SUBMISSION TO

Senate Community Affairs

References Committee

Inquiry into the Support at Home Program

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This submission is made in a personal capacity. The views expressed are the author's own and do not represent the views of any organisation with which the author is associated.

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Abbreviations

Abbreviation	Meaning
Ahpra	Australian Health Practitioner Regulation Agency
ANAO	Australian National Audit Office
CHSP	Commonwealth Home Support Programme
Department	Department of Health, Disability and Ageing
MBS	Medicare Benefits Schedule
MoWA	Meals on Wheels Australia Ltd

Executive summary

1. This submission addresses principally paragraphs 1, 5 and 7 of the Committee's Terms of Reference, and, more generally, paragraph 9 ("any other related matters"),[1] by examining a workforce-inclusion gap in the Support at Home Program's design, and an administrative case study that shows how such gaps arise and persist inside the Department of Health, Disability and Ageing (the Department).

2. The Department's Support at Home service list names every practitioner category through which clinical and therapeutic services may be delivered under the program.[2] Registered paramedics do not appear on that list, in any category, despite having held national registration under the Health Practitioner Regulation National Law since 1 December 2018.[3] Acupuncturists, chiropractors, osteopaths and remedial masseuses do appear.

3. The Australian Auditor-General's May 2025 performance audit of the Future Fit Program — an $8.74 million initiative the Department administered to prepare the Meals on Wheels (MoWA) network for the same Commonwealth Home Support Program (CHSP)-to-Support at Home transition this inquiry examines — found that the Department's default practice in that transition work was not to consult affected stakeholders unless they escalated the matter themselves.[4]

4. The author submits that this finding, made independently by the Auditor-General about the Department's conduct within the same program group, provides the Committee with evidence of the administrative culture in which workforce-inclusion decisions are made.

5. The author recommends that the Committee require the Department to document, and make public, the evidentiary and consultative basis on which registered health professions are included in or excluded from the Support at Home service list, and that the Committee treat the Future Fit Program audit as the standard of governance evidence it should expect from the Department in this inquiry generally.

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[1] Parliament of Australia, Senate Standing Committees on Community Affairs, *"Support at Home Program,"* Terms of Reference, referred 4 November 2025, submissions close 31 July 2026, reporting date 24 November 2026, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/SupportatHomeProgram (accessed 20/07/2026).

[2] Department of Health, Disability and Ageing, *Support at Home service list*, August 2025, https://www.health.gov.au/sites/default/files/2025-08/support-at-home-service-list.pdf (accessed 20/07/2026).

[3] Australian Health Practitioner Regulation Agency, *"Paramedics: Welcome to the National Scheme,"* media release, 30 November 2018, https://www.ahpra.gov.au/News/2018-11-30-Paramedics-Welcome-to-the-National-Scheme.aspx (accessed 20/07/2026).

[4] Australian National Audit Office, Auditor-General Report No.37 2024–25, *Administration of the Future Fit Program (Department of Health, Disability and Ageing)*, tabled 7 May 2025, paras 1.16–1.17, 2.56–2.57. (accessed 20/07/2026).

A. Introduction

6. The author has prepared numerous government and parliamentary submissions over the past two decades, principally on health access and equity, paramedicine workforce, regulation and funding policy. He is an Honorary Fellow of the Australasian College of Paramedicine and of the Australian Institute of Paramedic Practitioners. The author also holds an adjunct appointment at Central Queensland University, and sits on the Executive Committee of the Australian Health Care Reform Alliance. This submission is made in a personal capacity.

7. The submission draws on three primary sources: the Support at Home Program's own design documents, an Auditor-General findings about the Department's conduct in an adjacent program, and the corroborating operational and peer-reviewed evidence contained in care delivery and research studies. The author submits that, read together, they are directly relevant to the Committee's ability to test whether the program's workforce settings were reached through a properly considered evidenced process.

