cases (5,299 out of the 13,486 advocacy cases).

As in the previous financial year, information about aged care programs was the top issue in advocacy cases related to accessing aged care (60%, 3,188 of the 5,299 access cases). Issues relating to finding and engaging a service provider were the second most common issue related to accessing aged care (48%, 2,549 of the 5,299 access cases)[14].

This financial year saw an increase in the number of advocacy cases relating to support for reassessments, comprising 1 in 4 2024-25 access cases (24%, 1,256 of the 5,299 2024-25 access cases) compared to 1 in 6 in 2023-24 (17%, 801 of the 4,611 2023-24 access cases).

The next most common care access issues in advocacy cases were support during the assessment process (12%, 652 of the 5,299 access cases) and introduction to My Aged Care[15] (10%, 517 of the 5,299 access cases).

Table 2 shows the count of issues raised in these care access cases, noting that more than one issue can be raised in each advocacy case so the count of issues is higher than the count of cases.

[14] An analysis of the case studies provided by network members revealed that issues related to finding and engaging a service provider also emerged in cases about CHSP and HCP service delivery, so the case numbers for this issue under accessing aged care are likely to be underestimates in the actual number of cases.

[15] Cases reported as involving 'Introduction to My Aged Care' include a range of potential actions by network members, including; 'introducing' the older person to My Aged Care via a warm phone transfer, a three-way phone call between the advocate, older person and My Aged Care, and/or accompanying the older person to a Services Australia outlet with an Aged Care Specialist Officer.

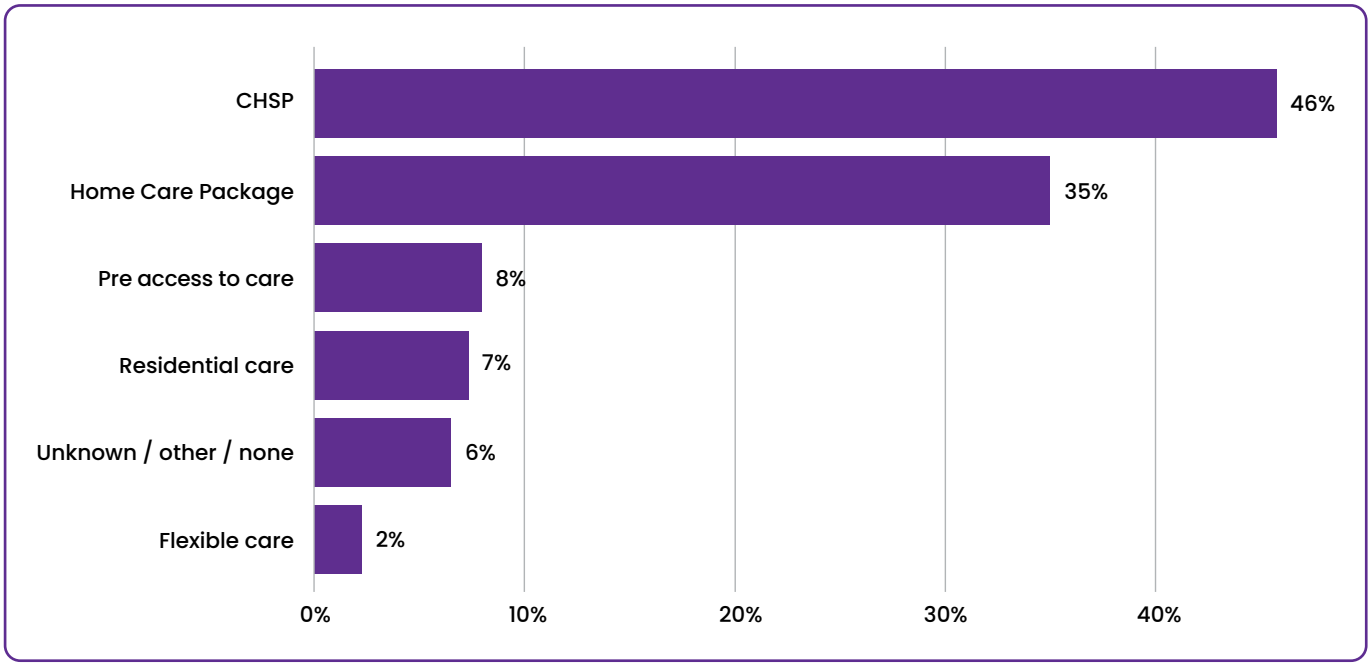

Figure 13. Proportion of accessing aged care advocacy cases by aged care type.

The Commonwealth Home Support Programme (CHSP) rose to being the top program of concern in 2024-25 care access cases (2,429 (46%) of the 5,299 2024-25 care access cases, Figure 13), a noteworthy increase when compared to 2023-24 (36% of the 4,611 2023-24 access cases). Home Care Packages (HCP) were the second most common program of concern in case access cases, followed by people who were yet to access aged care and residential aged care (Figure 13).

This financial year, the top three care access issues often co-occurred:

1. information about aged care programs
2. finding and engaging a service provider
3. support for reassessment.

The exploration of the qualitative case study data in the remainder of this chapter showed that this joint demand on advocacy for information about aged care programs, to find and engage a service provider, and to receive support for reassessment was due to a range of interacting underlying factors.

- A lack of available CHSP services leading to people seeking to be re-assessed for lower-level Home Care Packages instead.
- Co-contributions for HCP services, in particular resulting from older people's and provider's transport costs in regional rural and remote areas, leading to people seeking to move from the HCP program to the CHSP.
- Wait-times for Home Care Packages leading to people seeking to engage a provider under the CHSP and flexible care programs or, if those services were also unavailable, considering entry into residential aged care as their only option.
- A lack of aged care service availability leading to older people being unnecessarily hospitalised.

This financial year the advocacy cases revealed that service availability and financial considerations were driving older people's decisions about which aged care program to seek services under, rather than decisions based on which program can best meet their needs.

The last quarter in the 2024-25 financial year, saw an increase in advocacy cases relating to consideration of whether to move from HCP to CHSP or residential aged care due to concerns about the future Support at Home co-contributions and changes to service and fee structures resulting from providers - sometimes incorrectly - pre-empting the upcoming Support at Home changes.

There were emerging concerns about the Single Assessment System, showing that the new system may not have resolved and may even have exacerbated the issues seen in previous years.

Information about aged care programs

The most common reason for people to need advocacy support - related to care access - was due to a lack of understanding of the aged care programs and options that may meet their needs.

Many older people who contacted OPAN expressed being unclear about the outcome of their engagement with My Aged Care, Services Australia and assessment teams. In particular, older people were often unclear about which services (if any) had been approved and the next steps in engaging a provider. In many cases, older people had repeated contacts with My Aged Care following an assessment and were still unclear on what services they were approved for and how to access services.

The reliance on information about aged care online and via the My Aged Care phone line created a significant barrier for many older people, especially those with limited or no internet access, hearing loss, and/or a lack of experience and ability to use information and communication technologies. In some cases, My Aged Care staff were able to resolve older people's concerns, but older people first required support to contact the My Aged Care phone line and navigate the online information.

Case Study 1

An older person contacted an advocacy organisation because they were very confused about their engagement with My Aged Care, particularly about which services they had been approved for. They explained to the advocate that they were unsure whether they had had an assessment, or when it may have occurred. The older person was seeking meal services and believed they needed an ACAT referral for a Home Care Package to access these.

The older person had attempted to contact My Aged Care but could not understand the phone system and what buttons they needed to press and had no idea what questions they would need to ask.

With their consent, the advocate assisted the older person to contact My Aged Care. My Aged Care confirmed that the older person had undergone an ACAT assessment earlier in 2024 and the wait period was 9-12 months for the package, making the date of support available closer to the end of 2024.

The My Aged Care representative offered to do a review and put CHSP meal services in place in the interim.

After considering their options and the expected wait time for the Home Care Package, the older person declined the CHSP meal service as they would rather wait for the package and access the meals through their provider of choice. The older person was happy with the outcome as they now understood the process and what they were entitled to.

The complexity and lack of combined processes and consistent messaging between Services Australia, assessors, My Aged Care, and providers contributed to older people unable to navigate their aged care journey and falling through the gaps with associated financial implications. Older people face a disjointed system where My Aged Care, assessors and providers are unable to provide information on income and asset test requirements and potential impacts on fees and charges, and Services Australia are unable to provide information to older people on next steps in engaging a provider and ensuring fees are appropriate after an assessment.

Concerns about co-contributions to Home Care Package service fees was a recurring theme in advocacy cases. In these cases, older people had not received information from their provider, My Aged Care, or their assessment service about the need to contact Services Australia for an income and assets assessment or the option to apply for financial hardship. Sometimes, after this information was received and older people had actioned their Services Australia tests and received notification of their contribution amount, they chose to forgo Home Care Package services or seek CHSP services instead as they could not afford the contribution.

Case Study 2

An older person who lives independently with their spouse contacted an advocacy service. They are currently undergoing cancer treatment and have significantly limited mobility.

The older person explained that an assessment has been completed, referral codes for the CHSP had been assigned, and they are on the waiting list for a Level 3 Home Care Package. They were unsure of what this all meant and what to do next.

The advocate explained the details of the CHSP program and the services available including the referral codes that have been assigned to the older person. The advocate also explained the difference between the CHSP and Home Care Packages programs. It was noted that the Home Care Package assignment is estimated to occur within 6 to 9 months. The advocate also discussed options for self-management of a Home Care Package versus case management of a Home Care Package. The advocate went through the Income Test Fee information and provided Services Australia contact details, which the older person was unaware of before.

Concerns were raised across the year regarding wait times for Services Australia assessments, with reports of people waiting up to 6 months for a response to their application for financial hardship or income and means assessment. In many cases, it was only after an advocate became involved that it was discovered that further information was required. There were also reports of Services Australia processing assessments, but older people and their providers not being notified of the outcome. In some cases, this lack of communication impacted older people's ability to seek a review of the outcome of their application for financial hardship within the required 90-day timeframe.

Information provision as a result of upcoming Support at Home program

Provider actions in anticipation of the upcoming Support at Home program was a dominant theme in the final quarter of the 2024-25 financial year advocacy cases where information on Home Care Packages, CHSP, and residential aged care were sought, as well as OPAN network member reflections on information provision themes. This likely explained the significant increase in information provisions in the last quarter of 2024-25, especially for people currently receiving CHSP services (see 'Overview of OPAN services in 2024-25' chapter, Figure 3).

Advocates reported that some older people were being placed under pressure by their CHSP providers to be reassessed for a Home Care Package. The recommendations to transition to Home Care Packages were made without considering the older person's level of need, how Home Care Package services may be better able to meet their needs or any associated financial implications to the older person. In some cases, older people contacted My Aged Care to seek a reassessment at their CHSP provider's advice, only to be told they were not eligible for the Home Care Packages program due to their low level of need.

Many older people explained to advocates that their CHSP providers were saying they were no longer taking on CHSP clients or were reducing CHSP staffing and services in preparation for the upcoming Support at Home program. There was also an increase in contact with OPAN advocates because of fears and concerns about co-contributions, fees, charges and service limitations under the upcoming Support at Home program. Older people were concerned about whether they would be able to afford home care services in the future. In some cases, providers told older people they were reducing services and/or increasing charges for their Home Care Package services in preparation for the upcoming Support at Home program requirements. In other cases, older people were unnecessarily concerned about proposed Support at Home policies that were no longer in place, in particular caps on gardening and cleaning services.

In addition, OPAN network members provided many reports of older people being told by My Aged Care and providers that they needed to utilise their Home Care Package unspent funds before the commencement of Support at Home, or they would lose them. In many cases, people had been accumulating their unspent funds to purchase assistive technologies and/or home modifications recommended by an occupational therapist and were concerned they would now not be able to afford these under the new program. Although it was seen as positive that assistive technologies and home modifications had a separate budget under Support at Home, planned client co-contributions for assistive technology and home modifications left many concerned they would not be able to afford these.

OPAN network members also shared concerns of older people receiving letters sent by many Home Care Package providers regarding the use of automatic direct debits for co-contributions funds to be held in trust in preparation for the new Support at Home program. There were concerns older people would not be able to financially manage variable direct debit amounts, which will automatically occur when their funds held in trust by the provider for future co-contributions fall below twice the minimum average fortnightly contribution, as stated in some letters from providers.

Finding and engaging a service provider

Many of the advocacy cases related to finding and engaging a service provider were due to a lack of clear information from assessors and follow-up by My Aged Care staff on the next steps after services had been approved. Barriers associated with information and communication technology access and ability compounded these issues.

Case Study 3

An older person approached an advocate in a stall their organisation had in a local shopping centre. The older person wanted to receive aged care services, but did not know how to get them. They had no access to the internet at home and had never tried to access it before.

Using the My Aged Care Support Portal, and by creating an Agent Relationship with the older person's consent, the advocate discovered the client had a previous ACAT assessment. The older person could not remember having the assessment, or what the outcome of it was. They also did not know that they already had CHSP referral codes issued, what they are for, or how to use them.

As the older person had no access to the internet, the advocate supported the older person to contact the two local CHSP providers displayed in the My Aged Care 'Find a provider' function. The older person chose a provider that sounded the best to them over the phone. The advocate ensured that the older person had started receiving services before closing the case.

This financial year also saw ongoing issues with the My Aged Care 'Find a provider' function, with providers continuing to list themselves as available to deliver services in areas where they have no services or capacity to deliver services. Their lack of availability is often only realised once contacted by older people and their advocates.

The issues older people faced with understanding aged care programs and their aged care journey were exacerbated by variable understandings of My Aged Care contact centre staff of programs and options for older people with no approved service availability in their area. While care finder programs continue to be a welcome addition by advocates to the aged care ecosystem, not all areas have an available care finder. Increasingly, due to an apparent lack of other options or knowledge of available options, My Aged Care staff referred people to advocacy services if they were waiting allocation of a Home Care Package or experiencing difficulties finding available CHSP, Home Care Package and residential aged care providers.

As exemplified by the quantitative data trends and case studies in the previous section, wait-times to be allocated approved Home Care Packages, and a lack of available CHSP services to fill the gap in the interim was a contributing factor to many of the advocacy cases where older people sought information about aged care programs and how to manage their aged care journey. This led to advocates having to support older people to navigate between programs as they attempted to secure urgently required services. In some cases, no available CHSP services were located, and older people were forced to consider privately financing their required services despite being approved for CHSP and Home Care Packages. In many cases, older people were not able to self-finance required services, so went without.

Case Study 4

In late 2024, an older person contacted an OPAN network member and explained they were assessed in 2023 and were still awaiting allocation of their Home Care Package. The older person explained they had leukaemia and urgently needed an adjustable bed, adjustable chair and light-weight wheelchair. The older person also explained that they had polio when they were younger and had only one lung.

The older person had previously contacted My Aged Care to see if their package could be allocated sooner as they required urgent support. However, they were advised there was nothing that could be done and they would need to await allocation.

At the direction of the older person, the advocate accessed the older person's My Aged Care portal to understand their current service approvals. The older person's priority for a Home Care Package was listed as 'medium' with notes stating the older person did not meet the criteria for 'high.'

The advocate and the older person contacted My Aged Care and requested interim support whilst the older person awaited allocation of a Home Care Package but were told interim support of a level 1 or 2 package did not exist anymore and was no longer an option.

The My Aged Care representative explained the older person had a referral code for Goods Equipment and Assistive Technology (GEAT) - access up to $1000 - which they could use for equipment. However, they needed an occupational therapy (OT) assessment prior to requesting any GEAT.

The advocate and older person contacted all service providers in their region to request support with an OT assessment. No service providers were able to accept the referral.

The advocate and older person contacted My Aged Care and explained they had contacted all service providers to no avail. The My Aged Care representative attempted to send a referral to CHSP providers directly, however, was rejected due to no availability.

At the direction of the older person, the advocate spoke to the assessors about options and was advised that average wait times for an OT assessment under the CHSP in their state was at least 9 months. The assessor attempted to send referrals directly to CHSP service providers, however, these were also rejected due to unavailability.

The assessor estimated the older person's Home Care Package would be allocated within 1-2 months, and they could use package funds for an OT assessment. The advocate noted the older person needed to accrue sufficient funds for the assessment, and would need to wait for OT availability, and would then need to accrue funds for the purchase of recommended equipment.

The advocate provided the older person with the option of seeking a private OT and self-funding the assessment – or negotiating an amount with the OT based on the CHSP referral code. The older person explained they would self-advocate and explore options of privately funded OT.

In particular, the advocacy cases show an alarming decrease in the availability of CHSP services in the past year, with many CHSP services closing, being short-staffed, or no longer accepting new clients. As previously mentioned, advocates reported that some CHSP providers indicated they were no longer taking on CHSP clients or reducing CHSP staffing and services in anticipation of the upcoming Support at Home program. CHSP services that were most often raised in advocacy cases as being unavailable in local areas were simple home maintenance (e.g. gardening and gutter cleaning), cleaning, transport and allied health services – in particular, access to occupational therapists, which was in turn affecting the ability to obtain assistive technology. This lack of CHSP services was then placing increasing demand on Single Assessment System services for clinical reassessments and the Home Care Packages program, further exacerbating the excessive wait times for these services.

The lack of CHSP providers in the local area was also an issue that resulted in people being unable to change providers if they were dissatisfied with the quality of their services. In some cases, older people were unable to find a new CHSP provider if they had a significant breakdown in communication with their current provider, and the provider refused to provide services to them. In some cases, but not all, advocates were successful in re-opening lines of communication between the older person and their provider so that they could continue to receive services. In cases where the client was unable to have their service concerns addressed by the provider, they were forced to either consider moving, applying for a Home Care Package, or entering residential aged care.

Case Study 5

An older person contacted an aged care advocate because they were unsatisfied with their CHSP service provider. The client expressed they did not wish to try to resolve issues with their current service provider and would prefer to change providers.

The advocate supported the older person to understand, and navigate, the My Aged Care 'Find a provider' function and worked with the older person to identify service providers that were listed as having availability in their area.

The advocate supported the older person to contact the service providers listed to confirm availability. Seven service providers were contacted, all of which stated they did not have availability – despite being listed as having so on the My Aged Care website. Furthermore, the service providers were not running wait lists and were unable to advise when they would next have availability to join a wait list.

The advocate offered the older person the option of seeking a comprehensive reassessment for a Home Care Package. No CHSP providers were available in their area, and their care needs had significantly changed since their initial assessment. The advocate also discussed the option of communicating with their current provider to remedy the quality of service issues they were experiencing.

The older person chose to communicate with their current service provider and self-advocated to request an improvement in the quality of services received. The client explained they now understood their options – and would seek a comprehensive reassessment if the service quality did not improve.

Shortages in residential aged care availability were reported in the 2024-25 financial year across Australia. This included a lack of available places for people with high or complex needs, with many residential providers refusing older people on the basis that they cannot meet those needs. There were case examples of older people waiting for Level 4 Home Care Packages due to a lack of available residential aged care and respite services, even though the Level 4 package was unable to meet their complex needs, and their preference was to be in residential aged care.

These service shortages were also reported across the Flexible Care programs, in particular Respite Care, the Short-Term Restorative Care (STRC) pathway and the Transition Care Programme (TCP). These programs were in turn under increased pressure due to a lack of CHSP, Home Care Package and residential aged care availability. Also, staffing issues experienced in other aged care programs impacted service availability, as STRC and TCP are commonly delivered by residential aged care and home care providers.

There were many case studies and reflections by OPAN network members relating to respite care being used to 'screen' people seeking to enter residential aged care. For people with high, complex or uncommon care needs, this resulted in them being denied a residential aged care place. This impacted the ability of older people with disabilities to access aged care. In one case example, a provider required a respite care stay by the older person before a permanent bed would be offered.

Long-term hospital stays and unnecessary hospital re-admissions resulting from a lack of aged care services

This financial year saw an increase in advocacy cases across Australia relating to people in long-term hospital care because of the acute lack of aged care service availability outlined above. This lack of ability to transition out of hospital care into aged care was compounded by the lack of ability and/or willingness of aged care providers to provide services to older people with complex health needs. Once again, this impacted people with disabilities or other complex needs, for example those in need of trauma-informed care.

