The Senate

Community Affairs References Committee

The transition of the Commonwealth Home Support Program to the Support at Home Program

June 2026

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Contents

Members ..... **iii**

Abbreviations ..... **ix**

List of recommendations ..... **xi**

Chapter 1—Introduction **1**

Introduction 1

Referral and conduct of the inquiry 2

Acknowledgements 2

Structure of the report 2

Previous inquiry 3

Concurrent inquiries 4

Commonwealth Home Support Program 5

Service types 5

Funding 5

Aged Care Act 2024 6

Funding 7

Chapter 2—Successes and challenges **9**

CHSP successes 9

Comparative cost to government 12

Affordability 13

Communities with specific needs 15

Challenges 18

Audit of performance 22

Chapter 3—The future of the CHSP **27**

Opposition to transition 27

Block funding 30

Fee-for-service funding and co-contributions 31

Thin-market funding 38

Modernised program 40

Mixed-funding model 42

New funding model 45

Chapter 4—Transition readiness **47**
Information and consultation 47
Modelling and data collection 49
Consultation 51
Provider readiness 53
Recipient readiness 58
Roll-out proposals 59
Lessons from previous programs 61
Chapter 5—Support at Home Program **65**
SAH Program challenges 65
Waiting periods 67
Implementation and evaluation 70
Single Assessment System 71
How assessments are conducted 73
Rural, remote and very remote areas 74
Assessments and culturally inappropriate practices 75
Chapter 6—Assistive technology, home modifications, and the End-of-Life Pathway **79**
Assistive technology and home modifications 79
Criticism of $15,000 lifetime cap on home modifications 81
Concerns with the SAH Program 89
Recommendations 92
End-of-Life Pathway 94
Time limit and funding cap 95
Clarification of alignment between programs 99
Other concerns 100
Recommendations 101
Government announcement 103
Chapter 7—Committee view and recommendations **105**
Transition of the CHSP 105
Funding models 108
Home modifications 110
End-of-Life Pathway 111

Additional Comments - Labor Senators **113**

Additional Comments - Coalition Senators **119**

Appendix 1—Submissions and additional information **121**

Appendix 2—Public Hearings and Witnesses **125**

Abbreviations

Aged Care Act	*Aged Care Act 2024*
AAG	Australian Association of Gerontology
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ACTA	Australian Community Transport Association
AHCSA	Aboriginal Health Council of South Australia
AKPS	Australia-modified Karnofsky Performance Scale
ANAO	Australian National Audit Office
ANMF	Australian Nursing and Midwifery Federation
ARAS	Aged Rights Advocacy Service
AT	Assistive technology
AT-HM Scheme	Assistive Technology and Home Modification Scheme
ATSA	Assistive Technology Suppliers Australia
CALD	Culturally and Linguistically Diverse
CHSP	Commonwealth Home Support Program
COTA Australia	Council of the Ageing Australia
ECCQ	Ethnic Communities Council of Queensland
EOL / EOL Pathway	End-of-Life / End-of-Life Pathway
FECCA	Federation of Ethnic Communities Council of Australia
HAAG	Housing for the Aged Action Group
HM	Home modifications
IAT	Integrated Assessment Tool
Inspector-General	Inspector-General of Aged Care
LGASA	Local Government Association South Australia
MMM / MM	Modified Monash Model

NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIAACC	National Aboriginal and Torres Strait Islander Ageing and Aged Care Council
NDIS	National Disability Insurance Scheme
NSA	National Seniors Australia
NWRH	North and West Remote Health
OPAN	Older Persons Advocacy Network
PCA	Palliative Care Australia
RACP	Royal Australasian College of Physicians
Royal Commission	Royal Commission into Aged Care Quality and Safety
SAH / SAH Program	Support at Home Program
SAS	Single Assessment System
The Department	The Department of Health, Disability and Ageing
UWU	United Workers Union
VACCHO	Victorian Aboriginal Community Controlled Organisation

List of recommendations

Recommendation 1

7.19 The committee recommends the Department of Health, Disability and Ageing immediately implements the recommendations of the Auditor-General in the Effectiveness of the Commonwealth Home Support Program report tabled 14 May 2026. The implementation of these recommendations should not be conditional on any future decisions regarding the transition of the Commonwealth Home Support Program.

Recommendation 2

7.20 The committee recommends that the Department of Health, Disability and Ageing commissions an independent cost-benefit analysis that examines the value of the CHSP against the cost of delivering aged care through other programs, including the Support at Home Program and residential aged care. This should also include analysis of the level of funding required to ensure that it is able to meet current and future demand. The final report of this cost-benefit analysis should be made public.