B. The Support at Home service list omits paramedicine

8. The Support at Home service list is the instrument that defines which services attract Commonwealth clinical funding and, with three exceptions, which professions may deliver them. The Department says that the service list "does not provide guidance on who should deliver services, with the exception of listing the professions covered by the service types 'nursing', 'allied health and other therapeutic services' and 'therapeutic services for independent living'.[5]

9. Table 1 outlines those three named lists.

Named service type	Professions named
Nursing care	Registered nurse; enrolled nurse; nursing assistant.
Allied health and other therapeutic services	Aboriginal and Torres Strait Islander health practitioner; Aboriginal and Torres Strait Islander health worker; allied health therapy assistant; counsellor or psychotherapist; dietitian or nutritionist; exercise physiologist; music therapist; occupational therapist; physiotherapist; podiatrist; psychologist; social worker; speech pathologist.
Therapeutic services for independent living	Acupuncturist; chiropractor; diversional therapist; remedial masseuse; art therapist; osteopath.
Paramedic (nationally registered under the Health Practitioner Regulation National Law since 1 December 2018)	Not named in any of the three lists above. The author believes that as an Ahpra-registered profession, paramedicine is an Allied Health Profession under the recognised Australian "Three Pillars" of practice — not being Medicine or Nursing/Midwifery.

Table 1: Professions named in the Support at Home service list, by service type. Source: Department of Health, Disability and Ageing, Support at Home service list, August 2025.

10. Registered paramedics do not appear in any of the three lists, notwithstanding that paramedicine has been a nationally registered profession under the Health Practitioner Regulation National Law since 1 December 2018,[6] regulated by the Paramedicine Board of Australia on the same statutory basis as nursing, physiotherapy and podiatry, all of which are named.

[5]Department of Health, Disability and Ageing, "*Support at Home service list*," https://www.health.gov.au/resources/publications/support-at-home-service-list (accessed 20/07/2026).
[6]Ahpra, "*Paramedics: Welcome to the National Scheme*," 30 November 2018 (accessed 20/07/2026).

11. Acupuncturists, chiropractors, osteopaths and remedial masseuses are also named as eligible professions — none of which is a profession educated to provide mobile assessment, treatment or management of acute clinical deterioration. Meanwhile, a registered profession trained for those roles, including deterioration management (paramedicine) is not listed.

12. The entries for both allied health categories separately exclude "ambulance and hospital costs" from Support at Home funding, as being services *"more appropriately funded through the primary health care system."*[7] The service list treats ambulance service attendance (thereby ignoring the professional capabilities of the registered paramedic as the actual provider) as a cost the program sits outside of, rather than as a cost its own workforce settings might help a provider avoid.

13. Resolving that question is not what this submission asks of the Committee. What it asks is narrower: was the omission of paramedicine a deliberate evidence-based decision, or a categorisation never reviewed since the service list was first drafted or paramedicine became a registered health profession.

C. The Future Fit Program: what the evidence shows

14. On 7 May 2025, the Australian Auditor-General tabled *Report No.37 2024–25*, *Administration of the Future Fit Program*, examining the Department's governance, procurement and contract management of an $8.74 million initiative to prepare Meals on Wheels Australia (MoWA) and its state network for the shift from CHSP to Support at Home. This matters because the Committee's current inquiry covers the same transition the Future Fit Program was meant to prepare for, administered by the same Department, and over the same period. The author submits that the Auditor-General's findings are directly applicable evidence of the Department's institutional conduct when making decisions that affect patients, providers and the workforce — which is what this Committee is examining.

15. The Auditor-General found that the Department's handling of the Future Fit Program was "ineffective," that it failed to set up sound governance arrangements, and that it did not consult stakeholders the way its own Stakeholder Engagement Framework required.[8] Three findings matter most for this Committee's Terms of Reference.

16. First, the Department changed the program's governance structure to remove the peak body representing the affected provider network, without consulting that body or advising the responsible minister.