Case Study 6

An older person has spent most of the last 12 months in hospital with only 15 days in total at home. They live with long term mental health issues, incontinence and poor mobility. The older person had agreed to discharge to residential aged care and contacted an advocate with the support of the hospital social worker. They agreed to advocacy to support them with decision-making and choice regarding a residential aged care provider. A team of hospital social workers contacted a total of 21 residential aged care providers in the region and all 21 had declined the older person's application or enquiry. The reason given was no current vacancy and, it was implied that the older person's past suicidal ideation and complex care needs were deciding factors.

Advocates involvement in supporting older people to transition from hospital with aged care supports in place revealed a lack of understanding and respect of human rights by hospital-based assessors and other staff regarding choice, control and dignity of risk. In some cases, older people and their families were pressured to consider residential aged care as the only option, rather than considering what supports they could get in place at home. In other cases, older people are discharged without the necessary aged care supports in place, only to be re-hospitalised soon thereafter. This lack of hospital staff and assessors' knowledge was compounded by a lack of support for older people to connect with relevant services to help them navigate the aged care system, including beginning the financial steps necessary to enter residential aged care.

The urgency of older people's need to secure aged care services to enable them to transition from hospital was heightened by hospitals placing them in hotels and hostels while they awaited aged care, many of which lacked supports to enable them to live independently and with dignity. In addition, a lack of ability to secure aged care services and transition from hospital had significant financial impacts on many older people. According to the Private Health Insurance Act 2007, older people can be classified as a 'Nursing Home Type Patient' after being in hospital for more than 35 days if they are not receiving acute care, and charged a minimum patient contribution which in most states and territories is $78.65 per day or 97.5% of the aged care pension with hardship applications to the relevant health department often unsuccessful.

Support for reassessments

As reported in the introduction to this chapter, the 2024-25 financial year saw an increase to 1 in 4 care access advocacy cases relating to support for reassessment, compared to 1 in 6 in 2023-24. The analysis of the reflections on advocacy case issues by OPAN network members suggests that the increasing lack of CHSP services was a main driver in the increase of advocacy related to supporting people to be reassessed. The lack of CHSP services, as explored above, shows that there were often no or very limited CHSP services in the older person's area and the only option to remain at home would be to secure a Home Care Package. This in turn limited the options for older people to find a service provider who could meet their needs or change service providers if they had concerns about the quality of the services they were receiving.

In some cases, CHSP providers were not appropriately monitoring their clients and informing them of the need for, or how to seek, support plan reviews for new CHSP service codes or reassessments for a Home Care Package. There were reports of older people who had been receiving CHSP services for over 5 years without a support plan review or reassessment despite significant increases in needs.

Older people in several cases proactively contacted their CHSP service provider and asked about how they could apply for more services to meet their increased needs. They were told to contact My Aged Care, who would in turn tell them to go back to their provider. Frustrated by the back and forth, older people sought advocacy support, and advocates ensured their provider initiated the support plan review and reassessment process.

In some cases, CHSP providers played an active role in connecting older people with advocates so that older people could understand the reassessment process and potential benefits, participate in the process, and be connected with a care finder program to secure the services they were reassessed as needing.

There were also reports of My Aged Care unnecessarily requesting a reassessment by a clinical team rather than a support plan review by the assessment team when CHSP services that were not identified during initial assessment process were requested.

Single assessment system services

The qualitative data suggested emerging issues with the new Single Assessment System, which was implemented in November 2024.

Advocates had first-hand experience with the new Single Assessment System service staff being unfamiliar with the aged care system and providing incorrect information to older people regarding service options that may meet their needs.

Concerns were highlighted by OPAN in the 2023-24 Presenting Issues Report regarding wait times for ACATs and de-prioritisation of clients seeking reassessment due to changed needs. These issues appeared even more severe in this financial year, with excessive wait times for clinical assessments. By the end of the fourth quarter in 2024-25, OPAN network members across Australia reported that some older people were waiting up to 10 weeks for initial contact from an assessment service, only to then be told they needed to wait a further 2-9 months for an assessment or reassessment. Poor communication by Single Assessment System services with older people on their wait lists about delays in receiving an assessment led to older people seeking advocacy services at the advice of My Aged Care. There were many reports of Single Assessment System services not answering their phone, not returning calls and having voicemails referring older people booked with their service for an assessment back to My Aged Care for queries about their assessments.

Case example 7

An older person had applied for a Home Care Package through My Aged Care and was told they would be assessed. The older person then did not have any further contact from My Aged Care or the Single Assessment System service for six months.

During this time, the older person's mobility worsened, and they became more dependent on family members for personal care and domestic assistance. This led to a deterioration in the client's physical and mental health.

After the advocate was engaged, they sought to expedite the assessment process by contacting My Aged Care directly and raising the urgency of the case. After repeated follow-up calls to My Aged Care by the advocate, the assessment was prioritised, and the client was placed on the waitlist for a Home Care Package.

Advocates described that the triage component of the single assessment process was not working effectively or efficiently, with some older people undergoing a 1-2 hour triage/eligibility assessment before being able to progress to a clinical assessment. Asking older people to spend this length of time on the phone describing their needs was negatively impacting individuals and further delaying access to urgently required services. Increased frustration and delays are caused by Single Assessment System services, which require clients to undergo a new triage/eligibility assessment if they miss a call from the clinical assessor, rather than allowing them to call and request an alternative time for the clinical assessment. This shows that the issue of older people being forced to enter hospital to receive a comprehensive ACAT assessment, as documented in previous Presenting Issues Reports and observed in the first two quarters of 2024-25 (prior to single assessment rollout), has not been resolved.

There were also many examples of assessments only being conducted over the phone, which led to older people's needs not being appropriately assessed as they either faced communication barriers over the phone or did not appropriately articulate the full extent of their needs.
Once advocates supported older people to secure face-to-face assessments, assessors were able to observe the older person and correctly identify their needs.

Concerns were also raised about older people's ability to be supported by others during the assessment process, with carers and family members not being at the assessment and/or included in communications from assessment services at the older person's request. Issues were also raised regarding people from linguistically diverse backgrounds not being connected with professional interpreter services so they could participate in the assessment process.

Advocates also raised concerns about the new Integrated Assessment Tool (IAT) being too prescriptive and not providing adequate opportunity for older people to express their complex needs. However, advocates also reflected that it was unclear whether these issues were with the tool itself or its application by inexperienced staff at the new Single Assessment System services. For example, despite concerns about the IAT being overly prescriptive, reports from OPAN network members indicated high variability in assessment decisions among individual assessors.

Home Care Packages

Issues relating to Home Care Packages (HCPs) were raised in 42% of the OPAN network member advocacy cases in the 2024-25 financial year (5,654 of 13,486 advocacy cases). This is a similar proportion of advocacy cases relating to HCP seen in the 2023-24 financial year (44% of the 14,238 advocacy cases in 2023-24).

The proportion of advocacy cases relating to HCPs is two times higher than expected given that Home Care Package recipients comprise only 21% of the total aged care population[16].

There were also 1.5 times more information provisions related to HCPs than would be expected by the size of the aged care population (see Figure 8 and more detail in chapter 'Overview of OPAN services in 2024-25').

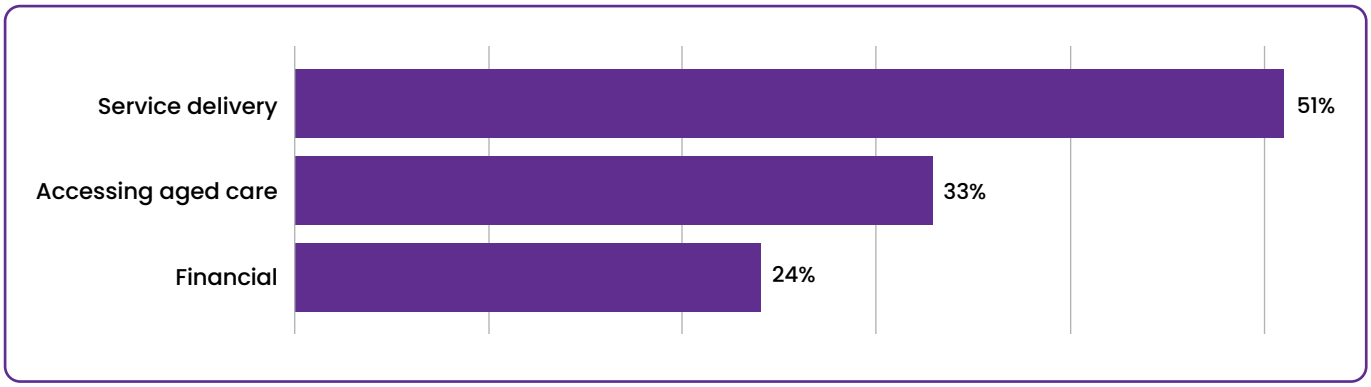

Figure 14. Proportion of HCP advocacy cases by issue category.

The top HCP issue categories also followed a similar trend to the previous financial year. Issues relating to HCP service delivery were the most common reason for advocacy support (2,877 cases; 51% of all HCP cases). Issues relating to accessing aged care were the next most common issue (1,856 cases; 33% of all HCP cases) and have been explored in detail in the 'Accessing aged care' chapter. Financial issues were the third most common issue in HCP advocacy cases (1,357 cases, 24% of all HCP cases). (Figure 14)

[16] See the 'Overview of OPAN services in 2024-25' chapter and Figure 9 for more information and data sources.

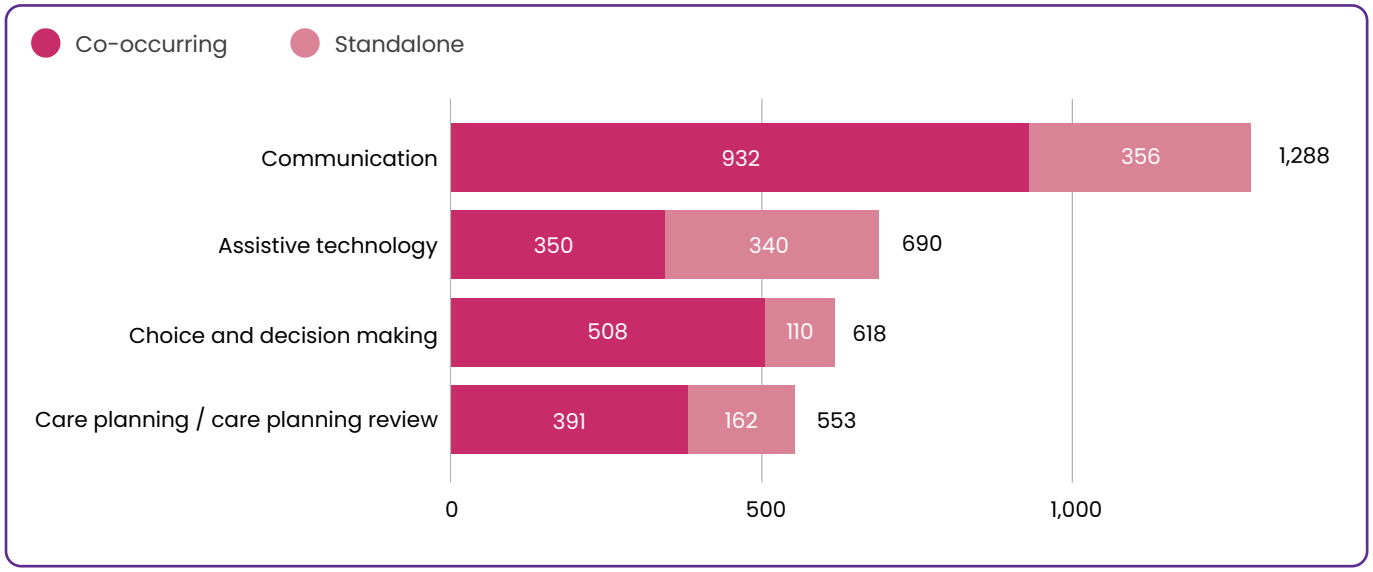

Figure 15. Top four service delivery issues in HCP by category (count of issues).

As in the 2023-24 financial year, the top issue related to HCP service delivery was communication (Figure 15). Communication issues commonly co-occurred with issues relating to choice and decision making, care coordination, and care planning. Issues relating to choice and decision making, and care planning were also in the top 4 presenting issues for HCP service delivery (Figure 15).

Issues relating to assistive technology were the second most common issue in HCP service delivery advocacy cases, also showing a similar pattern to the 2023-24 financial year (Figure 15).

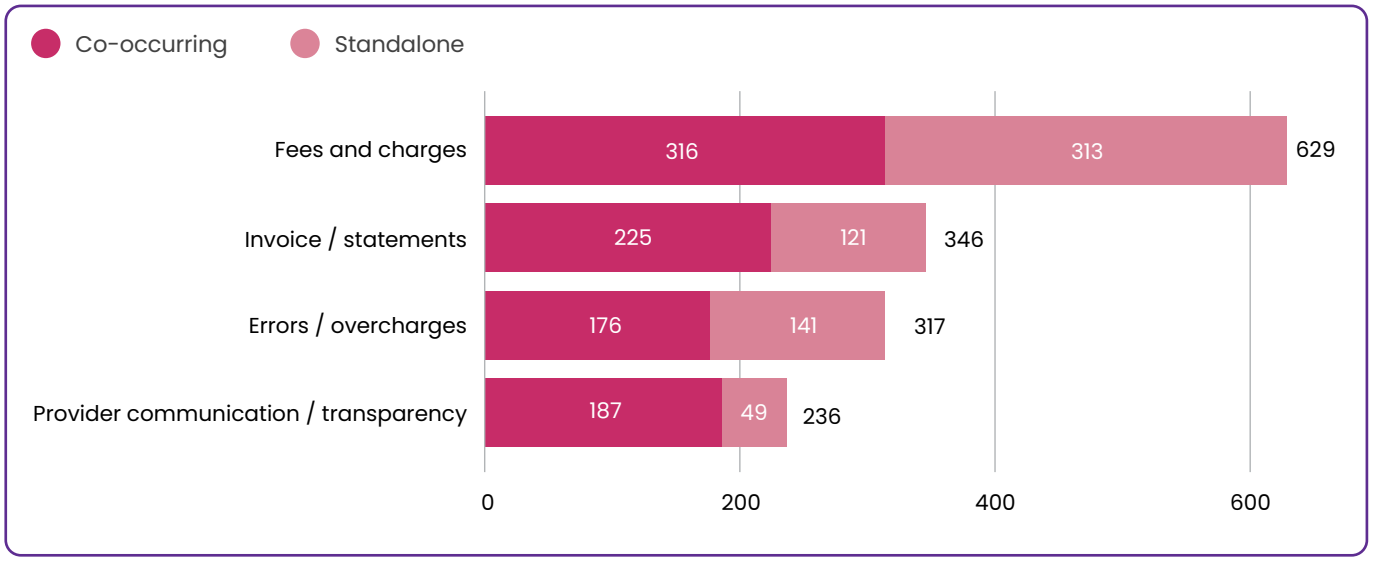

Figure 16. Top four financial issues in HCP by category (count of issues).

HCP financial issues most often related to fees and charges, which commonly also co-occurred with the next most common financial issues relating to invoices or statements, errors or overcharges, and poor provider communication and transparency (Figure 16).

The quantitative data and qualitative analysis of these top HCP service delivery and financial issues in advocacy cases are explored in the following sections in this chapter.

HCP communication, choice and decision-making, and care planning issues

The top issue relating to HCP service delivery was poor communication by providers, being raised in 40% of service delivery advocacy cases (1,138 of the 2,877 HCP service delivery cases). Also in the top 4 HCP service delivery issues were choice and decision making (20%, 562 of 2,877 HCP service delivery cases) and care planning (17%, 477 of 2,877 HCP service delivery cases).

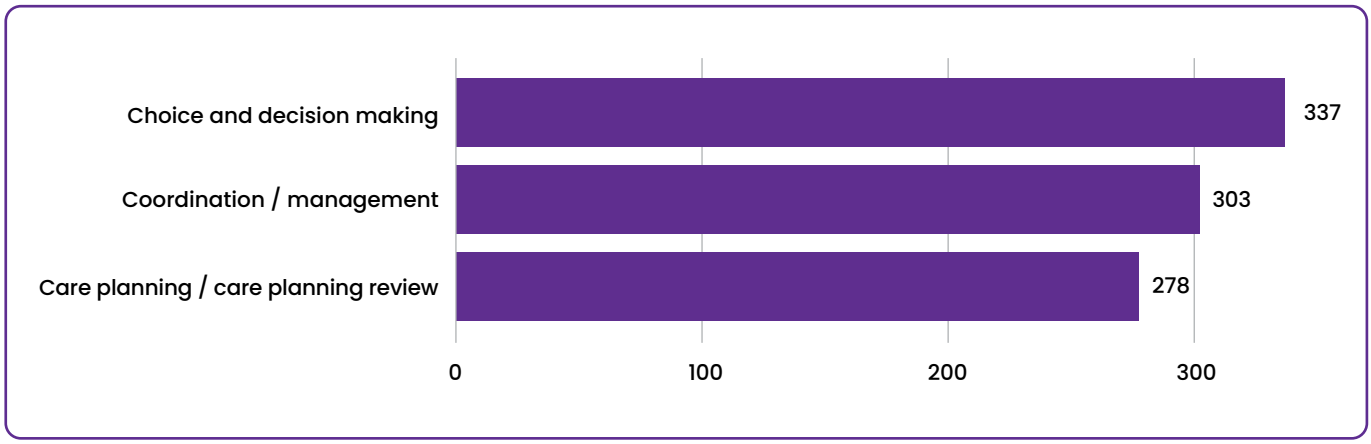

Figure 17. Top three co-occurring issues with HCP communication issues (count of issues).

This theme continued when considering issues that commonly co-occurred with HCP communication issues. The top co-occurrent issues with poor HCP provider communication were choice and decision-making (27%), care coordination (22%), and care planning (20%) (co-occurring in 304, 250 and 233 of the 1,138 HCP communication cases, respectively). Figure 17 shows these top co-occurring issues with HCP communication issues, noting that more than one issue can be raised in each advocacy case, so the count of issues is higher than the count of cases.

OPAN network members reflected that many HCP services are at capacity and are having difficulty recruiting and retaining suitably trained and experienced staff, as explored in the chapter 'Accessing aged care'. This further exacerbated communication issues. In many cases, staff were not available in care worker, coordination and planning roles. This meant that poor communication was sometimes a result of services having no staff available to communicate with the older person. In other cases, poor communication was because the staff who were available were not experienced in the issue that the communication was about.

The relationship between communication and staffing was further compounded by the fact that often transparent and intensive communication was required by the provider to explain to the older person changes to, or cancellations of services, due to staffing shortages. Multiple case examples were provided across Australia where older people ceased receiving scheduled HCP gardening services for months and attempts to contact their provider for an explanation were unsuccessful as no one returned their calls.

While staffing shortages may be beyond providers' control, how they communicate and manage the impacts of these on older people is within their control. There were examples of providers stating that they had shifted to an automated rostering system to increase efficiencies and that specific requests were no longer able to be considered. Other providers simply did not consider the older person's feedback and requests, even after the involvement of an advocate. However, in some cases, the advocates were able to support the older person in having their voice heard and respected by their provider.

Case study 8

An older person engaged an advocate due to concerns their Home Care Package (HCP) provider was not communicating with them about staff changes and when services would be delivered.

The older person explained that the care workers were constantly changing or not turning up at the agreed time. As supports were required mornings and evenings, the older person sometimes missed attending planned social events as they were waiting for care workers to arrive.

In addition, the assigned care workers also regularly changed, and the older person felt unsafe and unsure of who was walking into their home. This was made worse by care workers often letting themselves into the older person's house, as they were slow to answer the door due to their reduced physical function.

With the advocate's support, the older person attended many meetings with care coordinators and management at the provider. Eventually, the older person's concerns were addressed, and they were assigned a new care coordinator. The provider also undertook to allocate a specific care worker to the older person and ensure that, whenever possible, they were assigned. It was also agreed that, if running late, the care worker needed to ring the older person so they could organise their day.

Communication issues also arose because of HCP providers and staff not considering older people's right to make decisions that involve an element of personal risk.

