Ageing Australia

Submission to the Senate Community Affairs References Committee on an inquiry into the transition of the Commonwealth Home Support Program to the Support at Home Program

January 2026

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About Ageing Australia

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

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

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

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

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

Introduction

The Commonwealth Home Support Program (CHSP) remains the cornerstone of entry-level aged care, delivering timely support that help older Australians stay safe, well, and connected at home. While the program broadly meets its objectives, access varies significantly across regions and service types due to funding limitations, thin markets, workforce shortages, assessment delays, and increasing participant complexity.

This submission addresses the Senate inquiry's Terms of Reference, focusing on:

1. The timeline for the CHSP's transition to the Support at Home (SaH) program
2. Provider readiness for transition
3. The potential impacts of transition on:
    - assessment wait times and receipt of care
    - the $15,000 lifetime cap on home modifications
    - End-of-Life (EOL) Pathway time limits
    - thin markets
4. Other related matters – financial sustainability, sustainability of volunteers and non-award staff, and the need for a multi-provider data system.

The submission draws on insights from consultations with CHSP providers, including:

- Ageing Australia's Home and Community Care Policy Feedback Group (over 400 members nationally)
- A national CHSP survey (December 2025) with 206 provider responses across metropolitan, regional, rural, and remote areas (26% CHSP-only providers; 74% both CHSP and SaH providers)
- A sector-led CHSP Summit (September 2025) attended by providers, consumers, and sector experts, which generated ten design principles to guide the future of entry-level aged care and inform government policy.

Recommendations

R1 Retain entry-level aged care services in the community under the SaH program, designed in line with our recommended design principles (see pg 6).

R2 Ensure that SaH implementation issues are identified and addressed before transitioning CHSP, to protect access to care.

R3 Co-design the CHSP reform and roadmap with providers, older people and carers, to ensure the model is fit-for-purpose, locally responsive and clearly communicated, with targeted consideration given to First Nations peoples, culturally diverse communities, and regional and remote participants.

R4 Commit to appropriate lead times to ensure transition is not rushed, including the publication of final program details and clear guidance at least 12 months prior to transition.

R5 Introduce a funded 'Transition Support Package' to support IT and GPMS readiness, change management, system preparedness, participant transition, paid training time and retention incentives for critical roles.

R6 Provide CHSP providers with flexibility to reallocate grant funding across geographic regions and service types, in response to changing community needs and service gaps.

R7 Establish temporary, immediately accessible, surge funding pools for CHSP providers to manage periods of high demand, reduce waitlists and reduce service backlogs.

R8 Retain the annual $15,000 cap on home modifications for entry-level aged care participants under SaH and index the cap annually, to prevent erosion of its real value.

R9 Redesign the EOL Pathway for entry-level care by:

a) streamlining assessment processes and guaranteeing rapid EOL Pathway activation (e.g. within 48–72 hours);
b) replacing rigid time limits with flexible, clinically guided periods (e.g. 12-week blocks extendable on clinical advice);
c) introducing a rural loading; and
d) funding mobile palliative outreach teams.

R10 Undertake foundational funding design activities as part of the CHSP reform, including:

a) regional service mapping and gap analysis to identify underserved communities, and the allocation of targeted funding (such as start-up grants) to attract and retain providers in thin markets;

b) sector consultation on the continuation of block funding for meals, transport, respite and social support services, or the adoption of hybrid funding models for these services;
c) a review of sector financial viability, including an assessment of CHSP funding levels against the actual unit costs of service delivery;
d) alignment of indexation rates with real cost growth and regional cost-of-living variations; and
e) a review of the impact of SaH participant contributions on consumer behaviour and care outcomes.

R11 Support participant access and provider viability during and beyond the transition, by:

a) investing in the aged care workforce and volunteer development through targeted recruitment, retention, training, and incentives, underpinned by a national workforce strategy with regionally tailored initiatives; and
b) establishing a volunteer and non-award staff supplement to recognise increasing reliance on volunteers and workers not covered by Fair Work wage cases (e.g. cottage respite nurses).

R12 Co-design the development and implementation of a multi-provider data system under the SaH program.