17. Second, when the Department later selected replacement meal providers for two Victorian local government areas whose incumbent councils had withdrawn, it did so *"without consultation with key stakeholders,"* and, when providers across the sector subsequently objected, the Department told the Auditor-General that *"the department's usual practice when selecting a replacement for a CHSP provider … does not involve consultation with peak associations."*

18. Third, despite the significant $8.74 million in cumulative contract payments, the Department had not evaluated the program's outcomes as at April 2025 — more than two years after it commenced — and the contracted supplier, Miles Morgan Australia, had already been placed into liquidation in September 2024.

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[7] Department of Health, Disability and Ageing, "*Support at Home service list*", 4 August 2025, p. 2.

[8] ANAO, Report No.37 2024–25, "*Administration of the Future Fit Program*" paras 11 (first quotation); para 12 (remaining two). https://www.anao.gov.au/sites/default/files/2025-05/Auditor-General_Report_2024-25_37.pdf

19. Table 2 sets out these findings, with their paragraph references, against the criteria most relevant to how the Support at Home Program's design decisions — including its workforce settings — were made, and can now be assessed.

NAO finding — Future Fit Program	Source	Implication for this inquiry
No senior responsible officer was assigned to the program; the Department had no established role in its oversight or delivery.	Paras 2.5, 2.11	Who within the Department is accountable for the Support at Home service list's professional categories.
The Department removed the affected peak body from the program's governance structure without consulting it or advising the responsible minister.	Para 2.14	Were paramedicine peak bodies consulted before the service list's settings were finalised.
Replacement providers were selected "without consultation with key stakeholders"; the Department told the ANAO its "usual practice … does not involve consultation with peak associations."	Paras 2.56–2.57	Establishes the Department's default posture toward professional groups affected by, but not party to, its decisions.
$8.74 million was spent across three contracts; the program had not been evaluated as at April 2025.	Paras 1.16–1.17, 2.79, 4.32	No comparable evaluation is on the public record for how the Support at Home service list's workforce settings were reached.
Recommendation 3: develop stakeholder engagement plans reflecting purposeful, inclusive, timely, transparent and respectful engagement for projects with complex stakeholder relationships.	Para 2.64	The process should extend to decisions about which registered professions are included in service settings, not only to individual provider transitions.
Recommendation 4: evaluate pilot programs to inform future program design before further rollout decisions are made.	Para 2.80	Sets the standard the Committee should expect before any future confirmation or variation of Support at Home's clinical workforce categories.

Table 2: Selected ANAO findings on the Future Fit Program, mapped by the author to their implications for this inquiry. Source: ANAO, Report No.37 2024–25, paras 2.5–2.80.

20. The author does not suggest that the details of the Future Fit Program should determine how the Support at Home service list of professional categories were settled. The author submits, more narrowly, that a Department whose "usual practice" the Auditor-General has found to exclude peak bodies from consultation on adjacent transition decisions cannot be assumed, without evidence, to have conducted a documented, consultative process when deciding which health professions would appear on that list. That evidence is for the Department to produce, and the Committee is well placed to require it.

D. A recurring pattern of omission

21. The author has documented this structural pattern — a profession formally within the scope of a program's stated purpose, but absent from the mechanisms that decide funding, eligibility and delivery — across more than a dozen submissions to Commonwealth and state inquiries since 2019.[9] Paramedicine fits this pattern because it has not been perceived as an Allied Health Profession. Despite nominal inclusion in the frameworks that describe who health services are for, and despite holding advanced competencies, it is left out of the mechanisms that decide who delivers those services and is paid to do so.

[9] The author's submission archive, in which this recurring pattern is termed "two doors, one window," is published at The Paramedic Observer, paramedprof.com.