There were also examples of HCP providers not respecting older people's privacy, the confidential nature of their personal information, and their right to make decisions.

Case study 9

An older person contacted an OPAN network member because they were frustrated that their Home Care Package (HCP) provider was communicating with their adult child about their care needs, without consent. There were no concerns about the older person's ability to make decisions, and the adult child was not an appointed substitute decision-maker.

The older person explained that when they received nursing support from their HCP provider, the nurse told them they had been speaking with the older person's adult child about their care needs. In one case, the nurse told the older person they needed to visit their GP and get some tests done, and the older person then found an appointment had already been scheduled with their GP without their knowledge or consent.

The advocate supported the older person to raise their concerns with the HCP provider, drawing attention to their rights under the Charter of Aged Care Rights, and requesting that communication with the adult child cease immediately. The advocate supported the older person to exercise their rights and advised the provider that they did not consent for communication with the adult child to occur without their consent.

The HCP provider confirmed the communication with the older person's adult child would cease immediately and only occur in the future with their consent.

HCP assistive technology issues

Issues relating to assistive technology were the second most common HCP service delivery issues (22%, 642 of 2,877 service delivery cases). Issues relating to assistive technology were also the second most common HCP service delivery in the 2023-24 financial year.

Also, as in 2023-24, issues relating to assistive technology for older people receiving a Home Care Package most commonly co-occurred with poor communication (24%), choice and decision-making (17%), allied health and therapy services (11%), and HCP included/excluded items (11%) (151, 106, 73 and 72 of the 642 HCP assistive technology cases).

Issues about whether providers considered the required assistive technology to be an HCP included or excluded item were ongoing in 2024-25. This was a particular issue if the provider was of the opinion that the assistive technology was not a 'medical' item. This occurred even when an allied health and/or medical professional had identified the assistive technology as essential to the person maintaining their function and independence.

Significant delays, or an inability in some regions, to secure assessments by Occupational Therapists (OTs) and physiotherapists also contributed to a number of the issues relating to older people receiving HCP services securing necessary assistive technologies. In some regions, a six-month wait for an occupational therapy assessment was common, while in other regions people were told there were no OTs available at all. Some HCP providers were paying for OTs to fly in from other states to undertake assessments for older people receiving HCPs once a sufficient number had accumulated on wait lists.

Issues for people allocated a Home Care Package in securing assistive technology also occurred if they were receiving services under the Transition Care Programme (TCP). While access to occupational therapy and other allied health assessments was often better for TCP recipients, they were then unable to purchase the necessary assistive technology with their Home Care Package as it was temporarily suspended while they received TCP services.

Case study 10

An older person with foot-related issues was prescribed specific shoes by a podiatrist. However, the older person sought advocacy services as the Home Care Package (HCP) provider refused to cover the cost of these shoes, citing rigid guidelines on what could be funded through the package.

Advocacy efforts sought to challenge this interpretation of the HCP guidelines, but the issue persisted. Despite clear advice from the podiatrist and other medical professionals, the provider remained inflexible.

HCP fees and charges issues including invoices, errors and poor communication

HCP financial issues arose from poor financial management and communication by HCP providers, showing the same ranking and co-occurrence of top HCP financial issues as in the 2023-24 Presenting Issues Report. Issues related to fees and charges arose as the top HCP financial issue in 2024-25 (593 cases, 44% of the 1,357 HCP financial cases). The next most common HCP financial issues related to invoices or statements (24%), errors or overcharges (23%), and poor provider communication and a lack of transparency (16%) (325, 306, and 219 of the 1,357 HCP financial cases, respectively). These next most common HCP financial issues were also those most likely to co-occur with fees and charges issues in advocacy cases: invoices or statements (23%), errors or overcharges (17%), and poor provider communication and a lack of transparency (16%) (136, 98, and 93 of the 593 fees and charges cases, respectively).

Administrative errors, including overcharges and charges for services not received, were common issues raised in advocacy case examples related to HCP financial issues. Some people did not receive invoices from their HCP provider for months or even years, to then be told after an advocate's involvement that these records had been lost due to human error or IT system changes. Other people did not receive paper invoices as requested, even though they had explained to their provider that they had no access to email or the internet to view online invoices. In some cases, older people were incorrectly invoiced thousands of dollars in purported co-contributions for services they never received. In these cases, older people's HCP accounts entered into thousands of dollars of debt before the HCP provider notified the older person. Only after the involvement of an advocate did the older person realise that many of the service charges that contributed to the debt were errors.

Poor management of HCP funds and care coordination was reflected in the many examples where HCP funds went into deficit before a conversation was held with the older person. In some cases, older people chose to forgo necessary services so the debt could be repaid from future HCP funding. In other cases, older people's services were ceased by the provider due to debt, without notifying the older person of the cessation of services or the reason why. Once the debt had accumulated, many older people were so distressed by the notification that they could not make decisions and communicate constructively with their provider without an advocate's support. If the older person in these examples had been notified in time of the impact of their selected services on their HCP funds, they would have been able to make an informed decision about whether to reduce some services before entering into debt with the provider.

Case study 11

An older person contacted an OPAN network member with concerns that their HCP budget was $4,000 overspent and that HCP services had been ceased by the older person in an attempt to address the debt. The older person explained that they were not warned by their provider that their budget was going into overspend.

The provider had sought a meeting with the older person to discuss the budget deficit and cessation of services. The advocate organised a meeting with the provider and the older person to discuss the concerns.

The provider stated they had not requested the older person cease all services, with the older person explaining they had offered no alternative options for addressing the overspend.

During the meeting, the relevant sections of the Aged Care Act 1997, HCP Program Operational Guidelines, and Improved payment arrangements for home care – provider fact sheet were discussed. However, the provider stated that they do not follow the Act or the Guidelines, but instead run the packages 'practically'.

A review of the invoices by the advocate showed that the older person was being incorrectly billed for previous months' overspend in subsequent months. Copies of the original and updated care plan and budget were requested, but the HCP provider did not supply them to the older person.

The advocate sought advice from the Department of Health, Disability and Ageing and were advised that the older person could consider a complaint to the Aged Care Quality and Safety Commission about this issue.

OPAN network members reflected on the increasing number of reports of HCP providers engaging debt collection agencies with aggressive 'scare tactics' in an attempt to recover debt. OPAN members reported cases where debt collection agencies were engaged before the HCP provider had attempted to communicate transparently about the fees and charges, determine if the charges were correct and, if so, work out a plan for the older person to be able to manage their debt. There were many examples where older people were not transitioned appropriately when moving from the CHSP to a Home Care Package within the same provider. In one case, this resulted in an older person having funds taken from their personal bank account for the full CHSP cost of meal services rather than the smaller contribution they would need to make under the HCP. This same person did not receive invoices or statements from their HCP provider for months after transitioning from the CHSP.

Fees and charges advocacy cases also resulted from poor communication by providers with older people upon entry into the HCP program. In particular, older people who transitioned from the CHSP to HCP within the same provider were often not provided with clear information about the impact of the change in program on the fee structure, how funds could be utilised, and any co-contributions they would be required to pay. As explored in the chapter on 'Accessing aged care', providers were often remiss in advising older people of the importance of, and need to, undertake an income and means assessment with Services Australia and/or applying for financial hardship. In some cases, once the Income Tested Care Fee had been determined, older people chose not to accept a Home Care Package but instead continue to receive CHSP services, where they only needed to pay a co-contribution for the days they received services. Many advocates assisted older people in understanding the difference between CHSP and HCP funding and which option may better suit their needs at that time.

Case study 12

An older person lives independently in their home with the support of minimal gardening and cleaning services under the CHSP. They had learnt English as a second language after entering Australia as an adult refugee.

A local Home Care Package (HCP) provider then encouraged the older person to take up their referral code for a HCP with them as this would offer more support. The HCP provider did not discuss the differing fee structure or financial implications or offer translation support to explain these. The older person commenced a Level 1 HCP with the provider based on their encouragement.

The older person did not know they needed to complete the Services Australia income and means assessment, and they were not alerted to the need to do this by their HCP provider.

After several months on the HCP, the provider accrued more than $7,000 of fees that the older person was unaware of. The HCP provider then stopped providing the minimal mowing and cleaning services due to the account deficit. The older person then cancelled the HCP out of fear of the alleged debt to the provider.

The advocate supported the older person to negotiate a hold on collections with the provider and to contact Services Australia to complete an income and means assessment. The outcome of the income and means assessment was that the Income Tested Care Fee was $0 and the accrued debt would be retrospectively reassessed to $0. The advocate also supported the older person with education around CHSP and HCP fees and charges.

OPAN network members noted that the legislation was unclear on the responsibility of previous providers for their poor financial management when an older person had changed to another provider, often as a result of the poor financial management. In many cases, providers claimed they were not able to reimburse errors and overcharges they had made against an older person's HCP as the package fund management no longer sat with them. In other cases, advocates successfully supported the older person during the Aged Care Quality and Safety Commission's (ACQSC) complaints process, resulting in a waiver of debt or reimbursement of erroneously charged fees into the older person's HCP funds via Services Australia.

The transparency regarding fees and charges for 'brokered' third-party services by HCP providers was a recurring issue. In some cases, advocates were able to ensure older people received copies of the original invoices from the third-party provider to the HCP provider to confirm services and fees, but in other cases not. Scrutiny of these third-party charges sometimes revealed significant overcharges and errors, with the third-party provider invoicing the HCP provider for services they never actually provided to the older person. At times, scrutiny of third-party invoices to the HCP provider also revealed significant 'brokerage fees' and mark-ups by the HCP provider, on top of the actual service cost.

Issues related to fees and charges for transport for HCP recipients was a common issue in the HCP advocacy case examples. As community transport for HCP recipients is not subsidised by the government, many people who had been reliant on community transport prior to receiving a HCP were suddenly faced with exorbitant fees to access these services, with multiple examples of people being charged $280 per trip out of their HCP on a community transport bus. This impacted not only people's ability to attend necessary health appointments, but also opportunities for social engagement. Some older people were told by a provider that a care worker could do the shopping for them and bring it to their house, which would be cheaper than the cost of accessing the community transport. However, this did not consider that going out on the bus to do the shopping was an important part of the older person's social life and perhaps their only point of engagement with people other than their carers during the week.

Concerns about the changes to the Social, Community Home Care and Disability Services (SCHADS) Industry Award 2010 raised in the 2023-24 Presenting Issues Report continued in 2024-25. There were many case examples of HCP providers interpreting the SCHADS Award as meaning that older people had to receive a minimum of two hours of service in each instance, rather than rostering their staff with multiple clients and/or other duties for a minimum two-hour shift. This had a particularly negative impact on people with high frequency care needs, but with each episode of care requiring only a small amount of time. In some cases, this meant that people were forced to use their HCP funds for a few 2-hour episodes of care a week, rather than supports daily or multiple times per day. This led to cases where older people were forgoing meals and daily care or paying significant out-of-pocket costs for extra care.

Case study 13

An older person who uses a wheelchair to mobilise needs assistance with getting ready for bed – a task that takes 15-30 minutes. Not only must they go to bed at 5pm due to lack of choice regarding the timing of this HCP service, but they must also pay for a minimum two-hour service out of their HCP funds which are rapidly depleting. As a result, they have been paying privately for assistance instead.

The requirement for at least two-hour services for each client in areas where older people were geographically close to each other appears paradoxical when the same providers reported that staff shortages were the reason older people could not have their needs met. This suggested a lack of appropriately skilled and experience in the care coordination and management side of the providers' businesses.

OPAN network members reflected that while raising complaints regarding financial issues to the Aged Care Quality and Safety Commission (the Commission) helped to seek a resolution of providers' errors and overcharges at times, in other instances, this was not the case. They reflected that sometimes the HCP provider's evidence was considered as 'stronger', even if the older person had warranted concerns about their consumer and human rights not being upheld. In some cases, HCP providers significantly increased fees and charges without informed consent from the older person. For example, there were cases where emails that the older person could not access had been sent with agreement clauses stating that if older people continued to accept services from the HCP provider, this was taken as agreement to the increased fees and charges. A similar experience was noted when complaints were raised with the Commission regarding the aggressive debt collection policies of HCP providers. Even if these policies did not align with the older person's rights, the Commission would rule that the HCP provider had not breached any requirements as they were operating in line with their own policies.

Commonwealth Home Support Programme

Issues relating to the Commonwealth Home Support Programme (CHSP) were raised in 24% of the OPAN network member advocacy cases in the 2024-25 financial year (3,259 of the 13,486 advocacy cases). This is an increase in the proportion of advocacy cases relating to CHSP when compared to the 2023-24 financial year (16% of the 14,238 advocacy cases in 2023-24).

When considering that people receiving CHSP services comprise 63% of the total aged care population, the 24% of advocacy cases related to CHSP is relatively low[17].

There were 5.9 times fewer advocacy cases and 2.6 times fewer information provisions related to CHSP than would be expected by the size of the aged care population for this aged care type (see Figures 8 and 9 and more detail in chapter 'Overview of OPAN services in 2024-25').

However, there was a 54% increase in information provisions relating to CHSP in the 2024-25 financial year when compared to 2023-24 (see chapter 'Overview of OPAN services in 2024-25'). As explored in the 'Accessing aged care' chapter, an analysis of the case studies and reflections provided by OPAN network members showed that many of these contacts resulted from provider actions in anticipation of the upcoming Support at Home program.

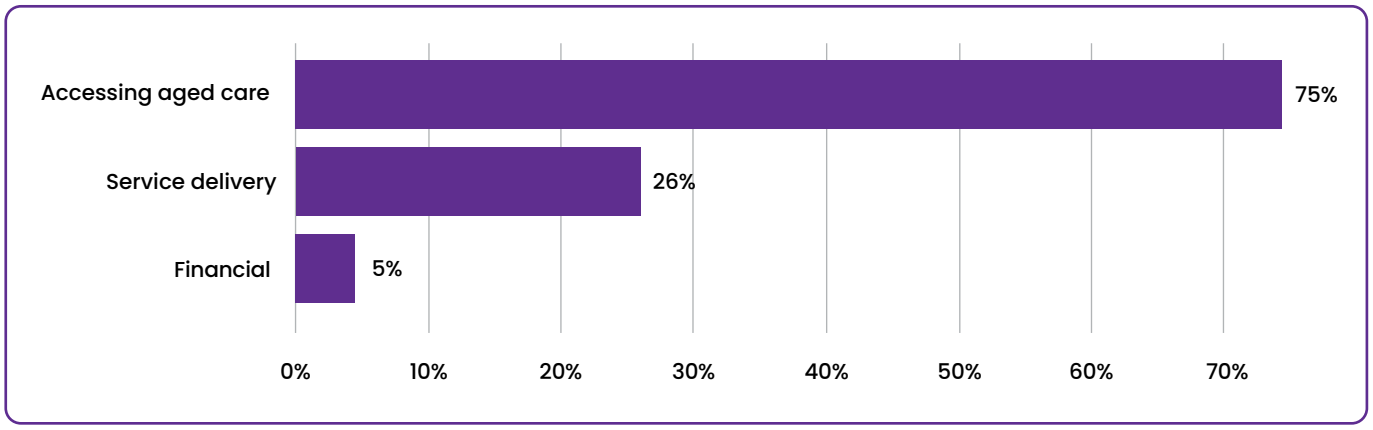

Figure 18. Proportion of CHSP advocacy cases by issue category.

Issues relating to accessing CHSP services were the most common reason for advocacy support (2,429 cases; 75% of all CHSP cases, Figure 18) and have been explored in detail in the 'Accessing aged care' chapter. Issues relating to CHSP service delivery were the next most common issue (847 cases; 26% of all CHSP cases, Figure 18). It is noteworthy that while the majority of advocacy cases for Home Care Packages (HCPs) (51%) and residential aged care related to service delivery (46%), for CHSP advocacy cases the top issues related to accessing CHSP services. This trend was also observed across aged care programs in the 2023-24 Presenting Issues Report.

The analysis of the 2024-25 case examples provided by OPAN network members suggests that the increase in CHSP advocacy cases in 2024-25 related to issues largely resulting from the CHSP providers being at capacity, experiencing staffing shortages, and starting to limit services and/or exiting the CHSP market due to the new Support at Home program. These issues are explored in more detail in the chapter on 'Accessing aged care'. The staffing issues and capacity of providers also underpinned many advocacy cases relating to CHSP service delivery. As reflected in the 'Home Care Packages' chapter, while staffing shortages may be beyond providers' control, how they communicate and manage the impacts of these on older people is within their control.

[17] See the 'Overview of OPAN services in 2024-25' chapter for more information and data sources.

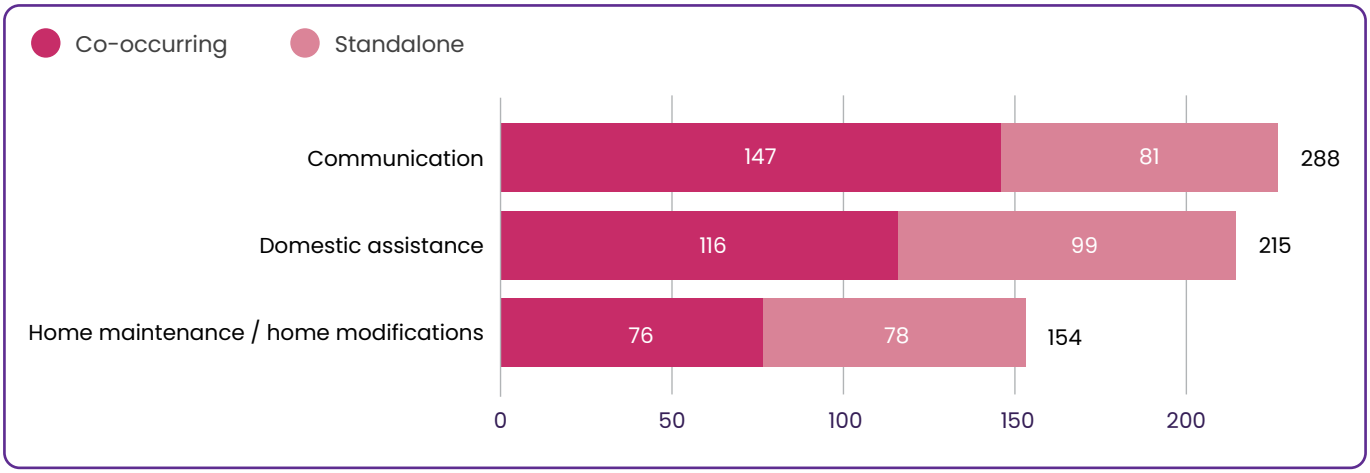

Figure 19. Top three service delivery issues in CHSP by category (count of issues).

The top issues in CHSP were relatively evenly spread when compared to Home Care Packages, where poor communication was the most common service delivery issue by far (being raised in 40% of HCP service delivery cases, see 'Home Care Packages' chapter). Communication was the top issue raised in CHSP service delivery cases (Figure 19). Communication issues commonly co-occurred with issues relating to choice and decision making, and advocacy support in raising complaints. Communication issues were closely followed by issues related to domestic assistance, and home maintenance or home modifications (Figure 19).

Financial issues were the third most common issue in CHSP advocacy cases (147 cases, 5% of all CHSP cases, Figure 18). It is noteworthy that the proportion of CHSP advocacy cases where financial issues were raised (5%) is much lower than the proportion of Home Care Packages (HCP) advocacy cases where financial issues were raised (24%, see 'Home Care Packages' chapter).