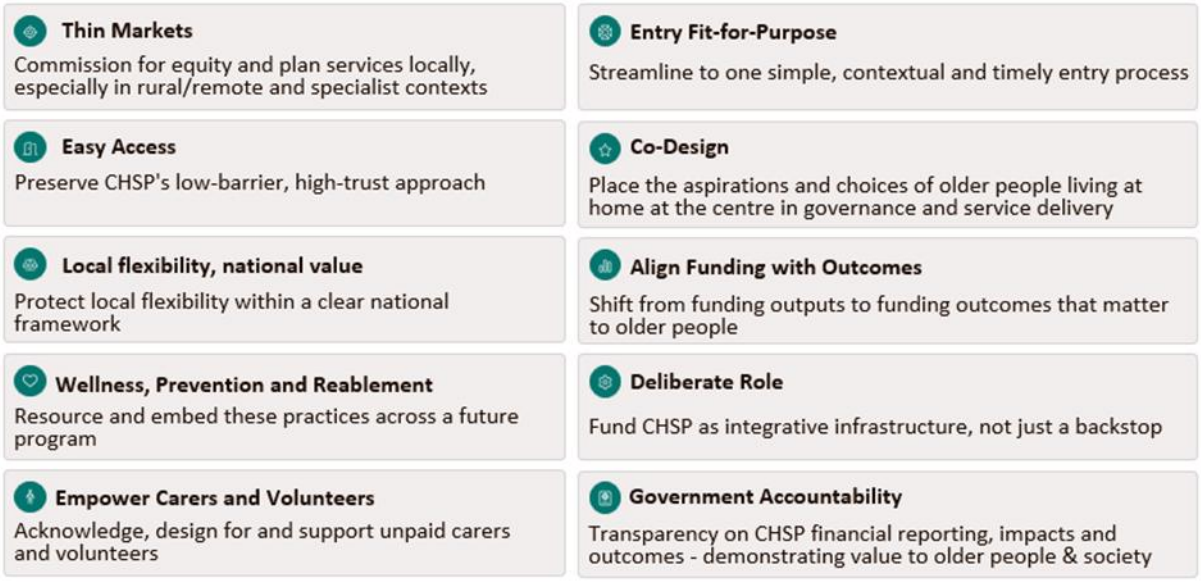
Future directions for entry-level aged care support

As Australia prepares for the CHSP reform and transition to SaH, there is a clear opportunity to build on what works well and address current gaps to establish a more robust, fit-for-purpose program and practice model. The program would be well integrated, appropriately funded, and designed to deliver flexible, entry-level aged care. This would both improve individual outcomes and deliver broader benefits across the health and human services system.

Design principles for a re-designed entry-level aged care program

Ageing Australia has developed 10 design principles (Figure 1), which reflect the collective insights of CHSP members and CHSP Summit attendees. These design principles aim to ensure that future reforms are grounded in the needs, experiences and aspirations of older Australians.

Figure 1. Principles for a re-designed entry-level program



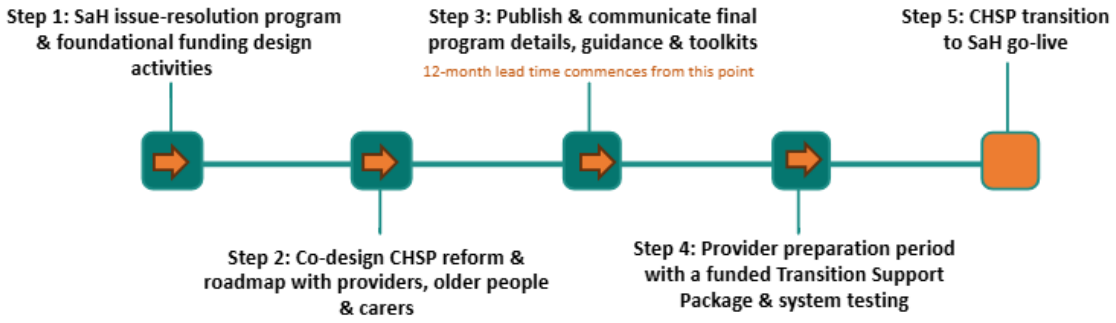
R1 Retain entry-level aged care services in the community under the SaH program, designed in line with our recommended design principles.

Timeline for the transition of the CHSP to SaH, no earlier than 1 July 2027

The CHSP currently supports 838,694 older Australians, 37% of whom live in regional and remote areas, making continuity of service provision essential[1]. Transitioning almost three times the number of people compared to those who moved from Home Care Packages (HCP) to SaH in November 2025, will require careful preparation for participants, providers, systems, and the workforce.

Providers report that SaH remains administratively complex and continues to present significant implementation challenges. CHSP integration should therefore be sequenced, after a targeted SaH issue-resolution program focused on assessments, waitlists, pricing and policy impacts (see Figure 2). This should be progressed alongside a series of foundational funding design activities as part of the CHSP reform (see more on this on pages 11-13).