Recommendation 3

7.21 The committee recommends that the Department of Health, Disability and Ageing begin a consultation and co-design process in collaboration with service providers, advocacy groups, older Australians, state and territory governments, and experts regarding the future of the Commonwealth Home Support Program.

Recommendation 4

7.30 The committee recommends that the Australian Government extend funding to the Commonwealth Home Support Program for an additional three years after July 2027 to allow time for consultation and co-design to occur. This additional time will also allow for the operation of the Single Assessment System and the Support at Home Program to be assessed in order to inform any future consideration of the transition of the Commonwealth Home Support Program.

Recommendation 5

7.31 The committee recommends that the Commonwealth Home Support Program be retained as a separate block-funded program, and not transitioned into the Support at Home Program.

Recommendation 6

7.32 The committee recommends that automatic thin market funding be provided via direct subsidy payments for eligible providers (replacing grant processes).

Recommendation 7

7.39 The committee recommends the Australian Government abolish the $15,000 lifetime cap on home modifications, and establish a new funding framework for home modifications that is more responsive to individual needs and circumstances.

Recommendation 8

7.44 The committee recommends the Australian Government abolish the funding and time restrictions placed on the End-of-Life Pathway. The committee recommends the development of a flexible, clinically guided, needs-based model that provides funding for end-of-life care for older Australians wishing to receive care in their home.

Chapter 1
Introduction

Introduction

1.1 The reforms introduced by the *Aged Care Act 2024* (Aged Care Act) were touted as a once-in-a-generation opportunity to ensure the viability and quality of aged care, and support older Australians choosing to retain their independence and remain in their homes as they age.

1.2 Instead the Support at Home Program (SAH Program) has delivered unrelenting waiting lists, priced out older people from receiving the care they need due to high co-contributions, filled hospital beds with older people unable to be discharged to their unsafe homes, and older Australians dying before they can receive the care they require.

1.3 Despite having evidence before the program even began that necessary changes would be required, the Australian Government chose to proceed with it. For example, the Australian Government has been forced to concede that showering, dressing and continence care should be categorised as clinical support. This should have been the case from the inception of the program, not months later after older Australians already experienced (and continue to experience) suffering as a result.

1.4 It was also obvious from this committee's *Aged Care Service Delivery* inquiry that changes would be necessary to the provisions of the End-of-Life Pathway (EOL Pathway) and the provisions for home modifications, in order to avoid needless suffering. As with the changes to clinical support under the SAH Program, the 2026 Budget announcement of additional funding for those who outlive their prognosis on the End-of-Life Pathway is a change that comes too late.

1.5 It is in this context that the committee has examined the Australian Government's proposal to transition the Commonwealth Home Support Program (CHSP) into the SAH Program after 1 July 2027.

1.6 The CHSP has delivered vital services to older Australians for over four decades. It provides services to nearly a million people – allowing them to age in their homes with dignity.

1.7 Before making changes to the operation of the CHSP, the Australian Government must pause, reflect on evidence received during the course of this inquiry, listen to advice from experts on the expected impacts of any changes, and most importantly only proceed with changes that will enhance the experiences of older Australians in receiving care at home.

Referral and conduct of the inquiry

1.8 On 4 November 2025 the Senate referred the following matter for inquiry and report by 15 April 2026:

The transition of the Commonwealth Home Support Program to the Support at Home Program with particular reference to:

(a) the timeline for the transition of the CHSP to SAH Program after 1 July 2027;
(b) the expected impact of this transition, including on:
    (i) waiting periods for assessment and receipt of care;
    (ii) the lifetime cap of $15,000 on home modifications;
    (iii) the End-of-Life Pathway time limits; and
    (iv) thin markets with a small number of aged care service providers;
(c) aged care provider readiness for the transition, including their workforce; and
(d) any other related matters.[1]

1.9 In accordance with its usual practice, the committee advertised the inquiry on its website, and invited relevant individuals and organisations to make submissions. The date for the receipt of submissions was 30 January 2026, and the committee received 131 submissions, which are listed at Appendix 1.

1.10 The Community Affairs References Committee (the committee) held two hearings as detailed below:

- Canberra on 6 February 2026; and
- Brisbane on 16 February 2026.

1.11 The witnesses who participated are listed at Appendix 2.

Acknowledgements

1.12 The committee would like to thank the organisations and individuals who provided evidence to this inquiry.

1.13 The committee particularly acknowledges those who shared their lived experiences. These personal accounts are vital in assisting the committee in understanding the impacts of the government's aged care policies on older Australians, their families and loved ones, and carers.

Structure of the report

1.14 This report is comprised of seven chapters as follows:

1.15 Chapter 1 contains an introduction to the inquiry and other related inquiries, and provides an overview of the CHSP;

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1 *Journals of the Senate*, No. 21–4 November 2025, p. 671.