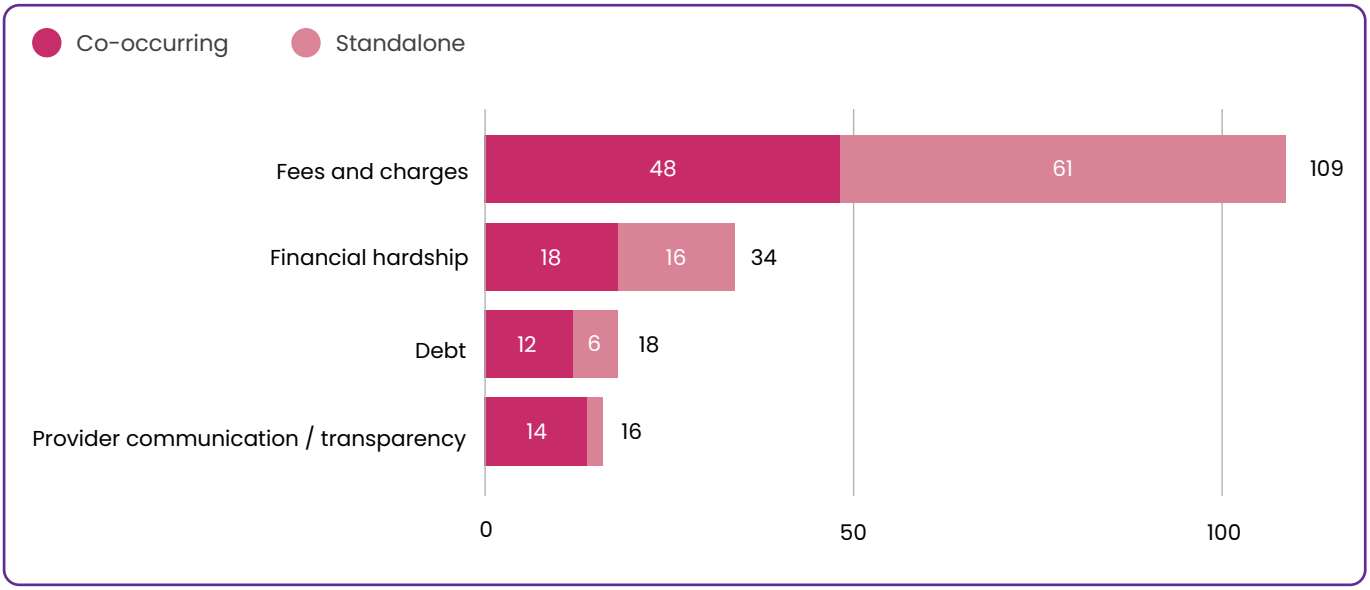

Figure 20. Top four financial issues in CHSP by category (count of issues).

While financial issues were relatively uncommon in CHSP advocacy cases (5% of all CHSP advocacy cases), they most often related to fees and charges. Issues relating to financial hardship, debt and provider communication about financial issues were the next most common issues, albeit in low frequencies. (Figure 20)

The quantitative data and qualitative analysis of these top CHSP service delivery and financial issues in advocacy cases are explored in the following sections in this chapter.

CHSP communication, decision-making and complaints

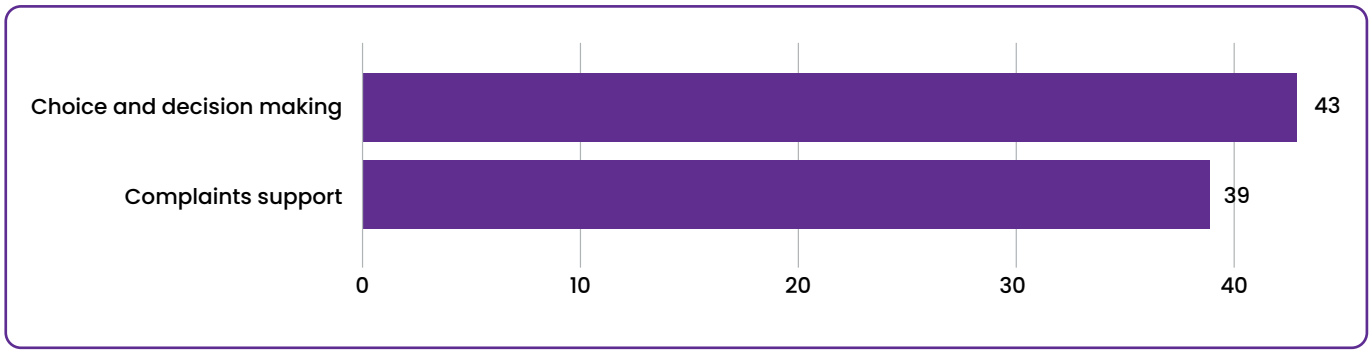

Figure 21. Top two co-occurring issues with CHSP communication issues (count of issues).

Issues relating to CHSP communication delivery were the most common in CHSP advocacy cases (214 (25%) of the 847 CHSP service delivery issues). The most commonly co-occurring issues with CHSP communication issues were choice and decision making (42 (20%) of CHSP communication cases) and complaints support (37 (17%) of CHSP communication cases). Figure 21 shows these top co-occurring issues with CHSP communication issues, noting that more than one issue can be raised in each advocacy case, so the count of issues is higher than the count of cases.

Poor communication by CHSP providers about the services available to older people contributed to older people not being able to make informed decisions about the services. As explored in the 'Home Care Package' chapter, poor communication from providers about older people's options under CHSP and Home Care Packages and the associated financial implications was a common issue also raised in CHSP advocacy cases.

Poor communication between providers and older people led to older people seeking advocacy support to raise their concerns with the CHSP provider. Most often, the older person had already made several attempts to raise their concerns with their CHSP provider but felt they had not been heard, and no improvements had been made. In some cases, the only way CHSP communicated with older people about important information was online or via email. This meant that those with limited internet access and limited access or ability to use computers could not receive important communications. In other cases, older people were not even provided with contact details to be able to request service changes, care plan reviews, or raise concerns with the CHSP provider.

The lack of available CHSP providers, explored further in the 'Accessing aged care' chapter, led to older people feeling reluctant to raise concerns and complaints with their CHSP providers. It also contributed to older people being forced to accept low quality and highly irregular, and infrequent services by their CHSP provider.

As seen in other aged care programs in 2024-25, there were also multiple issues related to privacy and decision-making raised in case examples where CHSP providers inappropriately discussed an older person's personal information with other people, without their consent. This included discussing health conditions, service plans, and the need for medical reviews with adult children and other relatives of the older person.

Case study 14

An older person contacted an OPAN network member as they were concerned about the care planning process and outcome with their CHSP provider.

The older person explained that after booking a time for a care planning meeting, the CHSP provider turned up hours later than agreed, with no explanation or apology. The assessor rushed through the assessment and quickly left the older person's home. When the older person received the CHSP Care Plan in the post, they discovered incorrect personal information on the completed forms.

At the bottom of the form was a note for the older person to contact the case manager if there were any issues or questions. The older person noted that the provider's representative who attended their home did not leave their number or a business card. They therefore had no contact information available to follow up on their issue. As a result of this, the older person said they no longer felt comfortable using the provider's services.

The advocate supported the older person to report this issue to the provider over the phone and inform the provider that they no longer wished to use their services.

The advocate then supported the older person to have their CHSP referral codes released from this provider and to use the My Aged Care 'Find a Provider' tool to find a new provider.

CHSP domestic assistance, home maintenance, and communication

Issues related to domestic assistance and home maintenance or home modifications were the second and third most common issues in CHSP advocacy cases (211 (25%) and 151 (18%) of the 847 CHSP service delivery cases, respectively). Analysis of the qualitative case study data and presenting issues reflections by OPAN network members revealed that home maintenance or home modifications advocacy cases predominantly related to gardening and yard maintenance (e.g. path clearing) services.

Communication was the most commonly co-occurring issue with issues related to CHSP domestic assistance and home maintenance or modifications (52 (14%) of the 362 CHSP domestic assistance, home maintenance, or home modification cases).

Issues with CHSP domestic assistance and home maintenance were also largely driven by a lack of service availability, high rates of staff turnover, and rostering issues. As with Home Care Packages, in some cases, providers had moved to automated rostering of staff, which meant that older people could not request a preferred worker or have consistent workers. This meant that they had to explain their service needs at each service instance. It also meant that older people had no ability to build rapport with care workers who may notice changes in their needs, including any signs of health concerns that may require urgent attention.

Case study 15

An older person was dissatisfied with their current CHSP provider due to poor cleaning service quality, including frequency and billing for services never provided. When the older person raised these concerns with their provider, the provider responded that there was nothing they could do to address the older person's concerns due to staffing shortages.

The older person attempted to switch to another provider but was placed on a waitlist for over 6 months due to capacity issues.

The advocate supported the older person in reattempting to negotiate an improvement in services from their current provider. This resulted in the provider agreeing to try to roster more consistent care workers with the older person.

A further 3 months had passed when the advocate reached out to the preferred CHSP provider and reminded them of the older person's wish to transfer and increasing unmet needs. Eventually the older person transferred to their preferred CHSP provider and the quality of their service and communication improved.

CHSP fees and charges issues

CHSP financial issues were raised in only 5% of the CHSP advocacy cases (147 of the 3,259 CHSP advocacy cases). One in four (73%) of the CHSP financial issues related to fees and charges (108 of the 147 CHSP financial cases). The next most common financial issues in CHSP advocacy cases were financial hardship (22%), debt (12%) and provider communication and transparency (11%) (33, 18 and 16 of the 147 CHSP financial cases, respectively). These next most common CHSP financial issues also commonly co-occurred with fees and charges issues with 15% co-occurrence for financial hardship issues, 12% co-occurrence for issues related to provider communication and transparency, and 9% co-occurrence for debt (co-occurring in 16, 13 and 10 of the 108 CHSP fees and charges cases, respectively).

Poor communication by providers regarding fees and charges underpinned many of the CHSP financial advocacy cases. In many cases, issues related to fees and charges with CHSP providers because of a lack of clear and transparent communication. Communication breakdowns and a lack of transparency often began with the agreement the older person was asked to sign and continued with unclear statements and invoices.

Case study 16

An older person contacted an OPAN network member as they had called their CHSP provider, whom they had been with for a number of years, to discuss their concerns about the invoices, including their lack of transparency.

Instead of communicating with the older person about their concerns, the provider called the older person's adult child and asked them about the older person's cognitive ability. The older person did not understand why the provider would call another party instead of addressing their concerns directly. The older person believed the provider had breached their privacy and rights.

When the older person made a complaint to the Aged Care Quality and Safety Commission, the complaint was finalised after the provider sent an apology letter.

The older person explained to the advocate that they were seeking further support as they did not want an apology, but rather an explanation as to what had occurred, as the provider had not acknowledged or taken any accountability for what they had done wrong.

The older person directed the advocate to assist them in communicating with the provider and to explain why they contacted their adult child, how the accounts clerk was able to access and use privileged information, and what they were going to do to ensure this does not happen again in future. The advocate assisted the older person to write a letter to the provider. At the time of writing the case study, the older person had not received a response from their provider.

There were also examples of errors being made where older people were charged for services that had been cancelled or not provided by the provider due to staff shortages.

As explored in the chapter on 'Accessing aged care' providers were often remiss in advising older people of the option to apply for financial hardship. In some cases, the financial hardship policies and processes for older people were not appropriate and led to older people going without services. For example, an advocate supported an older person to ask their CHSP provider for the financial hardship policy as they were unable to pay the co-contribution due to financial hardship. The provider declined providing the financial hardship policy, proposing instead that the older person agree to a payment plan for services.

Residential aged care

Issues regarding residential aged care occurred in 22% of the total advocacy cases in 2024-25 (2,970 of 13,486 advocacy cases), which is lower than the 34% of advocacy cases relating to residential aged care in 2023-24. However, this decrease in the proportion of advocacy cases relating to residential aged care in 2024-25 is partly driven by the increase in advocacy cases related to CHSP explored in the previous chapter.

When considering that people living in residential aged care comprise only 14.5% of the total aged care population, the proportion of advocacy cases and information provisions relating to residential aged care is still 1.5 times higher than expected[18].

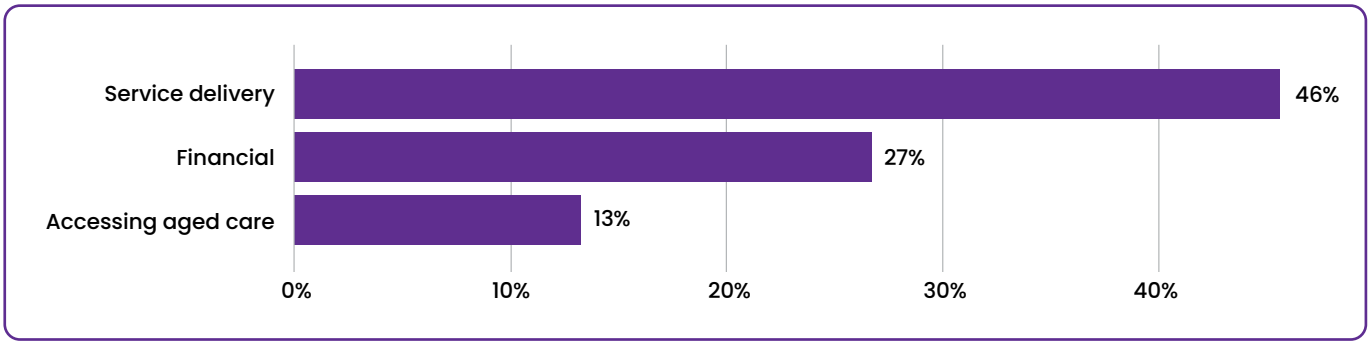

Figure 22. Proportion of residential aged care advocacy cases by issue category.

The top residential aged care issues categories followed a similar trend to the previous financial year. Residential aged care service delivery was the most common reason for advocacy support (1,358 cases, 46% of all residential aged care cases, Figure 22). Financial issues were the next most common (795 cases, 27% of all residential aged care cases), followed by issues accessing residential aged care (392 cases, 13% of all residential aged care cases) (Figure 22). This is in contrast to Home Care Packages where issues relating to service delivery and accessing aged care were more common in advocacy cases than financial issues (see 'Home Care Packages' chapter).

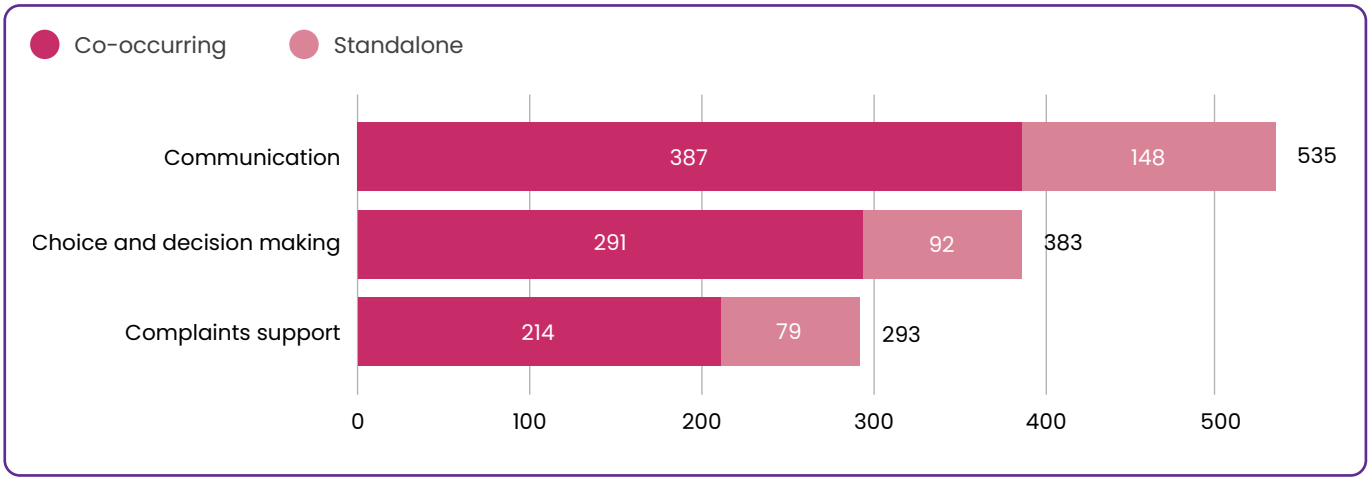

Figure 23. Top three service delivery issues in residential aged care by category (count of issues).

As in the 2024-25 financial year, the top issue relating to residential aged care service delivery was communication (Figure 23). Communication issues commonly co-occurred with issues relating to choice and decision-making, complaints support, care planning, and quality of care and services. Choice and decision-making and complaints support were also the second and third most common presenting issues for residential aged care service delivery (Figure 23).

[18] See the 'Overview of OPAN services in 2024-25' chapter for more information and data sources.

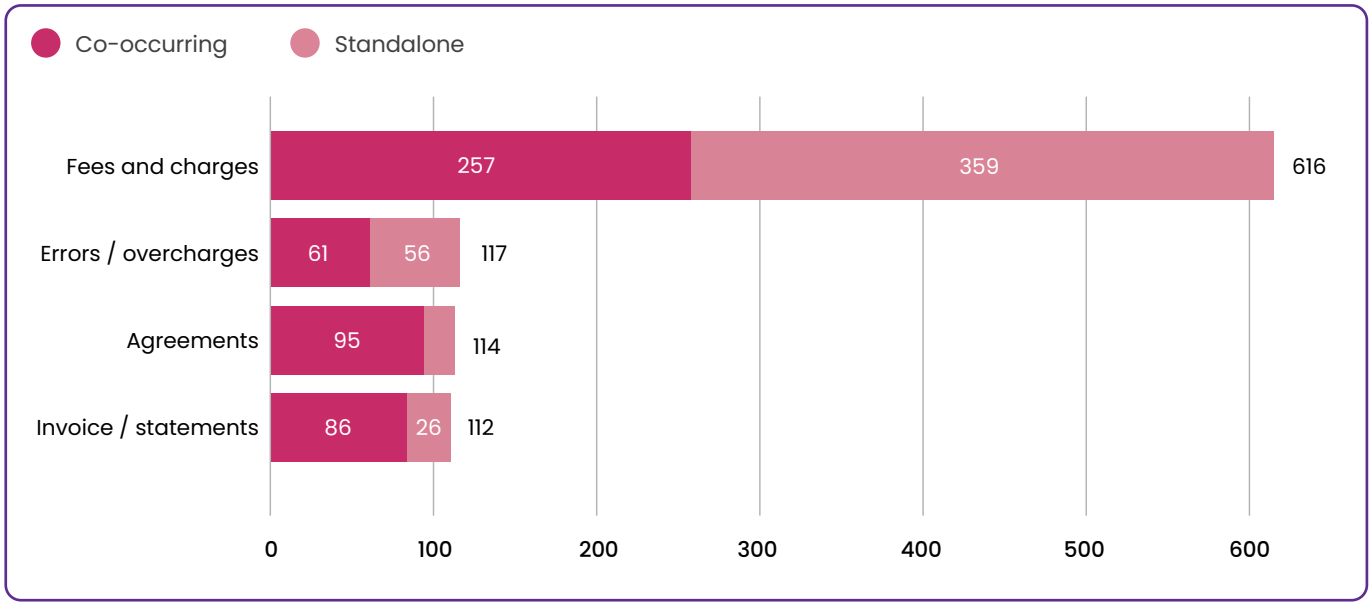

Figure 24. Top four financial issues in residential aged care by category (count of issues).

Issues relating to fees and charges were the most common financial issue in residential aged care advocacy cases (Figure 24). Issues relating to fees and charges commonly co-occurred with issues with agreements, invoices or statements, errors or overcharges, and financial hardship. These co-occurring issues with fees and charges were also in the top 5 presenting issues in residential aged care advocacy cases (Figure 24).

The quantitative data and qualitative analysis of these top residential aged care service delivery and financial issues in advocacy cases are explored in the following sections of this chapter.

Residential aged care communication, decision-making, care planning and complaints

The top issue relating to service delivery in residential aged care was poor communication by providers (450 (33%) of the 1,358 service deliver in residential aged care cases). The next most common service delivery issues in residential aged care were choice and decision-making (329 (24%) of the 1,358 service delivery cases) and complaints support (258 (19%) of the 1,358 service delivery cases).