Figure 2. Proposed CHSP reform timeline



R2 Ensure that SaH implementation issues are identified and addressed before transitioning CHSP, to protect access to care.

Consultation with the sector and community is essential to achieving a successful transition of CHSP into SaH. This would help mitigate design and implementation risks associated with the combined scale of SaH and CHSP. Co-designing the CHSP reform and roadmap with providers, older Australians, and their carers, is crucial to ensure the model is fit-for-purpose, locally responsive and clearly communicated. Co-design should include targeted considerations for First Nations peoples, culturally diverse communities, and regional and remote participants.

[1] Aged care data snapshot 2025 – third release. Department of Health, Disability and Ageing – Aged Care Data Warehouse. Available from: Aged care data snapshot—2025 - AIHW Gen

R3 **Co-design the CHSP reform and roadmap with providers, older people and carers, to ensure the model is fit-for-purpose, locally responsive and clearly communicated, with targeted consideration given to First Nations peoples, culturally diverse communities, and regional and remote participants.**

As observed with home care and SaH, successful transition requires significant lead time and should not be rushed. We strongly recommend at least 12 months, including the early release of final program details and comprehensive program guidance, with access to sandbox testing of data migration. This is critically important for the CHSP sector which has a far greater number of providers, often quite specialised and with many based in small communities. These providers will not be able to successfully transition in an environment of uncertainty and confusion.

R4 **Commit to appropriate lead times to ensure transition is not rushed, including the publication of final program details and clear guidance at least 12 months prior to transition.**

Aged care provider readiness for the transition

The cumulative impact of ongoing reforms has placed sustained pressure on staff capacity, increasing change fatigue and reducing the sector's ability to effectively absorb further reforms. Uncertainty about CHSP reform remains high among providers, with 85% of CHSP-only providers and 60% of those already delivering SaH concerned they are unprepared for the CHSP reform and transition to SaH.

Smaller not-for-profits, rural and remote services, culturally diverse providers, meal programs and councils reported the lowest levels of readiness. Ongoing uncertainty around program design and the funding framework, along with the early stage of SaH implementation, present barriers. These factors are discouraging providers from investing in transition preparations at this stage.

CHSP provider numbers have been declining over the last decade, and inadequate time for providers to prepare for reform will almost certainly result in further exits which cannot be covered by other providers, potentially leaving older people without services. To protect ongoing participant access to entry-level aged care, the Department should implement a targeted 'Transition Support Package' that offers transitional funding, guidance and practical support.

R5 **Introduce a funded 'Transition Support Package' to support IT and GPMS readiness, change management, system preparedness, participant transition, paid training time and retention incentives for critical roles.**

Assessment and care wait-times

The existing assessment system is under significant strain, with older people experiencing wait times of up to 12 months or longer, combined with reports of inconsistencies in assessment quality. The CHSP survey results indicate that around 90% of providers expect the CHSP-to-SaH transition to exacerbate assessment and care waiting times. Transition may also prompt significant numbers of older people to apply for services or request reassessment, creating a material risk of overwhelming assessment and service systems.

Providers propose that several strategies be considered, with the aim of reducing assessment wait-times, including:

- fast-tracking approval for transport, meals and safety-related property maintenance - implementing a risk proportionate approach to service assessment and approval; and
- expanding assessment workforce capacity, providing incentives for growth in thin markets.

Following assessment, participants may still face barriers to accessing care due to structural limitations within the CHSP. Rigid regional funding allocations and limited flexibility, combined with fragmented service availability (where some services operate at capacity while others remain underutilised), can prevent older people from receiving the support they need and undermine confidence in the system.

Providers emphasise that increased flexibility to reallocate grant funding across geographic regions and service types, in response to changing community needs and service gaps, would strengthen the program's ability to support older Australians.

R6 Provide CHSP providers with flexibility to reallocate grant funding across geographic regions and service types, in response to changing community needs and service gaps.

Insufficient funding has also contributed to providers operating at or beyond capacity, as evidenced by 'closed books' and extensive waiting lists that reflect high demand unmet by current resources. These constraints undermine the program's effectiveness. Introducing temporary surge funding pools would give CHSP providers the flexibility to respond to demand pressures, reduce waitlists, and prevent service backlogs.

R7 Establish temporary, immediately accessible, surge funding pools for CHSP providers to manage periods of high demand, reduce waitlists and reduce service backlogs.

Potential impact of transition on the lifetime cap of $15,000 on home modifications

Under the CHSP, participants can access up to $15,000 per year for home modifications, allowing staged adjustments as needs evolve. In contrast, SaH imposes a one-off $15,000 lifetime cap, which may leave participants without funds for essential modifications as health or functional needs progress.