22. Independent evidence points the same way: a 2022 Tasmanian parliamentary inquiry into rural health services found paramedic and paramedic practitioner workforces underutilised and recommended their scope of practice be reviewed alongside nurse practitioners, rural generalists and pharmacists.[10]

23. The Support at Home service list and the Future Fit Program audit follow that same pattern: one framework that omits a registered profession from every operative category without documented reasoning, and one Auditor-General finding that the Department's default practice in the same program family is not to consult affected stakeholders before making equivalent decisions.

24. This submission does not ask the Committee to mandate a specific funding rate or service category for paramedicine — that is a technical assessment task, not one for a Senate inquiry. Unlike Medicare Benefits Schedule items, which go through independent technical appraisal by the Medical Services Advisory Committee, the Support at Home service list has no equivalent external check — it is set by the Department alone. The ask is narrower: that the Department provide the consultation, evidence, and risk assessment behind the professional categories it has settled, and that the Committee test that record against the standard the Auditor-General has already set.

E. Corroborative evidence: the HMS Community Ltd experience

25. The author has collaborated with HMS Community Ltd, a Victorian charity operating a community paramedic-led multidisciplinary homecare and clinic model. That organisation has provided evidence documenting the practical consequences of the gap described in Section B.[11] Two elements of that evidence are independently verifiable and bear directly on the record the author asks the Committee to require from the Department in Recommendation 1. Disclosure: The author is also a member of the Victorian CP@clinic advisory committee.

26. First, the international evidence compiled by the HMS Community is peer-reviewed rather than self-reported. A cluster randomised clinical trial of the Canadian CP@clinic community paramedicine model, involving nearly 3,700 older residents across 30 social housing buildings in Ontario, found the intervention group had higher rates of primary care engagement and lower rates of transfer to long-term residential care than the control group.[12] Separate community paramedicine programs in rural Nova Scotia and rural Ontario recorded reductions of approximately 40 per cent in annual emergency department presentations and 20 to 24 per cent in emergency callouts respectively.[13]

27. That evidence shows that the underlying practice — registered paramedics delivering planned, non-emergency clinical care for chronic disease management — has been tested against a control group and published in a peer-reviewed journal, at a standard of evidence higher than that available to the Committee for most other design questions.

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[10]Tasmania, Legislative Council, Government Administration 'A' Sub-Committee, "*Inquiry into Rural Health Services in Tasmania, Final Report"* (tabled 25 October 2022), Findings 31–32, Recommendation 6(d).

[11]HMS Community Ltd, *Support at Home: The Missing Link — Community Paramedics and Multidisciplinary Teams in Home Based Care*, submission to the Senate Community Affairs References Committee inquiry into the Support at Home Program, (seen July 2026).

[12]Agarwal, G., Pirrie, M., Angeles, R., Marzanek, F., Paterson, J. M., Nguyen, F., & Thabane, L. (2024). *Community paramedicine program in social housing and health service utilization: A cluster randomized clinical trial*. JAMA Network Open, 7(10), e2441288. https://doi.org/10.1001/jamanetworkopen.2024.41288 (accessed 20/07/2026).

[13]Nolan, M. J., Nolan, K. E., & Sinha, S. K. (2018). *Community paramedicine is growing in impact and potential*. CMAJ, 190(21), E636–E637. https://doi.org/10.1503/cmaj.180642 (accessed 20/07/2026).

28. This is evidence about the practice model in principle, not about the outcomes of any single Australian provider. The randomised evidence base is for a clinic-based delivery model; a home-based variant of the same practice exists and is consistent with these findings, but has not yet been tested to the same standard.

29. The particular relevance to a lower-acuity program such as Support at Home lies in prevention rather than acute management: the reductions in emergency department presentations and emergency callouts reported at paragraph 26 show that routine paramedic-led assessment and monitoring reduces the rate at which low-acuity conditions escalate to an acute event, rather than establishing a need for Support at Home itself to deliver acute care.

30. This evidence also bears on paragraph 5 of the Committee's Terms of Reference (impact on the residential aged care system and hospitals), through the lower rate of transfer to long-term residential care, and to paragraph 7 (thin markets affected by geographic remoteness), through the rural Nova Scotia and Ontario results.