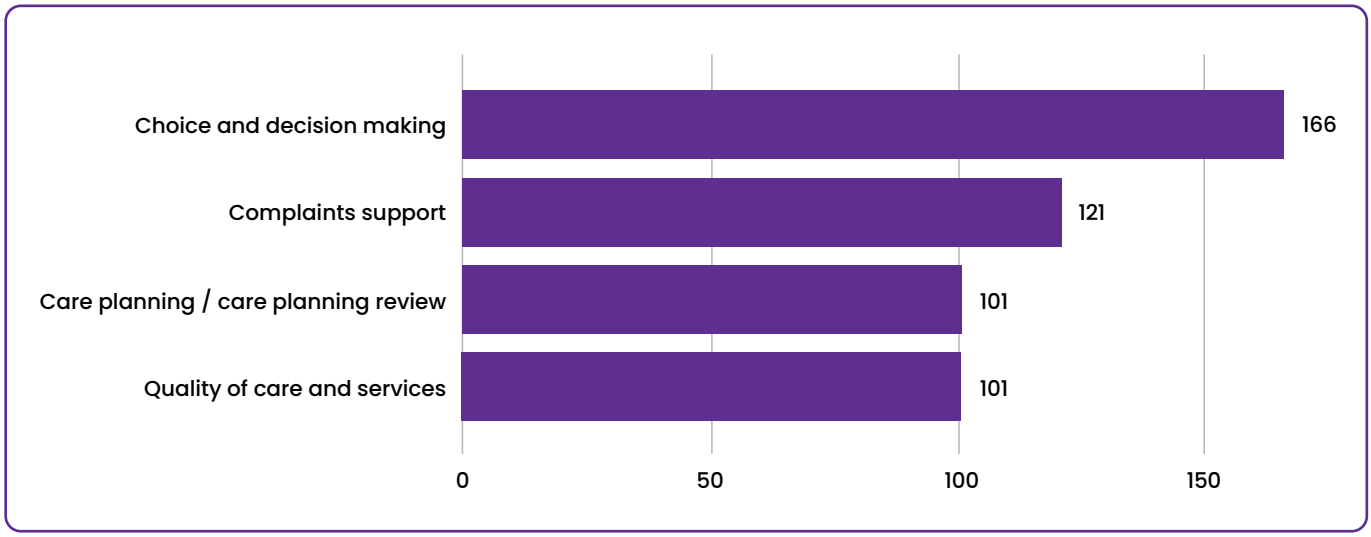

Figure 25. Top four co-occurring issues with residential aged care communication issues (count of issues).

The top three issues relating to residential aged care service delivery were also the most commonly co-occurring. Communication issues most commonly co-occurred with choice and decision-making issues (32%) and complaints support (26%) (co-occurring in 145 and 115 of the 450 residential aged care communication cases, respectively). Figure 25 shows these top co-occurring issues with residential aged care communication issues, noting that more than one issue can be raised in each advocacy case, so the count of issues is higher than the count of cases.

The next most commonly co-occurring issues with communication in residential aged care cases were related to quality of care and services (20%) and care planning (20%) (co-occurring in 91 and 89 of the 450 residential care communication cases, respectively).

As in HCP and CHSP advocacy cases, staff shortages appeared to have influenced several of the advocacy cases related to service delivery in residential aged care. From the older person and advocates perspective, stretched staff, inexperienced care workers, and high staff turnover were considered contributing factors to communication breakdowns between older people and their residential aged care provider. However, staffing shortages did not explain the majority of communication and related issues in residential aged care.

In contrast, a general lack of respect for the older person and their decision-making rights underpinned most of the service delivery issues. In particular, residential aged care providers failed to uphold the older person's right to be presumed to have decision-making ability and a right to make decisions that involve an element of personal risk. In many cases, providers dismissed older persons' repeated requests and concerns and only responded once an advocate became involved. In other cases, older people's concerns about care workers' lack of respect for their personal space and belongings, and/or disrespectful communication were not addressed by management until an advocate became involved in the cases that were dealt with by OPAN network member advocates. Many of these situations would not have required an advocate's involvement and/or escalation of a complaint to the Aged Care Quality and Safety Commission (the Commission) if the residential aged care staff had just listened to the older person and responded to their requests and concerns.

Case study 17

During an education session at a residential aged care home an advocate asked the quality coordinator at the home about how residents can provide feedback and make a complaint.

The quality coordinator stated that they have a QR code in each room which the residents can use to give feedback and complaints. The advocate asked the residents if they were familiar with the QR code, if they all have smart phones, and if they know where the QR codes are situated. None of the residents were aware of the QR code and some did not have access to a smart phone.

The advocate asked how an older person who wanted to provide feedback or make a complaint could do so if they could not use the QR code. The quality coordinator stated they would be told to raise their issues with the Aged Care Quality and Safety Commission.

Choice and decision-making around medication management was a trending issue that continued from 2023-24 advocacy cases. For older people who required Schedule 8 medications dispensed at specific times and points in the day, the lack of available nursing staff to dispense the medication in residential settings significantly impacted their daily routines and quality of care. Older people were often not given the option to self-manage their medications and thereby time them appropriately throughout the day and with meals etc. For many, it took significant advocacy work to reach an agreement with residential aged care providers about the self-management of medication, even for low-risk medication such as allergy eye drops. The analysis of the case studies suggests that these medication self-management issues arose not only because of an over-heightened focus on risk by providers, but also because the providers often presumed that the older person lacked the ability to self-manage their medication.

There were also several examples of medication being prescribed without the General Practitioner (GP) ever having met with the older person, and cases where the GP mistakenly prescribed the wrong medication for the wrong resident. This stemmed from residential aged care staff and GPs' dismissal of the older person's attempts to communicate their knowledge of, and preferences for, their medications, a lack of GP interaction with residents, and a lack of coordinated GP introductions to older people and their supporters during GP visits in residential aged care.

Case study 18

An older person sought support from an advocate in communicating with their residential aged care provider about their pain management schedule.

The older person had recently moved into residential aged care. Within the first week of living in residential aged care, their pain medication schedule was changed from every four hours to every six hours with no explanation. The older person asked the residential aged care medical team why the medication had been changed and was told the GP had changed the pain medication schedule.

The older person said they had never met the GP who made the changes and was not provided any contact information to ask the GP questions. They said they had been told the GP had been in the room to meet them, but that they were asleep at the time.

When the advocate visited the older person, the GP was doing their rounds at the residential aged care home and came into the older person's room. The advocate observed that the GP did not introduce themselves or address the older person by their name and proceeded to ask questions that had nothing to do with their diagnoses or health needs.

A personal care worker explained to the GP that they were talking about the wrong resident. The GP did not apologise or engage with the older person, even after the older person told the GP about their increased pain and wanting the pain medication schedule to go back to normal.

Following this visit from the GP and still no return to the original pain medication schedule, the advocate supported the older person by writing an email to the residential aged care provider's general manager about the situation. The older person received a return apology email stating that the provider staff had discussed the situation, and their previous medication schedule had been reinstated.

Access to appropriate medical services in the community, in line with the older person's preferred choice, was also actively inhibited by aged care providers in many cases. The limited coordination of and/or connections to transport options for residents to attend appointments severely limited their ability to access medical services. In one example, the residential aged care provider stated that the client was not allowed to attend their preferred community dental service for urgent treatment. The resident and advocate were told that a request for emergency community dental services was not made, and the older person had to wait for the dental truck to visit the facility. This inaction by the provider significantly delayed the older person's ability to access an essential medical service. In other cases, providing people with access to the technology required to attend telehealth appointments would have helped address their health and allied service needs in a timely way.

Engagement by residential aged care providers about older people's dietary needs and preferences was a recurring issue in the advocacy case examples provided by OPAN network members. In many cases, providers only responded to older people's concerns and complaints about the quality of the food once an advocate got involved. In some cases, providers provided extremely poor quality food or limited options for those with dietary needs and preferences. For example, only offering cold salads as an alternative to a warm meal. Older people who did not have family members who could prepare alternative meals that were appropriate for them to eat, often went without meals.

There were numerous case examples and reflections by OPAN network members regarding residential aged care staff and visiting health professionals not including older people in conversations if they had a representative listed with My Aged Care or the provider. This is a breach of older people's right to be informed about their care and services and be engaged in decision-making, even if they have been deemed not to have the legal capacity to make those decisions themselves. However, oftentimes, the decisions were not even ones that would fall under a substitute decision-making authority under state or territory legislation and instead related to minor, low risk, day-to-day considerations such as food preferences, social interactions, and access to different areas of the residential aged care home.

The recurring issue of older people being required by residential aged care providers to have a substitute decision-maker under state or territory legislation appointed and active upon entry into residential aged care continued in 2024-25. It is good practice to remind older people of the potential benefits of advance planning and nomination of substitute decision-makers in case of future need upon entry into residential aged care. However, it is inappropriate and a breach of older people's human rights to make decisions and exercise legal capacity to require those with decision-making ability to activate those appointments, in case of future need.

A lack of understanding, or perhaps an awareness of abuse of substitute decision-making powers was reflected in a number of cases where the same residential aged care manager had applied for guardianship and administration of all residents in their care home. In most cases, the applications were dismissed at the first tribunal hearing as the provider was unable to provide the necessary documentation.

While substitute decision-makers should not be overly involved in older people's decisions, they must be appropriately engaged regarding decisions that do fall under their authority. In some cases, substitute decision-makers appointed for health issues were not notified of significant changes and decisions about the older person's health condition. In other cases, substitute decision-makers became aware of issues that fell outside their authority, but then appropriately acted as supporters of the older person to ensure their voice was heard and that the provider responded to their requests and concerns. A case example was provided where ongoing issues raised by the client that advocacy support had been unsuccessful in resolving only improved once the older person's Public Guardian representative visited the facility and supported the older person to raise their concerns.

OPAN network members raised that older people were increasingly seeking advocacy support in drafting and revising wills and advance plans. This issue is out of scope for NACAP advocacy, and in many cases, older people were unable to access free legal services, as none were available to them, and they could not afford to pay for a private lawyer's support.

Residential aged care fees and charges issues

Issues relating to fees and charges were raised in almost 3 out of 4 (72%) of the residential aged care advocacy cases relating to financial issues (571 of the 795 residential aged care financial cases). The next most common issues occurred in lower proportions of the 795 residential aged care financial cases: errors or overcharges (14%, 114 cases), invoices or statements (14%, 109 cases), agreements (13%, 107 cases), and financial hardship (13%, 101 cases).

The next most commonly co-occurring financial issues with fees and charges in residential aged care cases were related to these same next most common top issues: agreements (13%), invoices or statements (13%), errors or overcharges (9%) and financial hardship (9%) (co-occurring in 76, 72, 52 and 51 of the 571 residential care fees and charges cases, respectively).

As in 2023-24, the lack of coordinated processes and consistent information and terminology between Services Australia, assessment teams, My Aged Care and residential aged care providers about residential aged care financial matters continued to underpin many of the advocacy cases. Older people were often overwhelmed and didn't know where to turn next as they entered residential aged care and navigated complex financial matters. Many sought advocacy later in the process and stated that they were shocked and distressed to receive an invoice or statement from their residential aged care provider with fees and charges they were not expecting. The lack of coordination between parts of the aged care sector and the resulting lack of understanding by older people and their substitute decision-makers was compounded by the fact that people are often making residential aged care financial decisions in times of stress or a care crisis.

In many cases, older people and their substitute decision-makers were not able to get the requested clarification regarding fees and charges from their service provider, Services Australia or My Aged Care and turned to OPAN network members for support. In some cases, it was revealed that not only was the information provided to older people unclear and inconsistent, but it was also sometimes not correct. These issues included agreements that did not clearly outline fees and charges, and which services they relate to.

Wait times for Services Australia income and assets assessments led to older people being invoiced for, and providers aggressively demanding payment of, significant fees while the application was being processed. Wait times of 3 months for a Services Australia income and assets assessment were reported by OPAN network members across Australia. In many case examples, the fees demanded while waiting for income and assets assessments were in the tens of thousands. In other cases, residential aged care providers did not inform older people or their substitute decision-makers for financial matters, of the need to undertake an income and assets assessment with Services Australia.

A number of case studies arose because older people who thought their residential aged care fees were being deducted from their age pension via Centrepay (direct debit via Services Australia) were told they were in debt to their provider for thousands of dollars. Upon review by the advocate, it became apparent that this was because the direct debit amount had not increased in line with the CPI increases in fees by the provider. The older person had not been told by Services Australia or their residential aged care provider of the need to update their direct debit payments in line with the increased fees and charges. They were also not notified of the accumulating debt until it had reached a significant amount. In one case example, the residential aged care provider demanded that the older person pay 100% of their age pension to the provider in order to settle the debt, or they would be evicted.

Advocacy cases relating to residential aged care fees and charges resulted in a number of cases with older people being supported to apply for financial hardship with Services Australia. In these cases, residential aged care providers had not advised the older person of the financial hardship option. Once people did apply for financial hardship, they often experienced significant delays in getting a response from Services Australia. In one case, the delay in the financial hardship application resulted in the residential aged care provider invoicing the older person tens of thousands of dollars while the application was being considered. Attempts to contact Services Australia for an update on progress were unsuccessful, and the family were left experiencing significant financial hardship as they attempted to pay the fees. The advocate successfully supported the older person in negotiating that any further invoices be put on hold until the Services Australia assessment had been received. For other people, they had no family or friends in their network who could assist with paying residential aged care fees and charges, and they were placed in situations of immense pressure as providers demanded payment. In one case example, an older person contacted Services Australia as their provider had told them that if they did not pay the $90,000 in fees owing to them, they would be evicted from the residential aged care home. The provider had not mentioned to the older person that they had the option to apply for financial hardship with Services Australia. The advocate supported the older person to apply for financial hardship, the outcome of which was that no money was owing to the residential aged care home.

Case study 19

An older person decided that they wanted to stay in residential aged care after a 6-week respite stay as they could no longer look after themself at home alone. Their total aged care fees were assessed at almost $3,000 per fortnight, with their only income being the age pension. They had a small amount of savings, which were used by the end of the first 3 months of residential aged care. Their savings account then went into overdraw, increasing the debt and causing considerable stress to the older person.

When the advocate met the older person for the first time, they were going back and forth to their home where they had lived alone for 35 years almost every day in order to pack up and sell the home to cover their aged care expenses. The older person was trying to get some maintenance jobs done before the house could be sold, but they could not afford to pay these bills.

The advocate assisted the older person to apply for financial hardship, which was a lengthy process as they needed to locate all the documentation amongst the disarray and stress of moving home.

After the financial hardship application was submitted to Services Australia, it took almost 3 months to process.

The outcome of the financial hardship assessment was that the older person's aged care fees dropped from $3,000 per fortnight to $350 per fortnight, backdated to the date of entry into residential aged care. This meant that the residential aged care provider cleared the older person's $17,000 debt. In addition, it meant the older person could now utilise their age care pension to pay all their outstanding bills. The older person felt they now had time to pack up and sell their home without the added stress of accumulating debt.

The issue of providers charging 'additional services' fees for services that the older person did not want and could not participate in or benefit from was an ongoing issue in 2024-25. Some residential aged care providers required agreement to the charging of 'additional services' as a condition of entry. This leaves many older people in areas with limited residential aged care availability feeling forced to accept the charges and at risk of significant financial hardship and debt. There have also been cases where older people have been denied a place at a residential aged care home because they don't have the means to pay for additional services. In many cases, 'additional services' have been bundled into a single fee and the range of available services are not clearly outlined to older people in their agreements, invoices, or statements. Even older people assessed by Services Australia as not having to pay an accommodation contribution have been asked to pay for additional services, and while these are often at a reduced rate, they still place the person into significant financial hardship. Involvement of advocates in cases relating to additional services most often revealed no link between the additional services the residential aged care provider claims the older person is receiving and the older person's care plan. In some cases, advocates were able to support older people to raise questions about their additional services fees and ask for changes to their agreements so that they were only charged for those services they used. In one example, the additional service fee was $72 per day, and the advocate supported the older person experiencing financial hardship to negotiate it down to $55 per day.

Case study 20

An older person had recently entered residential aged care and was in the advanced stages of their illness. Their substitute decision-maker for financial matters sought advocacy services after raising concerns about additional service fees for services their parent could not benefit from and being told by the residential aged care provider 'if you don't like it, you can look for somewhere else'. The additional services being charged included pay TV, alcohol and other services the parent could not use. The substitute decision-maker wanted to make a complaint to the Aged Care Quality and Safety Commission (the Commission).

The advocate provided extensive information on additional service fees and the Commission's complaint process. The advocate explained that if a complaint were raised with the Commission, they would look to see if an appropriate assessment had been completed upon entry to determine if the client could access and derive a benefit from the services offered. The older person's substitute decision-maker explained that this did not happen.

The advocate explained that it is not enough for the older person to be able to 'access' the additional services, but that they must also be able to derive a benefit from them. The advocate provided the substitute decision-maker with written guidance on additional service fees.

The substitute decision-maker then met with the service provider and was successful in having the additional service fees removed from the older person's statements and agreement.

Often older people with active substitute decision-makers for financial matters did not receive copies of their invoices and statements. This meant that errors made by the substitute-decision maker went unnoticed. In some cases, the involvement of advocates at the older person's request due to suspected issues with errors and overcharges revealed that the substitute decision-maker had made errors in the income and assets assessment forms submitted to Services Australia or had failed to submit required evidence. This resulted in older people being charged at a higher rate than they should have been.

OPAN network members noted that the 2024-25 financial year saw more cases of older people entering financial hardship earlier than before. This was a result of the maximum Refundable Accommodation Deposit (RAD) being increased to $750,000. However, the income and assets limit above which people must pay the full RAD plus means-tested fees has not increased proportionately. As explained above, there are often also additional service fees to be paid. This means that older people close to the income and assets limit quickly use all of their financial resources and enter into financial hardship.

Flexible care

Flexible care service programs include:

- Respite care
- Disability Support for Older Australians (DSOA)
- Innovative Care Programme (ICP)
- Multi-Purpose Services (MPS)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC)
- Short-Term Restorative Care (STRC) pathway
- Transition Care Programme (TCP)

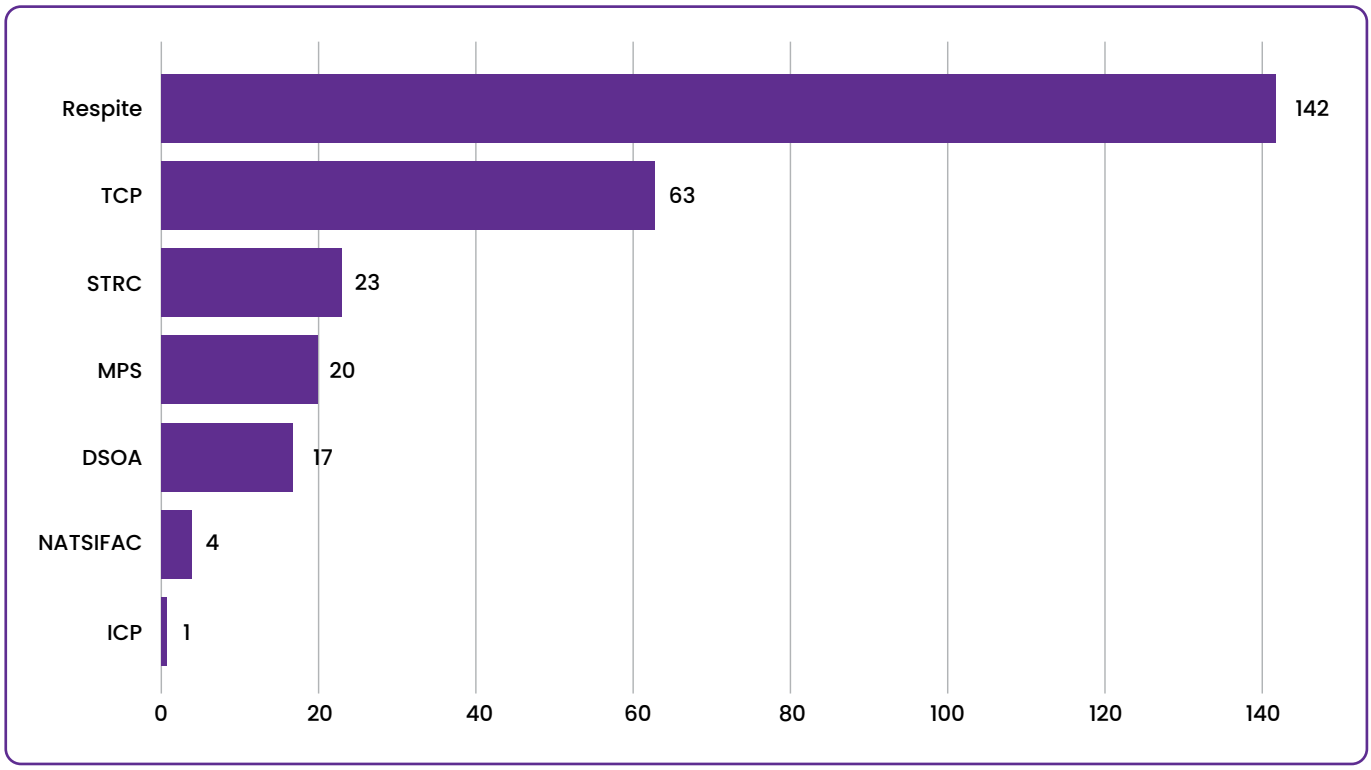

Figure 26. Number of flexible care advocacy cases by care type relating to client's issue.