Over half of provider survey respondents expect the lifetime cap to negatively affect participants' ability to remain living at home, reducing quality of care and increasing incidents and the need for people to access more costly services.

To implement a person-centred care model, the program must recognise that a person's needs change over time, potentially requiring essential modifications – such as bathroom adjustments or ramps, that exceed $15,000.

To guarantee that CHSP participants are 'no worse off' under SaH, it is vital that home modifications funding be capped annually, rather than for life, with additional labour and transport costs embedded for participants in rural and remote areas.

R8 Retain the annual $15,000 cap on home modifications for entry-level aged care participants under SaH and index the cap annually, to prevent erosion of its real value.

Potential impact of transition on the End-of-Life Pathway time limits

Effective end-of-life care requires rapid activation, clinically guided flexibility, rural loadings and protections against reversion to lower-level supports. Under the End-of-Life (EOL) Pathway, participants can access up to $25,000 for 12 weeks of support, extendable to 16 weeks, with funding temporarily replacing their ongoing SaH classification. Providers report high uncertainty about the practical impact of these limits on service continuity and quality of care.

While the EOL Pathway is trialled, close monitoring is required to identify risks to service continuity, participant and carer wellbeing, and administrative burden, particularly for unpredictable or prolonged end-of-life trajectories. These issues are amplified in rural and remote areas due to workforce shortages, limited palliative services, travel costs, and activation delays.

The pathway also shares known challenges with prognosis-based eligibility, including difficulty predicting life expectancy and rigid criteria that can delay access. Providers view the dedicated EOL Pathway as offering more timely, intensive support and a better chance for people to remain at home at the end of life. Its effectiveness, however,

depends on rapid approvals and flexibility. Rapid approval (48-72 hours) is required and should be built into the program design.

R9 Redesign the EOL Pathway for entry-level care by:

- **a) streamlining assessment processes and guaranteeing rapid EOL Pathway activation (e.g. within 48–72 hours);**
- **b) replacing rigid time limits with flexible, clinically guided periods (e.g. 12-week blocks extendable on clinical advice);**
- **c) introducing a rural loading; and**
- **d) funding mobile palliative outreach teams.**

Potential impact of transition on thin markets

Aged care delivery in rural, remote and specialist communities faces distinct challenges arising from distance, workforce shortages, complex care needs and limited provider availability. Regional service mapping and gap analysis are required to identify underserved communities and to direct targeted funding (such as start-up grants) to attract and retain providers in thin markets ahead of the CHSP–SaH transition.

Applying high-volume funding models to low-density markets risks service withdrawal and the loss of culturally safe, community-based supports. Providers warn this outcome is likely without local planning - particularly in rural and remote areas, for First Nations peoples, culturally diverse communities and low-income participants. While MMM loadings exist in SaH, they are insufficient on their own.

A future program (Figure 1) should adopt an equity-focused commissioning model to ensure older people in thin markets can access care. Localised planning, supported by flexible commissioning and tailored funding, is essential and may include place-based solutions, shared workforce models and cross-sector partnerships that reflect community strengths and culture.

Funding frameworks (e.g. block or hybrid block funding, capped pricing and recognition of rising overheads - see 'Other related matters – Financial sustainability') are critical enablers of local planning. As one provider explained:

"I see the transition to SaH without block funding as a major threat to service access and sustainability. In thin markets, block funding has been critical to offset low participant volumes and high travel costs"… "[Removing block funding] compromises the quality of care that participants deserve, but also places staff under moral and professional strain, increasing the likelihood of workforce attrition and further reducing access in already vulnerable communities."

Thin markets are especially vulnerable to workforce shortages, as existing challenges (e.g. split shifts, job insecurity, high administrative demands, emotional safety risks) are

more pronounced. Providers also warn that increased reporting, billing and co-contributions may further reduce direct care time.

Current thin-market grants are insufficient and, as they are non-recurrent funding, increase the administrative burden. Funding should cover costs and support innovation in technology, telehealth and shared workforce models to ensure a sustainable home care program.

R10 Undertake foundational funding design activities as part of the CHSP reform, including:

- **a) regional service mapping and gap analysis to identify underserved communities, and the allocation of targeted funding (such as start-up grants) to attract and retain providers in thin markets; and**
- **b) sector consultation on the continuation of block funding for meals, transport, respite and social support services, or the adoption of hybrid funding models for these services.**

Other related matters

Financial sustainability

Financial sustainability is a major concern for CHSP providers, who report that their current funding often falls short of the cost of delivery. SaH pricing uncertainty and anticipated costs of managing and administering the transition heighten viability concerns.