31. The scale of that remoteness-driven disadvantage is not confined to Canada. The National Rural Health Alliance's 2025 analysis found an annual $8.35 billion gap in government-funded health, aged care and disability expenditure between rural and metropolitan Australia — an average of $1,090.47 per person, rising to $4,701.89 per person in the most remote communities.[14]

32. Contemporary Australian evidence corroborates this. In 2025, the second full year of the Victorian CP@clinic pilot (paragraph 25), the program delivered 552 clinics across 31 locations and recorded 2,747 individual consumer visits, a 39 per cent increase on 2024, with 880 consumers engaged with the service since 2022. Consumers had a median age of 69; over a third reported frequent feelings of distress and almost one in five had diabetes mellitus. Two of the program's paramedics received an Ambulance Victoria commendation acknowledging the program's contribution to reducing pressure on emergency services.[15]

33. Second, the Commonwealth's own independent Scope of Practice Review, led by Professor Mark Cormack and reporting in November 2024, named paramedics within its scope alongside general practitioners, nurses, midwives, pharmacists and Allied Health Practitioners, and recommended better use of registered paramedics in aged care, home care and community settings.[16]

34. The absence of paramedics from the Support at Home service list described in Section B therefore sits in opposition to a Commonwealth-commissioned, whole-of-primary-care review the Department itself has already received.

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[14] Nous Group, *The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia*, prepared for the National Rural Health Alliance, 25 August 2025, https://www.ruralhealth.org.au/wp-content/uploads/2025/08/The_Forgotten_Health_Spend_Report_08_2025.pdf (accessed 26/07/2026).

[15] Spelten, E., Hardman, R., Reynolds, L., He, F., Sharples, R., Agarwal, G., & Hemming, L. (2026). *CP@clinic – 2025 Overview: Year 2 (2025) interim report for the CP@clinic IMOC Project (2024–2027).* Violet Vines Marshman Centre for Rural Health Research, La Trobe University. https://doi.org/10.26181/32817533 (accessed 20/07/2026).

[16] Department of Health and Aged Care. (2024). *Unleashing the Potential of our Health Workforce — Scope of Practice Review Final Report*. Australian Government. https://www.health.gov.au/sites/default/files/2024-11/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report_0.pdf (accessed 20/07/2026).

35. HMS Community's operational data — an estimated 90 per cent reduction in ambulance callouts and hospital admissions, and estimated system savings exceeding $1.4 million per week across its service region — comes from the organisation's internal briefing document and has not been independently audited.[17] The author draws the Committee's attention to that distinction deliberately: single-provider, self-reported figures are not a substitute for the peer-reviewed evidence at paragraph 26, and the Committee should treat them as illustrative of what the practice model can achieve locally, not as a national costing.

36. The direction of both evidence bases is nonetheless consistent, and HMS Community has provided evidence through de-identified case studies — among them a 91-year-old man returned to independent living after his existing provider had recommended residential care, and an 81-year-old palliative care recipient[18] kept at home for six months by an unfunded community paramedic and a nurse practitioner working largely as volunteers. These examples describe, in individual terms, the same workforce gap this submission identifies in the Department's service list.

37. The second case study illustrates something beyond the paramedicine-specific argument in Sections B to D. The nurse practitioner was funded for only one home visit under the care recipient's Support at Home package. Every subsequent visit was billed to Medicare Benefits Schedule item 82216, a nurse practitioner attendance item that carried a rebate of $114.20 at the time, with no travel allowance, for consultations regularly running two to three hours.[19] The community paramedic involved received no funding from either source, at any time.

38. Whether Medicare support or the Support at Home service is the correct funding pathway for either profession is not the argument here. The point of raising it is that the exclusion described in Section B is not confined to the service list: it recurs wherever the Department has had the opportunity to name paramedics alongside other registered professions and has not done so.