Advocacy relating to flexible care accounted for just 1.9% of all advocacy cases in 2024-25 with a total of 267 cases (see Figure 7 in 'Overview of OPAN services in 2024-25' chapter). However, the number of OPAN services is 1.7 times higher than expected when compared to the population of people receiving respite, STRC and TCP services (228 (1.7%) of the 13,486 advocacy cases relate to, and 13,350 (1%) of the 1,309,203 aged care population[19] receive respite, STRC and TCP services). Figure 26 shows the number of advocacy cases in which issues relating to each of the flexible care service programs were raised.

The low number of flexible care cases meant that any quantitative analysis of the top presenting issues was not appropriate. Therefore, this section does not present the quantitative data, but instead provides a narrative reflection on quantitative trends and how they aligned with the findings of the qualitative analysis of advocacy case examples provided by OPAN network members.

[19] Source: People using aged care. AIHW Aged care data snapshot - third release, October 2024. Available at: https://www.gen-agedcaredata.gov.au/resources/access-data/2024/october/aged-care-data-snapshot-2024

Due to the low number of cases in each program type, the narrative exploration of top issues across the quantitative and qualitative data in this chapter is pooled for all flexible care programs. However, where a scenario leading to an issue was related to one of the programs in particular, this is specified in the reporting on the qualitative analysis of the case examples.

The qualitative analysis of the case examples confirmed the findings in the limited quantitative data. Namely, the most common flexible care issue for advocates to be involved in was supporting older people with the lack of available services and therefore the need for support in accessing flexible care, in particular for respite care, the Short-Term Restorative Care (STRC) pathway and the Transition Care Programme (TCP). The lack of available flexible care services was partly a result of the wait-times for Home Care Packages, CHSP service shortages, and residential aged care availability. The lack of availability of other aged care services increased demand on flexible care programs, which have only limited places. In addition, the lack of available flexible care programs and/or understanding of flexible care programs led to people being unnecessarily hospitalised for both short-term and long-term hospital stays. These issues relating to accessing flexible care are explored further in the 'Accessing aged care' chapter.

Both the quantitative data and qualitative data revealed that the next most common issues raised in flexible care advocacy cases, excluding respite care, were poor communication, including regarding fees and charges; a lack support to make choices and to raise concerns with flexible care providers.

Flexible care communication issues

Communication issues in flexible care often co-occurred with the issues relating to choice and decision-making and complaints, as well as issues relating to fees and charges explored in the following sections.

Of the 267 flexible care cases, 53% (142 cases) related to respite care which is delivered by and in residential aged care homes. The quantitative data and case examples showed that the issues experienced by older people in respite care were the same as those experienced by older people in residential aged care. Specifically, the top respite care issues related to communication and decision-making, particularly where there was an element of personal risk. This is not surprising given that both long-term and respite care are delivered by the same provider management and staff, and through the same policies and practices. Therefore, the issues faced by people receiving respite care are not explored further in this chapter and are instead addressed under the 'Residential aged care' and 'Accessing aged care' chapters.

There were reports of issues where staff at residential aged care facilities who were involved in the delivery of TCP services to short and long-term residents were unable to effectively communicate with older people, and deliver services to meet their health needs after a hospital stay. In some cases, the advocates reflected that it appears there was insufficient discharge planning by hospital staff before the older person transferred to residential aged care for TCP services. This led to older people needing to attempt to understand and communicate their own care needs to their TCP provider, which was often not possible as the hospital staff had also not communicated these to the older person.

Exemplifying the complexity of navigating health and aged care systems that leads to advocacy services being sought was a query received by an OPAN network member relating to older people's understanding of the permanency of their Multi-purpose service (MPS) and their security of tenure. The advocate sought clarification from the Department of Health, Disability and Ageing who acknowledged that it was a grey area with no clear or distinct guidelines. It was determined that whilst MPS sits with the health system, MPS' also have residential aged care services. Therefore, a person who is accessing the residential aged care side of the MPS needs to have their security of tenure upheld. It is unlikely in this case that the older person or their family would have been able to have got this clarity without the involvement of an advocate.

The case examples and reflections from OPAN network members showed that in many advocacy cases, STRC funding is not fully utilised, often due to a lack of provider support and communication with the older person regarding available funding and how it can be used.

As with other aged care types explored in this report, a lack of choice due to limited local providers meant that older people were unable to choose another flexible provider if they were dissatisfied with the current provider. In some cases, but not all, the involvement of an advocate meant that communication between the provider and older person were addressed, and services improved.

Case study 21

An older person reconnected with an advocate who had supported them with concerns about the STRC programme. The programme did not meet their care needs, as they had a health complication that impacted their ability to attend scheduled appointments. This resulted in unspent STRC funds at the completion of their STRC period. The older person had also been approved for a level 4 Home Care Package and was confused and angry at the length of the wait time for this to be allocated.

The advocate and the older person agreed that the advocate would contact My Aged Care to explore options for having their STRC reassigned. After an assessment, the older person was approved for STRC for the second time, due to the returned funds from the previous round of STRC.

The older person explained that they may need to find a different provider for the STRC programme due to the poor support received last time. The advocate and older person explored what the older person expected from the STRC and agreed that the advocate would contact their previous STRC provider and try to find an alternate STRC provider for consideration.

The older person received calls from two alternative providers, with one able to accept the STRC but not the Home Care Package when it was assigned, and the other able to accept both referral codes. The older person made an informed decision on the provider they wished to sign up with.

The chosen provider consulted with the older person to arrange a home visit to complete the STRC assessment.

The advocacy case was closed when the older person had all assessments and approvals for the purchase of items they required. They were very happy with the STRC service provider they had chosen.

Choice and decision-making in flexible care

The complexity of transitioning between CHSP and Home Care Packages, and flexible care programs, in particular TCP and STRC, led to older people not understanding what their options were and how to receive services. In many cases, older people received contradictory advice from assessors, hospital staff, and providers regarding their program eligibility and the differences between the programs.

Case study 22

An older person contacted an advocacy service wanting to understand what their options were as their provider had told them that their STRC programme funding had been cancelled after a hospital stay. The STRC programme services were essential for the older person to be able to return home.

The older person consented to the advocate contacting the STRC provider to discuss the issues and to find out more. In making contact, the advocate spoke at length with the STRC provider, who insisted that because of the guidelines relating to the maximum length of hospital stays, the older person had to be suspended from the programme.

The STRC provider informed the advocate that the older person is receiving CHSP services from a dementia specific service and recently the older person has also been approved for a Level 3 Home Care Package but is waiting for it to be allocated.

The advocate contacted the dementia specific service with the older person's consent, and it was clarified that the older person was not receiving any other service other than physiotherapy, but due to their health conditions, the care plan was quite restricted.

The advocate then contacted the assessment team with the older person's consent and was told it was the assessor's understanding that the STRC package was still in place. The assessor's opinion was that the older person should have been receiving service under the STRC programme and that until that was complete, the Home Care Package would not be assigned.

Once it was determined that no services were currently in place beyond the limited CHSP Exercise Physiology, the advocate liaised again with the assessment service, and it was agreed that some interim services needed to be made available to ensure the older person was able to stay as independent as possible for long as able. In addition, the STRC programme needed to be signed off on so that the Home Care Package could be allocated.

The advocate provided this information to the older person to ensure they were aware of the timeline and progress. The older person stated that they would like everything to happen to help them stay in the home. The older person discussed options with the advocate and decided they would seek the support of family and friends in deciding how to proceed with aged care services.

OPAN network members described that in some cases, TCP providers in overnight stay settings did not provide older people with the full range of aged care options that may enable them to return home with supports in place. Instead, older people were assumed to be, or pressured into, entering residential aged care at the completion of the TCP. Reflections from OPAN network members suggest that TCP providers may also have recommended residential aged care as the only option for older people due to their understanding of the significant wait times for Home Care Packages. Older people and their family members contacted advocates due to difficulties in getting necessary allied health and geriatrician assessments conducted while receiving TCP services, which meant they felt unprepared and uninformed regarding future aged care needs and options.

In other cases, flexible care providers played an important role in identifying an older person's care needs and which aged care program would best suit them. Respite service stays allowed time for older people to receive urgently required nursing services, such as wound care, while also providing an opportunity for clinical assessments by occupational therapists and physiotherapists. With the support of advocates, older people were then able to navigate the sometimes contradictory views of their Home Care Package provider, assessors, and family members on whether they were able to return home and make that decision.

Issues around decision-making and control, especially where an element of risk to the older person was involved, arose across the flexible care programs, as in other aged care programs explored in this report. This reflects a health and aged care system-wide issue regarding respecting older people's autonomy and decision-making rights.

Flexible care fees and charges

There were case examples where older people had significant out of pocket expenses due to not understanding how to best navigate between programs. This was a common theme for people transitioning between Home Care Packages, TCP and STRC programme, and hospitals. In particular, moving between these settings often resulted in significant out of pocket costs relating to assistive technology and home modifications.

Case studies showed that people who had Home Care Package funds suspended upon entry into the TCP following a hospital stay were unable to access funding for necessary assistive technologies recommended by occupational therapists.

In one advocacy case, an older person was in the STRC programme and an occupational therapist assessed them as needing a specialist mattress which they paid a deposit on while on the STRC programme. The older person was then allocated a Home Care Package, which they accepted. The older person was then told by the STRC provider that they were unable to cover the full cost of the mattress as they had not been on the STRC programme for the full 8 weeks. The older person then involved an advocate, who discovered that the older person had been advised by the STRC provider to delay commencement of their Home Care Package, but the older person had decided to go ahead and commence the package. The advocate explored whether the remainder of the mattress cost, not covered by the STRC funding, could be covered by the Home Care Package, but there were not sufficient accrued funds. The older person was disappointed with this outcome and had to pay the balance for the mattress.

Diverse and marginalised groups

The 2024-25 Presenting Issues Report once again revealed that the aged care system does not adopt universal design principles creating barriers for all.

> *'Universal design is about creating a society where everyone feels welcome. It is not a type of product – it is a design thinking process. That means it can be applied to anything and everything that is designed in our world.[20]'*

The systemic barriers combined with lack of knowledge, ageist and ableist beliefs, and poor communication skills of aged care assessors, providers, and other services meant that the issues described throughout this report were often experienced to a greater extent by people in diverse and marginalised groups, including:

- people from Aboriginal and Torres Strait Islander communities
- people from culturally and linguistically diverse backgrounds (CALD)
- people living with disability, including dementia or other cognitive decline
- older people living in rural or remote areas
- older people who are financially or socially disadvantaged
- veterans of the Australian Defence Force or an allied defence force, including the widow or widower of a veteran
- older people experiencing, or at risk of, homelessness
- Forgotten Australians (former child migrants and the Stolen Generations)
- older people separated from their children by forced adoption or removal
- older people from lesbian, gay, bisexual, trans and gender diverse or intersex communities.

In many cases, people may not have disclosed information to an OPAN network member that identified them as belonging to one or more of these groups. For the cases where this was disclosed, network member case data shows that advocacy support and information was provided to 13,022 older people from one or more of the diverse or marginalised groups in the list above (33% of the 39,404 older people who received services from a network member).

Table 3. Top seven diverse and marginalised groups requiring services by count of issues.

Diverse and marginalised group	Total issues
People living with a disability, including psychosocial, dementia and cognitive decline	10,494
People who live in rural or remote areas	5,463
People from culturally and linguistically diverse backgrounds	4,966
People who are financially or socially disadvantaged	2,575
People from Aboriginal and Torres Strait Islander communities	1,217
People who are homeless or at risk of being homeless	425
Veterans	345

[20] Centre for Universal Design Australia. https://universaldesignaustralia.net.au/, cited 31 August 2025.

People living with a disability, including psychosocial, dementia and cognitive decline

Older people living with a disability, including dementia and cognitive decline, were the most common diverse or marginalised group to disclose their identity when seeking advocacy or information from an OPAN network member (Table 3).

This is perhaps not surprising given that these are the very people that the aged care system is designed to support. Anyone who requires aged care support must be experiencing some sort of loss of function resulting in the lack of ability to complete some tasks. However, the qualitative analysis of the case examples showed that older people experiencing significant impairments resulting in disabilities are further disabled by the aged care system. There are many points in their aged care journey where people with disability are discriminated against, either through the actions of individuals or through system design.

There were many case examples and reflections from OPAN network members this financial year of residential aged care providers using respite care to 'screen' older people and then deny them a place if they had high disability support needs, continuing the trend shown in the 2023-24 Presenting Issues Report. Indeed, network members reported hearing of some residential aged care homes having started to require a short respite stay before they will consider an application for a residential aged care room. Residential aged care providers seemed to particularly focus on 'screening out' people with high behavioural support needs (e.g. as a result of a mental illness or dementia) and complex interacting disabilities, for example, people who had a long-term disability which was now compounded by a series of later life traumatic health events.

This appears to be a misinterpretation of who residential aged care should be supporting, as it should be designed to support those with the highest support needs. Instead, these are the very people who end up falling through the cracks, having a poor quality of life and dying with pain that could have been managed, indignity and struggle at home, and/or in inappropriate long-stay hospital settings as explored in more detail in the 'Accessing aged care' chapter. In some cases, residential aged care providers moved older people with higher needs between their different homes as their needs changed, causing stress to older people and their supporters and often isolating them from their supports and communities. There were also reports of residential aged care providers accepting multiple applications for the same room from multiple people and then choosing the person with the lowest needs.

There were also reports of Home Care Package providers refusing people with specific disability needs, stating that they only had sufficient staff to address 'low' needs such as domestic assistance and home maintenance.

Case study 23

An OPAN advocate received a call from an older person who is a carer for their spouse who has Parkinson's disease and advanced dementia. The caller made contact after their spouse was asked to leave the residential aged care home they were currently residing in for respite. The caller added that they were extremely concerned as they had no alternative accommodation, and respite was due to end in about 2 weeks.

The caller explained that they had insufficient support at home, no informal support network, and felt at risk caring for their spouse alone. In addition, their spouse had multiple falls in the past, resulting in them being hospitalised multiple times.

The caller explained that their spouse had some issues adjusting when they first entered respite as the respite provider had not followed their medication regime which led to the spouse having two aggressive outbursts, something that they had not displayed for some time.

The caller said that it was because of these outbursts that the residential aged care provider had informed her they would not be offering their spouse a permanent place. The caller had tried to find another residential aged care home, but all said they did not have capacity to accommodate their spouse. The residential aged care provider had suggested another home, but this was over a 3-hour drive from their regional town and the caller did not drive.

The advocate advised that the caller could request a respite extension to give them time to look for another residential aged care home closer to where they live but needed to be aware that the provider may still deny the request. With the caller having no other informal support, the advocate explained the role of the care finders program and a referral was made. Given the lengthy wait times for the care finder Program, the advocate discussed alternate options of an interim return to hospital and an increase in home support to help manage in the short-term.

The advocate set about researching residential aged care homes that had possible vacancies closer to the caller's location and within the caller's public transport corridor. It was during this time that the caller informed the advocate that their spouse was now approaching end-of-life. This changed the direction of support needed, and the advocate provided the caller with information on Palliative Care Australia and other state based palliative care support services. With consent, a referral was made, and the advocate was able to get the caller an appointment with an Aged Care Specialist Officer.

The caller was thankful for the time, support, information and referrals that the advocate had provided stating that when the residential aged care home told them that their spouse was not going to get a place they felt overwhelmed and exhausted.

The barriers to accessing residential aged care for people living with long-term disability on the NDIS were discriminatory given many were recommended by the NDIA to explore aged care services, as the disability system was not able to meet their needs. OPAN network members reported increasing numbers of older people with disability being referred by the NDIA for support in accessing the aged care system.

OPAN network members also reported that Home Care Package providers declined to accept, or refused services, to older people with behavioural support needs who were still able to live independently at home. They stated that limited staffing meant they were not able to offer 'higher needs' services. This particularly impacted older people with mental illnesses.

People with specific communication needs or communication related disabilities were particularly disadvantaged by difficulties in accessing information about aged care, receiving support to navigate and access the system, and understanding their aged care services and fees, as explored in earlier chapters. For example, OPAN network members provided many examples of older people with significant hearing loss being instructed to call a phone line for more information, or for people with vision impairments and limited IT skills being told to look for information online or in their email. In many cases, the barriers to access experienced by older people with disabilities were not able to be overcome even with an advocate's support. However, examples were provided where aged care advocates were able to work with assessors, providers and/or My Aged Care to find a solution that worked for the older person.

Case study 24

An older person living in a remote area had been assigned a clinical phone assessment by an assessment service in a city over 8 hours drive away. The older person does not speak English as a first language, and has a severe hearing loss and speech impairment.

The older person had arranged for an interpreter, and social and emotional wellbeing support worker to be there during the phone assessment, but even with their support, it was not possible to complete the assessment. This was because the assistive technology the older person uses to communicate does not work with a speaker phone.

The advocate called My Aged Care with the older person's consent and a face-to-face assessment by a service that was closer was arranged.

There continued to be a lack of detailed consideration of dignity of risk for older people living with disabilities by aged care service providers. In some cases, older people were unnecessarily restricted in their ability to undertake tasks and activities that they had long-undertook with assistive technology. In other cases, older people were denied assistive technologies and other supports that may improve their quality of life but also involve a degree of constraint even when the older person had asked for them. In one example, an older person had a substitute decision-maker appointed following a mental health episode and substance abuse that led to hospitalisation. After hearing an OPAN network member present on rights at a public information session, a friend of the older person supported them to have their capacity reassessed. It was determined that the older person now had capacity to make their own decisions, and the substitute decision-maker's appointment was removed. However, the residential aged care provider continued not to listen to the older person, preventing them from leaving the home, stating, 'if you leave, you will start drinking again'. The older person felt that their provider did not respect them as they previously had a substitute decision-maker. The older person did not want to risk losing their residential aged care room and advised the advocate they did not want to pursue the issue further.

Case study 25

An older person contacted an OPAN network member for support in having their rights to independence and personal risk respected.

The older person explained that they had been in their current residential aged care home for about three months. They had vision and mobility impairments. Inside, they used a four-wheeled walker to mobilise. At their previous residential aged care home, they had been allowed to use their motorised scooter to leave the home. However, at their new facility they were GPS monitored and not allowed to use their motorised scooter to leave the residential aged care home.

After the advocate explained the older person's rights to the residential aged care management, they agreed the resident would be able to leave the home if a safety plan was developed with a GP's approval. Once this was complete, the older person was able to leave the residential aged care home and access their community again.

People living with disabilities, especially vision impairments, were particularly at risk of not being aware of issues with errors and overcharges, as explored in the fees and charges sections of the 'Home Care Packages' and 'Residential aged care' chapters. Often invoices and statements were only sent in paper or email form, and the provider did not take the time to verbally explain the fees and charges outlined to the older person. This also increased their vulnerability to financial abuse by substitute decision-makers. This is explored further in the 'Abuse of older people' chapter.

People living in rural and remote areas

Older people living in rural or remote areas were particularly impacted by the acute workforce shortages and service availability issues explored in the 'Accessing aged care' chapter.