Funding model

A comprehensive assessment of funding models for entry-level services is required and should be guided by the design principles outlined in Figure 1. Funding approaches aligned to outcomes are more likely to sustain social capital, such as relationships and connections between individuals and groups, and minimise service discontinuity during transition and over time.

Block funding should be retained, alongside the adoption of a hybrid funding model, consistent with Recommendation 10(b), incorporating targeted grants where appropriate. These models provide greater capacity to support preventive, low-volume and socially-oriented services — particularly in regional and thin markets —by reducing financial volatility and enabling the provision of shared infrastructure. These benefits are significantly constrained under SaH's individualised budget arrangements.

Providers of cottage respite services have consistently stated that these services are not financially viable without block funding, as reliance on individualised budgets would introduce substantial financial instability. Given that cottage respite is not funded under

SaH, the absence of block funding presents a material risk of this critical and unique service disappearing altogether.

Funding adequacy

Concerns about CHSP funding adequacy are increasing. Providers face rising operating costs, including wages, overheads and insurance, while indexation has failed to keep pace with these increases over the past decade. These costs include both visible expenses, such as strengthening agreement processes, and less visible pressures, such as coordinating volunteers and staff training. This is compounded by growing compliance and administrative obligations that have escalated since 1 November 2025.

Mechanisms previously used to manage cost pressures, including cross-subsidising from Home Care Packages or carrying over unspent funds, are no longer available. Indexation is not keeping pace with program requirements, limiting financial viability and affecting strategic planning, workforce development, and service improvement. A comprehensive review of funding against actual service delivery costs is needed before any transition to SaH. This should include aligning indexation with real cost growth, regional cost-of-living variations, and annually indexing the home modifications cap to CPI and construction costs.

Participant contributions increase affordability concerns for older people, particularly in rural and remote areas. Research indicates co-contributions can deter service uptake or lead providers to waive fees, increasing viability concerns. Reviewing the impact of participant contributions on behaviour and care outcomes will be critical ahead of the CHSP reform.

R10 Undertake foundational funding design activities as part of the CHSP reform, including:

- **c) a review of sector financial viability, including an assessment of CHSP funding levels against the actual unit costs of service delivery;**
- **d) alignment of indexation rates with real cost growth and regional cost-of-living variations; and**
- **e) a review of the impact of SaH participant contributions on consumer behaviour and care outcomes.**

Sustainability of volunteers and non-award staff

Volunteers and non-award staff are crucial for entry-level and community-based services, particularly those focused on social connection. However, rising costs of supporting volunteers, combined with wage pressures for staff not covered by Fair Work (e.g. cottage respite nurses), threaten service sustainability.

Investment in workforce and volunteer development, including recruitment, retention, training, and incentives, is essential and should be supported by a national strategy tailored to underserved areas.

Ageing Australia supports a supplement for volunteer and non-award staff, to offset operational costs. Without this, there is a risk of service contraction, increased reliance on paid staff (adding to system costs), and erosion of community-based, preventive care models.

R11 Support participant access and provider viability during and beyond the transition, by:

- **a) investing in the aged care workforce and volunteer development through targeted recruitment, retention, training, and incentives, underpinned by a national workforce strategy with regionally tailored initiatives; and**
- **b) establishing a volunteer and non-award staff supplement to recognise increasing reliance on volunteers and workers not covered by Fair Work wage cases (e.g. cottage respite nurses).**

Multi-provider data system

The transition from the CHSP to SaH requires robust, system-level data collection and seamless sharing of participant care information across providers. As care under SaH is delivered by multiple organisations, accessible, shared data is essential to ensure continuity, coordination and safety of care.

Enabling data sharing is critical to support coordinated, safe, and efficient service delivery and to facilitate a smooth transition from CHSP in a multi-provider environment. Without shared data systems, information remains fragmented, increasing the risk of care duplication, service gaps and inconsistent decision-making.

Effective multi-provider data systems rely on agreed mechanisms for data sharing. Co-design is therefore central to system development, ensuring solutions meet the operational needs of all stakeholders and are adopted in practice. Progress is urgently needed to establish shared data systems, with co-design being key to successful implementation. Applying co-design principles (see Figure 1) will enable holistic care delivery, reduce service duplication, address gaps in participant care and support appropriate governance (including privacy).

R12 Co-design the development and implementation of a multi-provider data system under the SaH program.