39. The author has not independently verified HMS Community's internal cost figures, its case study details, or its characterisation of individual clinical episodes, and offers no view on their accuracy beyond the distinction drawn at paragraph 37. However the author acknowledges the HMS Community service as an expertly managed service operation employing registered personnel, subject to ethical and practice constraints and having an operational record since 2020. The service and its staff have experience in delivering the service model this submission's recommendations would allow the Department to fund, but to date without program recognition.[20]

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[17] HMS Community Ltd. (2024). *Community paramedic service briefing: Gaps between the home, ambulance and hospital (Briefing V1.4)*, as cited in the HMS Community Ltd's submission to this inquiry. (seen 20/07/2026)

[18] Productivity Commission, *Report on Government Services 2026 (Ambulance Services)*, Canberra: AGPC, 2026, https://www.pc.gov.au/ongoing/report-on-government-services/health/ambulance-services/ (accessed 08/07/2026): emergency responses represent less than 50% of total ambulance sector responses nationally.

[19] HMS Community Ltd, *Support at Home: The Missing Link*, July 2026, case study two and accompanying note on MBS item 82216.

[20] *Recommendation 2 draws on ANAO, Report No.37 2024–25, Recommendation no. 3, para 2.64; Recommendation 3 draws on Recommendation no. 4, para 2.80; Recommendation 5 draws on paras 19–20 (findings that the Department's procurement planning and value-for-money assessments in the Future Fit Program did not comply with the Commonwealth Procurement Rules); Recommendations 6 and 8 draw on the Scope of Practice Review Final Report (Department of Health and Aged Care, November 2024), as raised in Section E — Recommendation 6 asks the Department to report on that finding, and Recommendation 8 asks the Committee to test the service list against it.*

F. Recommendations

40. The author recommends that the Committee:

Recommendation 1: Require the Department of Health, Disability and Ageing to table, as part of this inquiry, the consultation and evidentiary record behind the selection of the professional categories named in the Support at Home service list, including whether registered paramedics were considered and, if so, on what basis they were not included.

Recommendation 2: Request that the Auditor-General's Recommendation 3 in Report No.37 2024–25 — that the Department develop stakeholder engagement plans reflecting purposeful, inclusive, timely, transparent and respectful engagement for "projects that involve complex stakeholder relationships" — be applied prospectively to decisions about which registered health professions are included in Support at Home service and workforce settings, not only to individual provider transitions.

Recommendation 3: Note that the Auditor-General's Recommendation 4 — requiring evaluation of pilot programs before they inform future program design — establishes an accountability standard the Department should be held to before any further confirmation or variation of Support at Home's clinical workforce categories.

Recommendation 4: Seek from the Department a statement of which professional peak bodies, including paramedicine, were consulted in determining the Support at Home service list, consistent with the Department's obligations under its Stakeholder Engagement Framework.

Recommendation 5: Require that any future variation to the service list's named professional categories be supported by a documented value-for-money and access analysis, consistent with the Commonwealth Procurement Rules principles the Auditor-General found the Department did not apply in the Future Fit Program.

Recommendation 6: Require the Department to report on what action it has taken, or intends to take, on the Scope of Practice Review's recommendation for better use of registered paramedics in aged care, home care and community settings, consistent with the application of that recommendation to the Support at Home Program.

Recommendation 7: Report to the Senate on whether the Department's governance arrangements for the Support at Home Program, considered as a whole, meet the standard of independent evaluation and stakeholder inclusion the Auditor-General has already found the Department fell short of in the same program family.

Recommendation 8: Test whether the Support at Home service list's current professional categories are consistent with the Scope of Practice Review's finding that registered paramedics should be better used in aged care, home care and community settings and, if the Committee finds they are not, recommend that the service list be revised.

Final observations

41. The author thanks the Committee for the opportunity to contribute to this inquiry and is available to give oral evidence if that would assist.