Access to assessments, especially clinical assessments, was an issue in rural and remote areas. Allied health assessments and services were also difficult for older people to obtain in rural and remote areas. As described in the 'Home Care Packages' chapter, some Home Care Package (HCP) providers were paying for occupational therapists to fly in from other states to undertake assessments for older people receiving HCPs once a sufficient number had accumulated on wait lists. In other areas, older people went without essential assistive technologies as an allied health assessment could not be sourced.

Even older people with relatively low care needs, such as those requiring monthly gardening and fortnightly cleaning services under the Commonwealth Home Support Programme (CHSP), had trouble securing these services in rural and remote areas. OPAN network members reported that in some regional and rural areas, the sole CHSP provider had ceased to provide CHSP services or were going to soon. Limited access to Home Care Package providers in rural and remote areas were experienced by many older people. This was further exacerbated, as the same limited workforce often serviced both the aged care and disability home support programs.

The lack of CHSP and Home Care Package services increased demand on the limited residential aged care places in rural and remote areas. This meant that older people were often forced to consider leaving their social and support networks and community to receive services. In many cases, this led to older people isolating themselves and not seeking health and hospital services for fear that they would not be allowed to return home.

As explored in the communication issues sections under the 'Home Care Packages', 'Commonwealth Home Support Programme' and 'Residential aged care' chapters, limited service availability meant that people were reluctant to raise concerns about significant issues relating to their aged care services for fear of service withdrawal or refusal. If they did choose to raise concerns and this resulted in a communication breakdown with their provider, this left them with no other aged care service options. As a result, many older people decided to accept low quality services, even those that put them at significant risk, for fear that there was nothing else available in their area.

The high cost of Home Care Package services, in particular transport costs, led to many people in regional, rural and remote areas seeking to move from the Home Care Packages program back to the CHSP. In many cases, this was not possible as the CHSP could no longer meet their care needs. As a result, many older people went without essential aged care or health services as they attempted to remain at home on a Home Care Package budget.

OPAN network members reflected that assessors did not appear to take into account the person's location when undertaking an assessment of their required level of Home Care Package. For example, they did not consider transport costs for the older person or their service providers, distances they needed to travel for essentials such as health services or groceries, or the impact of their social isolation. However, sometimes the issue was not allocated funding but instead a lack of innovative care planning and effective HCP fund management by providers in rural and remote areas where services were limited.

Case study 26

An older person receiving a Level 4 HCP had accrued $74,000 in unspent funds due to limited service availability in their rural area. They live with their partner who also receives a HCP.

The older person can only access transport with a wheelchair lift once every two weeks as the provider has just one suitable vehicle which is booked months in advance.

The older person contacted an OPAN network member for support to use their surplus HCP funds to purchase a personal vehicle, as they had been told by the HCP provider that this was not possible. They had also been told that services to address the overgrowth on their rural property were also not considered eligible under standard HCP gardening services.

The advocate met with the couple to clarify permissible package uses of HCP funds and explore other service options that may meet their needs.

The provider approved double gardening hours for two months (drawing from both partners' packages), and increased cleaning services including regular high cleaning tasks. The couple thought they were already receiving the maximum support available and had hesitated to request more, fearing it would cause disruption.

While transport services could not be expanded directly, the advocate arranged for the provider to seek contracted transport options and secured additional funds for their taxi card.

People from culturally and linguistically diverse (CALD) backgrounds

The issues related to accessing the aged care system, and fees and charges relating to aged care fees and charges raised earlier in this report were all compounded when the older person spoke English as a second language.

Language barriers and lack of access to interpretation services continued to be an issue for people from linguistically diverse backgrounds. OPAN network members observed that older people were often encouraged by aged care service providers to use family and community contacts as interpreters. This presents a potential conflict of interest whereby the interpreter may not relay everything the older person says or means. It also may hinder the older person from speaking freely as they feel shame about what they are saying, fear judgement from others in their community, or do not want their interpreter to know some information for other personal reasons. In some cases where OPAN network member advocates were involved, older people communicated their frustration with not being understood by aged care staff non-verbally. This in turn led to misdiagnoses of dementia and/or restrictive practices. In other cases, aged care providers incorrectly assumed that an older person's limited ability to communicate in English reflected a broader inability to communicate and/or cognitive decline that meant they were unable to participate in aged care decisions.

Case study 27

An adult child who held an active Enduring Power of Attorney (EPOA) for their parent contacted an OPAN network member with concerns about an assessment conducted by an allied health care worker linked to their parent's aged care provider. The EPOA felt that the assessment did not reflect their parent's current level of independence and the fact that they had been able to independently or with limited support complete most daily activities despite a disability experienced for over 15 years.

The advocate asked if their parent was able to communicate directly with the advocacy service and to express their thoughts and feelings about the assessment. The EPOA said that in all their years supporting their parent with disability services in Australia, no one had ever asked this. They said that while their parent could not speak English, they were in no way limited in their ability to make decisions and could communicate in their language.

An interpreter service was organised, and the older person was able to communicate their concerns about the assessment and make decisions about what they wanted the next steps to be in addressing these.

The provision of culturally appropriate care by aged care providers continued to be an issue in the 2024-25 financial year. Many case examples were provided where an older person had a preferred gender for care workers, due to cultural and/or religious reasons, and this preference was not actioned. Advocates were often able to work with the older person so that the aged care provider understood the importance of this request and could look at rostering staff of the requested gender.

In residential aged care, the lack of provision of meals that were culturally appropriate was also an issue leading to several advocacy cases. In many cases, advocacy resulted in the residential aged care provider meeting the person's dietary requirements.

Case study 28

An older person moved to Australia ten years ago and has been living in residential aged care for 18 months. They contacted an OPAN network member for advocacy support because their residential aged care provider was not meeting their religious and cultural dietary needs.

The older person said that they could not eat meat as part of their religious and cultural practice. However, the 'vegetable soups' the aged care provider gave them as the only vegetarian meal option were often meat-based. The only other vegetarian option provided by the aged care provider most evenings was coleslaw or other low-nutrition options. For example, they had ordered a meal of 'mushrooms' from the menu the night before and had received a single mushroom for dinner.

The advocate asked if the older person had raised these issues with the residential aged care home's management team. The older person said they had not, as usually their partner would take care of these sorts of things for them, but they had passed away. At the older person's request, the advocate spoke to the residential aged care home's manager. The manager apologised and said they would address the issue with the menu and ask the chef to meet with the older person and discuss meal preferences.

On following up with the older person, they described that the menu had greatly improved and there was now a range of nutritious vegetarian options available.

OPAN network members provided examples of how the aged care system is failing to support older people who entered Australia as refugees. As described in the section above 'People living with a disability, including psychosocial, dementia and cognitive decline', many aged care providers are unwilling and/or incapable of supporting people with complex psychosocial needs such as those resulting from earlier experiences of trauma.

People who are financially or socially disadvantaged

This year saw an increasing number of contacts with OPAN network members due to financial concerns about Home Care Packages (HCP), the future Support at Home program, and residential aged care fees and charges. These concerns are explored in more detail in the 'Accessing aged care' and relevant sections of the 'Home Care Packages' and 'Residential aged care' chapters.

Older people with the age pension as their sole source of income are increasingly forced into significant financial hardship due to fees and co-contributions for their aged care services. This combined with significant delays in income and assets and financial hardship applications by Services Australia contributes to significant debt and stress to the older person.

There were also concerns raised by OPAN network members of a new cohort of people with some assets, but close to the limit for residential aged care contribution caps, entering into financial hardship at a faster rate than before. This is explored in more detail in the 'Residential aged care fees and charges issues' sections in the 'Residential aged care' chapter. The impact of this is that people who otherwise would not have experienced financial hardship in their lifetime are now doing so as a direct result of the cost of aged care services.

People with limited social support networks continued to be particularly disadvantaged and negatively affected by the issues raised throughout this report. The aged care system is complex and there are many systemic barriers which means that older people often rely on the support of friends, family and their community to access services and seek support from OPAN network members if concerns arise. This suggests that there are likely many socially disadvantaged people falling through the gaps. This financial year saw a number of information provision and advocacy cases resulting from socially disadvantaged older people approaching OPAN network members at public stalls and community information sessions. Continued outreach work such as this is key to ensuring all older people are able to access aged care services.

OPAN network members in areas where the Home Care Check In service was trialled noted that this service particularly benefitted people who were socially disadvantaged, allowing an increased amount of in-person supports while they navigated the aged care system. They noted that the discontinuation of this pilot project has left a complex service gap that cannot be filled by other similar services such as care finders.

Older people from LGBTI communities

OPAN network members reported that some older people from lesbian, gay, bisexual, trans, intersex and other gender and sexuality diverse (LGBTI) communities continued to face a lack of understanding of their experiences and needs when accessing and receiving aged care services.

Often needs of the older person that were essential to maintaining their identity and dignity were dismissed by service providers as 'whims' and not essential aspects of their care plan.

OPAN network members noted that older LGBTI people expressed reluctance to receive aged care services, in particular in residential aged care, due to media headlines such as 'Older LGBTI people would rather die than enter aged care'. Advocates noted that while articles such as these are crucial in shedding light on systemic issues, older LGBTI people also need practical examples of how to demand that their rights be upheld in aged care.

However, advocacy case examples were provided this financial year where aged care providers engaged with LGBTI older people and their advocates and improved their aged care services as a result. These examples showed how relatively small changes by an aged care provider can significantly improve an older LGBTI person's quality of life, health and wellbeing.

Case study 29

The advocate visited an older LGBTI person in their residential aged care home during Mardi Gras season. The advocate had been building a relationship with the older person and their partner for a while. The visit was organised as part of an effort to ensure culturally safe and inclusive opportunities for LGBTI older people to express their identity and feel a sense of belonging.

The older person had spent much of their life concealing their sexual orientation due to fear of discrimination and stigma. Mardi Gras provided a unique and meaningful occasion for them to engage in an affirming and joyful celebration of their identity. In attendance was their partner of over 40 years, whose presence added deeply personal significance to the event.

The residential aged care staff demonstrated warmth and respect, embracing the opportunity to create an inclusive environment. Both the resident and their partner expressed profound gratitude for the support and visibility offered. They shared that learning about the rights of older people and the availability of advocacy support gave them confidence and reassurance for the future.

The residential aged care staff were enthusiastic about fostering a culture of inclusion and committed to ongoing learning about LGBTI ageing experiences. Furthermore, the advocate was asked to visit another wing of the facility to increase visibility of advocacy support for another LGBTI resident.

Advocates note that it takes time to build trust with older LGBTI people due to the long-standing impact of stigma and discrimination they have experienced throughout their lives. Many older LGBTI people have shared with advocates that their past experience is that organisations often enter LGBTI spaces as a one-off gesture. The sustained presence needed to develop a genuine rapport or provide a safe space to voice concerns is rarely provided. This reinforces the importance of ongoing, consistent engagement to demonstrate authentic commitment and build meaningful, trusting relationships.

Aboriginal and Torres Strait Islander peoples

OPAN acknowledges the continued work of the Interim First Nations Aged Care Commissioner, Andrea Kelly, and her strong commitment to consulting with Aboriginal and Torres Strait Islander stakeholders and communities about their experiences accessing and engaging with the aged care system. OPAN and the National Aboriginal and Torres Strait Islander Advocates Network welcomed the release of the Interim Commissioner's report – Transforming Aged Care for Aboriginal and Torres Strait Islander people - and reflected that many of the issues raised in the report have been observed in the cases that advocates have supported Aboriginal and Torres Strait Islander peoples with throughout the year.

OPAN network members reflect that older Aboriginal and Torres Strait Islander peoples continued to fall through the gaps of siloed service systems that were not culturally safe and services spread across different locations not close to country. OPAN network members continue to report facing difficulties addressing a person's aged care advocacy needs without also addressing needs outside of the scope of NACAP, such as healthcare needs, housing issues, the high cost of food, petrol and other essential services and goods, and/or abuse by family members. In some cases, the numerous services supporting older First Nations people were able to work together to address their needs, but in other cases, the logistics of coordinating so many different services with no single 'lead' service was challenging.

An emerging issue this year was the number of requests to OPAN network members to support older Aboriginal and Torres Strait Islander peoples with legal matters, such as advance personal plans which include informed directions regarding aged and palliative care service preferences. Other common requests related to developing culturally sensitive wills and substitute decision-maker appointments. While out of scope for NACAP, some OPAN network members are linked to legal services and were able to provide this valuable support in a culturally appropriate manner. However, in many states and territories, support such as this is not available.

For Aboriginal and Torres Strait Islander peoples in rural and remote areas, there are often no services available at all. There were many reports of older people being linked with services that were either located across significant bodies of water from the island where they lived or geographically inaccessible due to other reasons. In many areas, care navigation services were not available, which left OPAN network members placed in a difficult position of how involved they should become in linking older Aboriginal and Torres Strait Islander peoples with appropriate services. However, the limited availability of services continued across Commonwealth Home Support Programme (CHSP), Home Care Packages and residential aged care providers, and often people were forced to go without care or move from their community.

The issue of inclusions and exclusions for Home Care Packages and the barriers strict interpretation of associated guidelines present for older Aboriginal and Torres Strait Islander peoples with complex needs continued to be an issue in the 2024-25 financial year. As noted in the 2023-24 report, excluded items such as white goods are essential in supporting some Aboriginal and Torres Strait Islander older people to stay in their homes and meet their health needs.

For Aboriginal and Torres Strait Islander peoples in some communities, English is not a first language and is instead a fourth or fifth language. There are often barriers to accessing independent interpreter services, which means that older Aboriginal and Torres Strait Islander peoples are reluctant to discuss personal issues in front of the interpreter. Language barriers also impact access to aged care services. A lack of translation or linkage services means that key departmental and Services Australia correspondence is not understood or actioned, and people simply miss out on the services they have the right to and have been approved for.

OPAN network members reported that the housing crisis was having a particularly negative impact on older Aboriginal and Torres Strait Islander peoples. Many older Aboriginal and Torres Strait Islander peoples living in remote areas cannot access the health services they need, particularly dialysis services, and have to travel to regional centres for services. Once there, they often do not have the funds to return home and are at risk of homelessness.

Older Aboriginal and Torres Strait Islander people's right to remain connected to Country and community is currently rarely recognised and/or able to be supported by the aged care system. This meant that many older Aboriginal and Torres Strait Islander peoples were reluctant to see aged care and health services out of fear they would be removed from Country. Indeed, there continues to be cases reported where older Aboriginal and Torres Strait Islander peoples have a public substitute decision-maker appointed while in hospital who makes the decision to move them to residential aged care. This decision appears to be made with no consideration of the psychological and physical impacts of removing a person from Country, or consideration of dignity of risk and what a good death may look like to an older First Nations person.

Issues with receiving culturally appropriate care are faced even in regional and metropolitan areas where there are few service providers with knowledge of First Nations cultures. The need for trauma-informed aged care systems, services a nd workers for older people who are members of Stolen Generations continues to be an issue. Their past experiences of abuse trigger trauma responses when interacting with the aged care system and providers. The lack of respect for an older person and their belongings, as described in the previous chapters, is distressing and degrading for any older person, and may be particularly traumatising for an Aboriginal or Torres Strait Islander person to experience.

In some cases, older Aboriginal and Torres Strait Islander peoples sought advocacy support to raise concerns about services provided by their local Aboriginal and Torres Strait Islander community provider. They sought to raise concerns while maintaining mutually respectful dialogue, as they supported the values and mission of these providers, and had close personal connections with many of the management and workers. In these cases, advocates were key to having the older person's concerns addressed while at the same time ensuring there was not a communication breakdown between the older person and their provider.

In rare cases, OPAN network members were successful in supporting older Aboriginal and Torres Strait Islander peoples in having their cultural needs and requests respected.

Case study 30

After an education session by an OPAN network member at a regional residential facility, an older person started talking to an advocate. The older person said they are an Aboriginal person and wanted to remain on Country, but that their aged care provider wasn't listening to their request.

Further discussion revealed that the older person was in the current home on a respite stay. The provider had said that they could not offer them a residential aged care room at this home, but that they could offer them one 45 minutes away in the same area.

The older person stated that they had tried to explain that it might be the same 'white man area' but to them, the new place was on a different Country. They went on to say that they had lived on Country their whole life and it was not only culturally important to them but also of spiritual importance.

At the older person's request, the advocate offered to speak with the care manager at the residential aged care home. During this conversation, the care manager stated that they were in the process of making an offer for an available room at their facility to another person, but the other care home would still be close to the older person's family and community. The advocate was able to outline the older person's cultural and spiritual connection to Country and the importance of this for their emotional and spiritual wellbeing and health. The care manager stated that they would need to take this away and discuss it with the team.

In following up with the older person, they stated that the residential aged care home had offered them a room, and they were very grateful that they could remain living on Country.

People experiencing or at risk of homelessness

The lack of affordable and accessible housing, siloed housing and aged care systems, and limited aged care services for people with high needs, in particular psychosocial needs, continued to have negative impacts on an increasing number of older people in 2024-25. OPAN network members continue to express frustration at not being able to address older people's aged care needs because they also need to have housing needs addressed, and these fall outside the scope of the NACAP. In some cases, multiple health, social, NACAP and housing services were able to work together to support older people, but this was rare. The lack of a lead service to support older people to navigate suitable, accessible and affordable housing and the aged care services they need to remain there continues to be an issue. Older people often require more intensive coordinated legal, health and social work than is available in their area, with few services funded to take on the 'lead agency' role in such cases.

As described in the previous section, older Aboriginal and Torres Strait Islander peoples were particularly disadvantaged by the lack of affordable housing on Country.

People living in homes such as caravans and or other temporary forms of housing were often refused aged care services as providers do not consider this a 'safe' workplace for their staff or appropriate 'home' that is in scope for aged care Commonwealth Home Support Programme (CHSP) or Home Care Packages (HCP) services. For people living a nomadic life or in temporary housing, it can be impossible to register with My Aged Care as no address can be provided and they often have limited or patchy access to internet and phone services, further exacerbating their ability to establish and maintain contact with aged care services.

Case study 31

An older person has been living in a caravan park in a remote location. They had a Home Care Package allocated, but providers would not provide services to them due to concerns about the safety of providing services in a caravan park. The HCP provider had said they would not begin providing services until the older person found permanent housing.

The older person had recently lost all of their identification and many valued possessions when the caravan park management had cleared up their site after a tree fell on it. The older person was very distressed by how their personal possessions had been treated, and also did not know how to proceed with getting new idenification as they were not born in Australia.

The advocate referred the client for legal services and counselling to a local faith-based service. The advocate could not progress the issue of securing HCP services until the older person's housing needs were addressed, so the advocacy case remains unresolved.

There were several case examples provided by OPAN network members where the aged care system had been able to appropriately support the needs of older people who had issues related to hoarding and squalor. By working with CHSP and HCP service providers, My Aged Care, assessment services and care finders, advocates were able to secure and appropriately time one-off services for hoarding and squalor. In many cases, this meant that the older person was able to retain their private or public housing lease.

Abuse of older people

Network members provided 3,352 information (2,707) and advocacy (645) services relating to abuse of older people by people other than aged care workers, comprising 6% of all services provided by OPAN network members.

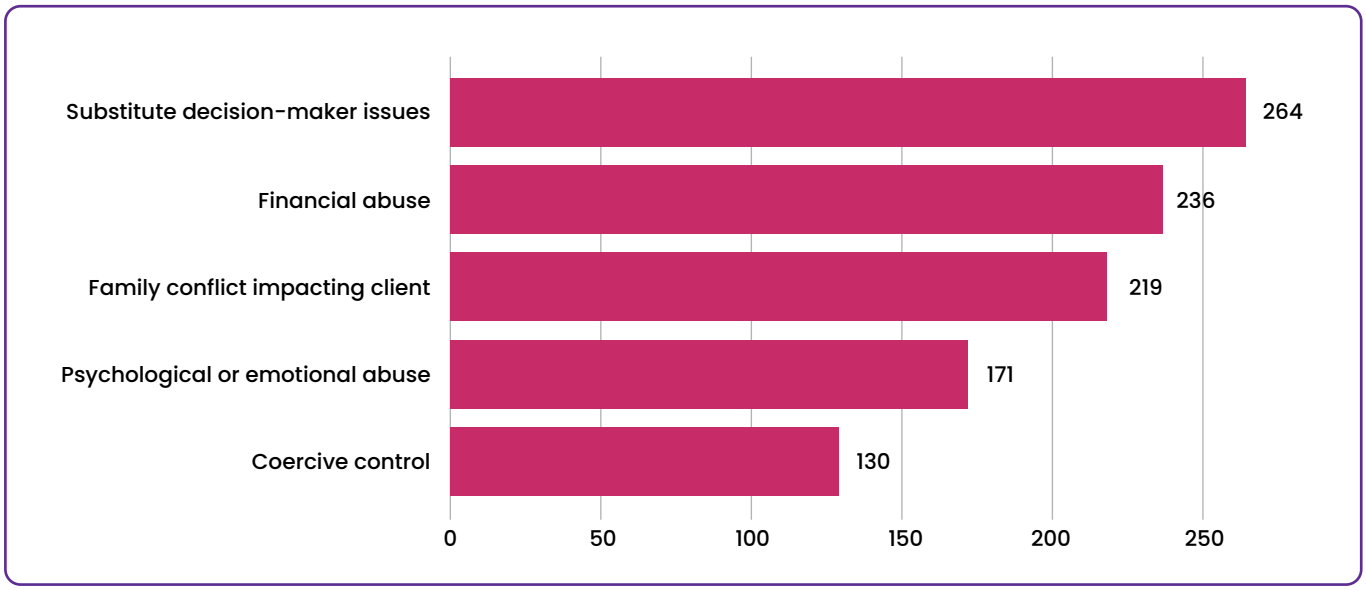

Figure 27. Top five abuse of older person issues (count of issues)

The most common form of abuse raised by older people in contact with OPAN network members were abuse of substitute decision-making powers, followed by financial abuse, family conflict impacting the client, psychological or emotional abuse, and coercive control.

Over three in four (120 of 165) cases of psychological and emotional abuse co-occurred with another form of abuse, in particular family conflict and coercive control. We therefore don't explore psychological abuse as a separate topic in this section.

People from diverse and marginalised groups, such as those explored in the previous chapter, are particularly at risk of experiencing abuse. This is strongly linked to reduced access to services or not receiving adequate or appropriate services, which increases their reliance on people in their personal network for support. This, in turn, contributes to the emotional and financial burden on carers and supporters, thereby increasing the risk of neglect or abuse of the older person.

Continuing the upward trend from 2023-24, OPAN network members reported an increase in contacts from aged care workers who suspected the older person was experiencing abuse and wanted to know how to proceed. Similarly, concerned family members, friends, and other community members did not know where to turn. While supporting people to address the abuse by people other than aged care workers falls outside the NACAP, OPAN network member advocates were able, at times, to support older people to get aged care services in place that contributed to their safety planning.

However, this year OPAN network members reported increasing dismay in the lack of services to support older people experiencing abuse. Not all areas in Australia have access to services that are dedicated to supporting older people and have the necessary understanding of disability in later life, aged care services, and respect for the process of ageing in later life and preparing for death.

Abuse of substitute decision-making powers

Figure 28. Co-occurring Issues with abuse of substitute decision-making powers (count of cases)

The 257 cases where abuse of substitute decision-making powers was raised co-occurred with issues relating to family conflict impacting the client in 101 cases (39%), financial abuse in 69 cases (27%), coercive control in 67 cases (26%), and psychological or emotional abuse in 53 cases (21%).

It was particularly difficult for aged care workers and advocates to support the older person when the abuser was also a substitute decision-maker for the older person. Oftentimes, the suspected abuser was using their appointment as a substitute decision-maker to isolate the older person from their social support networks, restrict access care services in the home, and to financially abuse the older person.

Unknowingly in many of these cases, aged care providers were fostering an environment where the abuse could occur by only taking directions from the substitute decision-maker on all decisions. In some cases, a lack of communication directly with older people about their services, fees and care planning meant that the older person was unable to identify significant financial abuse by the substitute decision-maker. For example, there were many case examples and reflections from OPAN network members regarding residential aged care staff and visiting health professionals not including older people in conversations if they had a representative listed with My Aged Care or the provider (see 'Residential aged care communication, decision-making, care planning and complaints' section in the 'Residential aged care' chapter).

This is a breach of older people's rights to be informed about their care and services and engaged in decision-making, even if they have been deemed not to have the legal capacity to make those decisions themselves. However, oftentimes, the decisions were not even ones that would fall under a substitute decision-making authority under state or territory legislation and instead related to minor, low risk, day-to-day considerations such as food preferences, social interactions, and access to different areas of the residential aged care home. This reflected the apparent lack of understanding of aged care providers of substitute decision-making appointments and which types of decision they relate to, as explored in the sections on 'HCP communication, choice and decision-making' in the 'Home Care Packages' chapter, and 'Residential aged care communication, decision-making, care planning and complaints' and 'Residential aged care fees and charges issues' in the 'Residential aged care' chapter.

Case study 32

An older person contacted an OPAN network member and explained that they were seeking support to access a GP to obtain results of specialist appointments they recently attended. The older person explained they had a substitute decision-maker for lifestyle and health decisions, and because of this they were often left out of communication with the residential aged care provider and medical professionals. The older person had been advised that the visiting GP would no longer see them, and they would like to understand why.

The older person explained that they had mobility issues and were not able to walk to the nurses' station to speak with staff about medical concerns or to request a visit from the GP. The older person felt their substitute decision-maker had completely taken over the medical aspect of their life and wanted to be consulted and involved in all communications moving forward.

The advocate supported the older person to understand their rights – particularly the right to be included in decisions and communications; despite having a substitute decision-maker in place.

The advocate supported the older person to communicate with the residential aged care provider, who explained that as the substitute decision-maker had organised all external medical support and was so involved, the visiting GP had suggested ceasing direct support to the older person.

The advocate supported the older person to understand their options including contacting the relevant medical centres to request their medical information and requesting the visiting GP continue seeing them. The advocate provided information on the role and responsibilities of substitute decision-makers and the older person's right to be consulted when decisions are being made.

At the older person's direction, the advocate asked for the older person to be included in all health and lifestyle discussions and for the visiting GP to continue to see them. The older person confirmed they were satisfied with the outcome and pleased to be involved in decisions relating to their health and aged care.

Financial abuse

Older people with substitute decision-makers active, or presumed to be active, were particularly vulnerable to experiencing financial abuse, as explored in the previous section. This is because substitute decision-makers often gained direct control over an older person's finances, limited access to invoices, bank statements, and funds.

In other cases, older people, particularly older women who had been or were married, had never had control or oversight over their finances. This made them particularly vulnerable to financial abuse by their partner or adult children later in life.

Case study 33

An older person with Parkinson's disease has been willingly living in residential aged care after their needs increased and could not be managed at home with supports.

The older person had nominated their adult child for future substituted decision-making but had recently been told by the residential aged care provider and adult child that these substitute decision-making powers had been activated.

The older person described feeling that they were still able to make financial decisions and had worked as a professional in the finance sector. The older person was curious to know how their finances were being managed, including after the sale of their home.

The older person also expressed concerns that their request to go and spend some time in a residential aged care home closer to other family members was denied by the adult child and therefore also the residential aged care provider.

At the older person's direction, the advocate requested a copy of the substitute decision-making authority from the residential aged care provider and the adult child. The provider refused to provide a copy of the document, and the adult child refused to communicate with the advocate.

The case was closed as the older person sought a review of the substitute decision-making appointment at the tribunal with the support of another family member.

Family conflict impacting the older person

Continuing the trend from last year, significant financial, practical and emotional ties between older people and their adult children often created family conflict.

The abuse of substitute decision-making powers by adult children also created conflict amongst siblings, with advocacy case examples often identifying siblings as the ones to reach out for advocacy support, followed by aged care workers.

The rising cost of housing meant that adult children and grandchildren are increasingly moving in with the older parent following a separation from their partner/spouse due to financial hardship after losing a job or due to mental health and substance abuse issues.

Sometimes other adult children viewed this emotional, financial and practical dependency between their parent and their sibling as an unfair financial and social advantage to their sibling. In several cases, siblings correctly identified that the adult child who was dependent on their parent was perpetrating abuse.

It was noted that it was very complex for advocates and aged care providers to intervene in cases where adult children perpetrating abuse of the older person were also caring for the older person at home. In one example, hospital nurses and social workers, aged care workers, and the GP all shared concerns that an adult child with substance abuse issues was abusing their parent both financially and through coercive control. However, the older person did not want support to move into safer accommodation and receive more services. The older person explained that they liked that their adult child still assisted them with going to the bathroom at night, even if they sometimes forgot because they were out or had friends over for a party. They did not want to move away from the home they had lived in for decades or lose contact with their only child. In this case, the advocate, older person and services explored options that might increase the safety of the older person including more regular care services, police welfare check-ins and stays in respite care. The older person declined all of these options.

For people from certain backgrounds and some tight-knit communities, for example cultural or religious groups or small towns, there is a reluctance to address abuse by family members due to not wanting 'others to know our business'.

By not following the expressed will and preferences of the older person, residential aged care providers often allowed family conflict to continue even once the older person was living in an environment where their decisions regarding social interactions could be limited. For example, in one case, an older person's adult child was sending photos to the older person's residential aged care home with the request to display them on the older person's wall. The older person had asked the residential aged care staff to take the photos down, but the residential aged care staff refused saying that this is a 'family issue' and none of their business.

Coercive control

'Coercive control is when someone uses patterns of abusive behaviour against another person. Over time this creates fear and takes away the person's freedom and independence. This dynamic almost always underpins family and domestic violence, which can include the abuse of older people (known as elder abuse).'[21]

Case examples provided by OPAN network members reported that it was indeed the case that coercive control underpinned most of the other cases where older people were abused by someone other than their aged care provider.

OPAN network members noted that some older people had their Australian visas sponsored by adult children, and 'in return' then transferred all their assets to the children. Older people then found themselves dependent on their adult children to release funds to pay for services, and if conflict arose between family members, they found themselves unable to afford housing and support. They were then further isolated and reluctant to approach services for support as they feared their community's or Australian service provider's judgement. In some cultures, there is also an expectation that if you are 'successful' in your relationships with family, then you should not need to seek external support services, as your family will support you.

It was reported that on one occasion, an older person ended up experiencing homelessness as their adult relative who had been living with them took over the home and refused the older person re-entry after they had been on a day out. The police were called but, stated that they could not assist as it was a family dispute, and the older person and their relative should have family counselling to resolve the issue.

A few case examples were provided by OPAN network members, where conflict arose between an older person with cognitive decline and their adult children acting as substitute decision-makers about who they should interact with. In most of these cases, the adult children claimed that the person they were restricting contact with was abusing their parent. In one case, this person was a former employee of the residential aged care home who the older person was making significant financial gifts to. Network members observed that residential aged care providers tended to follow the instructions of the substitute decision-makers and restrict contacts, even though it was unlikely this fell within the remit of their substitute decision-making appointment. In some cases, advocates supported older people, their adult children as substitute decision-makers, and their residential aged care providers to explore options to protect the older person from abuse, while still allowing them to make decisions about their social life.

Case study 34

An older person contacted an OPAN network member seeking support regarding their experience of abuse by their adult child. The older person was distressed and concerned for themselves and their spouse. The older person explained that their spouse has dementia, and they provide support with some daily tasks as the Home Care Package cannot support all their care needs.

The older person described experiencing harassment from their adult child. They explained that the adult child is always speaking badly about them to others and treats them horribly. The adult child also 'chooses' items from the home and takes them without permission. The older person said that the adult child had previously made allegations to the family GP and hospital that their spouse was not receiving adequate care.

The advocate confirmed that what the older person was experiencing was elder abuse. The provided options, including reporting concerns to the police and contacting a legal service to seek advice.

The older person asked for a referral to the legal service, which was accepted. When the advocate followed up, the older person described feeling relieved that they now know what their options were.

[21] Attorney General's Department. Understanding how coercive control can affect older people. Australian Government. https://www.ag.gov.au/families-and-marriage/publications/understanding-how-coercive-control-can-affect-older-people

Conclusion

This report presents an overview of key trends and findings from the quantitative data from the 52,206 instances of advocacy and information support, as well as the qualitative analysis of the 413 advocacy case examples for 2024-25.

The quantitative and qualitative analyses presented in this report revealed that the three top presenting issues across all programs were the same as in previous years:

1. **Poor communication, as well as a lack of information and support to make decisions about aged care.**
2. **Difficulties finding and engaging service providers.**
3. **Barriers to accessing necessary assistive technology.**

The second half of 2024-25 saw two emerging issues:

1. **Misinformation and concerns about the upcoming Support at Home program.**
2. **Issues with Single Assessment System services.**

Systemic barriers combined with a lack of knowledge, ageist and ableist beliefs, and poor communication skills of aged care assessors, providers, and other services meant that the issues described throughout this report were often experienced to a greater extent by people in diverse and marginalised groups.

Presenting Issues in 2024-25

Poor communication, as well as a lack of information and support to make decisions

Once again, numerous case examples highlighted a systemic lack of communication and information for older people regarding aged care programs and options that could meet their needs.

Many older people who contacted OPAN network members expressed being unclear about the outcome of their engagement with My Aged Care, Services Australia and assessment teams. After receiving contradictory or unclear advice during contacts with these services, older people sought the support of an advocate.

Older people were often not given clear and transparent information about their aged care fees and charges by their provider, My Aged Care or Services Australia. In many cases, older people had not been advised of the need for an income and means assessment or the option for a financial hardship application with Services Australia.

This sometimes resulted in significant debt accruing, the older person experiencing significant stress and financial hardship, and many providers beginning debt collection proceedings.

Ageist beliefs, including a lack of respect for older people's decision-making rights was a theme underpinning many advocacy cases. Poor communication and a lack of clear information in a format the older person can understand, as described above, is an abuse of older people's right to be supported to make informed decisions about their aged care. In some cases, aged care providers enabled or even participated in the abuse of older people by excluding them from information and decisions about their aged care, or by following the directions of people other than the older person receiving the care.

Difficulties in finding and engaging service providers

Many of the advocacy cases related to finding and engaging a service provider were due to a lack of clear information from assessors, and follow-up by My Aged Care staff on the next steps in engaging a provider after services had been approved. Barriers associated with information and communication technology access and ability compounded these issues.

The lack of clear information on next steps and options was further compounded by wait-times to be allocated approved Home Care Packages, and a lack of available Commonwealth Home Support Programme (CHSP) services to fill the gap in the interim. In particular, the advocacy cases revealed an alarming decline in the availability of CHSP services over the past year, with many CHSP services closing, operating with short staff, or no longer accepting new clients. CHSP service shortages were reported for simple home maintenance (e.g. gardening and gutter cleaning), cleaning, transport and allied health services – in particular, access to occupational therapists.

Increasingly, advocacy cases reported difficulties for older people in securing a residential aged care place if they had high behavioural support needs (e.g. as a result of a mental illness or dementia) and complex interacting disabilities. For example, people who had a long-term disability that was now compounded by a series of later-life traumatic health events. Advocacy casework showed that many providers are 'screening' older people with these needs and deciding not to offer them a place.

Service shortages resulted in some older people going without services as they were unable to find a provider, as well as unnecessarily entering residential aged care or staying in hospital. Long-term hospital stays for people without acute care needs also resulted from older people being unable to secure a residential aged care place.

Barriers to accessing necessary assistive technology

Older people reported experiencing lengthy delays, a lack of communication, and contradictory advice from service providers regarding the provision of assistive technology. This meant that many older people went without assistive technologies that were essential for their function and independence.

Issues related to whether providers thought the required assistive technology was a Home Care Program included or excluded item remained an ongoing issue in 2024-25. Some providers also claimed they had denied the purchase of necessary assistive technology due to new provider policies implemented to align with the upcoming Support at Home program.

Significant wait times for, or a complete inability to access, assessments by occupational therapists affected the ability of older people to obtain necessary assistive technology.

Emerging issues in 2024-25

Misinformation and concerns about the upcoming Support at Home program

There was a significant increase in information provisions in the last quarter of 2024-25. An analysis of the case studies and reflections provided by OPAN network members showed that many of these contacts resulted from provider actions in anticipation of the upcoming Support at Home program.

Some older people were being placed under pressure by their Commonwealth Home Support Programme (CHSP) provider to be reassessed for a Home Care Package (HCP), without consideration of which program best met their needs and the financial impacts.

Older people also reported that CHSP providers were starting to limit services and/or exiting the CHSP market due to the introduction of the new Support at Home program.

There was also misinformation from HCP providers about upcoming Support at Home requirements, including the transfer of unspent funds, financial co-contribution requirements, and included and excluded items.

There was also an increase in information provision in response to older people's concerns that they would not be able to afford to receive aged care services under the new Support at Home program.

Issues with Single Assessment System services

The qualitative data from Quarter 3 to Quarter 4 (2024-25) suggested emerging issues with the new Single Assessment System, which was implemented in November 2024.

Advocates had first-hand experience of the new Single Assessment System service staff being unfamiliar with the aged care system and providing incorrect information to older people regarding service options that may meet their needs.

Advocates described that the triage component of the single assessment process was not working effectively or efficiently, with some older people undergoing a 1 to 2 hour triage/eligibility assessment before being able to progress to a clinical assessment. Asking older people to spend this length of time on the phone describing their needs was negatively impacting individuals and further delaying access to urgently required services.

There were also many examples of assessments only being conducted over the phone, which led to older people's needs not being appropriately assessed, as they either faced communication barriers over the phone or did not appropriately articulate the full extent of their needs.

There were also reports of older people not being able to have the support they wanted and needed during the assessment process. For example, by only receiving a phone assessment, not having their requested supporters included, or not being connected with professional interpreter services. This meant older people could not appropriately articulate the full extent of their needs during an assessment and understand the next steps.

Appendix A: Scope and methods

The scope and methods used for the presentation of data in this report are described below.

Reporting Period

Unless otherwise stated, service data presented in this report relates to services that began in the period 1 July 2024 to 30 June 2025, noting that some services, particular advocacy cases, can continue over several weeks.

Geographic Coverage

Descriptions and statistics in this report cover all network operations across Australia.

Data Sources

The information relating to services presented in this report is principally based on data submitted to OPAN from network members.

Aged care client data is based on the Australian Institute of Health and Welfare's Aged Care Data Snapshot (release 3), which was current on 30 June 2024, and has been applied for the period 1 July 2024 to 30 June 2025 to enable comparisons of service type and aged care population.

Definitions

Statistics are predominantly based on the service definitions in the OPAN NACAP National Minimum Dataset Data Dictionary and Guidelines, Version 1.5.1, September 2024. Data is captured by network members based on the definitions in the version current at the time of their reporting to OPAN.

Methodology

This report refers to counts of services, cases and issues, which are derived from the quantitative data supplied by network members.

A 'service' can refer to advocacy casework or information provision.

A 'case' refers to advocacy casework only.

Counts of issues are presented in addition to counts of cases, as one case can involve multiple issues raised by an older person. Furthermore, one issue may involve multiple sub-issues, which are referred to as 'co-occurring' issues in this report. A 'standalone' issue refers to an issue without multiple sub-issues recorded in the same case, for the same issue category.

Counts of older people receiving services are based on de-identified client data provided by each network member.

Disclaimer

The statistics in this report may differ to other sources that utilise the same data and coding specifications. This will be due in part to the data collection and preparation methods used to generate the tables and charts in this report which included identification and correction of errors in historical data. As some services are still open or ongoing at the time of reporting, data is subject to review and amendment as more information becomes available, and as OPAN refines its systems for data capture, validation and reporting. This may result in variation between historical and future reports. OPAN and OPAN's 9 network members accept no legal responsibilities for this publication's contents. To the fullest extent allowed by law, OPAN, the 9 network members and their representatives exclude all liability in respect of the information and opinions expressed in this publication.

OPAN Older Persons Advocacy Network

OPAN member organisations by state or territory:

ADAAustralia Your Aged and Disability Advocates

ADACAS Advocacy

Advocacy Tasmania in your corner

Advocare Empowering older people in WA

aras Aged Rights Advocacy Service

CatholicCare NT

Darwin Community LEGAL SERVICE

ERA Elder Rights Australia Promoting the human rights of all older people

Seniors Rights Service

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