1.16 Chapter 2 examines the successes and challenges of the CHSP;

1.17 Chapter 3 outlines the diversity of views on the future of the CHSP including whether it should be transitioned to the SAH Program, and an examination of the different funding models and which would best support the future of the CHSP;

1.18 Chapter 4 considers the readiness of the sector and older Australians for the proposed transition of the CHSP to the SAH Program;

1.19 Chapter 5 examines the implementation and operation of the SAH Program and the Single Assessment System with a view to its readiness to absorb the CHSP;

1.20 Chapter 6 examines the evidence received in relation to the lifetime cap on home modifications, and the restrictions of the End-of-Life Pathway; and

1.21 Chapter 7 provides a committee view and recommendations.

Previous inquiry

1.22 On 28 July 2025, the Senate referred the following matter for inquiry and report by 15 September 2025:

> The implications for older Australians, their families, carers, service providers and state and territory health systems of the Government's decision to delay the commencement of the new Support at Home program until 1 November 2025 while also withholding the release of any additional Home Care Packages.[2]

1.23 On 11 September 2025, the Senate granted an extension of time to report until 1 October 2025.[3] In considering the evidence received both in relation to aged care service delivery at the time of the inquiry, and changes expected after 1 November 2025, the committee had a number of concerns. These included that:

- the lifetime cap of $15,000 on home modifications will be insufficient to meet the needs of older Australians;[4]
- palliative care recipients on the End-of-Life Pathway who outlive their 12 week prognosis (16 weeks if funding has not been exhausted) will have to seek assessment for the Support at Home Program or residential aged care;[5] and

2 *Journals of the Senate*, No. 4, 28 July 2025, pp. 146–147.

3 Senate Community Affairs References Committee, *Progress Report*, 11 September 2025.

4 Senate Community Affairs References Committee, *Aged Care Service Delivery*, 1 October 2025, p. 115.

5 Senate Community Affairs References Committee, *Aged Care Service Delivery*, 1 October 2025, p. 115.

- CHSP stakeholders, including older Australians and service providers, have not been provided with sufficient information about the expected transition of the CHSP to the SAH Program after 1 July 2027.[6]

1.24 As such the committee recommended:

> …the Senate refer to the Community Affairs References Committee the following matter for inquiry and report by the first sitting week of August 2026:
>
> - the timeline for the transition of the Community Home Support Programme to the Support at Home Program after 1 July 2027; and
> - the expected impact of this transition including on waiting periods for assessment and receipt of care;
> - the lifetime cap of $15,000 on home modifications;
> - and the End-of-Life Pathway time limits.[7]

Concurrent inquiries

1.25 The *Aged Care Service Delivery* inquiry also recommended that the Senate refer for inquiry and report, the expected impact of the SAH Program on older Australians' dignity, health, safety and access to care; and the residential aged care system and hospitals.[8] This committee was referred this inquiry on 4 November 2025, and is expected to table a report on 24 November 2026.[9]

1.26 As both inquiries examine aspects of the implementation of the Aged Care Act, inevitably some evidence discusses both the implementation and impact of the SAH Program and the expected outcomes of the transition of the CHSP.

1.27 While noting the evidence received about the implementation and impact of the SAH Program where relevant, this report nevertheless maintains a focus on the intersection of these issues and the potential impact of the CHSP being transitioned into the program.

1.28 Additionally, the Community Affairs Legislation Committee is conducting a review of the Aged Care Rules, as required by Section 602(12) of the Aged Care Act.

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6 Senate Community Affairs References Committee, *Aged Care Service Delivery*, 1 October 2025, pp. 110–111.

7 Senate Community Affairs References Committee, *Aged Care Service Delivery*, 1 October 2025, p. 11.

8 Senate Community Affairs References Committee, *Aged Care Service Delivery*, 1 October 2025, p. 114.

9 *Journals of the Senate*, No. 21 – 4 November 2025, pp. 670–671.

Commonwealth Home Support Program

1.29 The CHSP is an entry-level in-home aged care support program that helps older people to live independently in their homes and communities. It also provides respite services to enable carers to take breaks.[10]

1.30 The CHSP is available across the country and funds a large variety of service providers to deliver care and services to clients. Trained assessors determine what each person requires through face-to-face assessments in the home.[11]

1.31 There are currently more than 1300 CHSP providers in Australia, including government, non-government and not-for-profit organisations.[12]

Service types

1.32 The CHSP includes five categories of service: home support; assistive technology; home modifications; advisory services; and sector support and development.

1.33 Home support includes: allied health and therapy services; therapeutic services for independent living; community cottage respite and home or community respite; domestic assistance; home maintenance and repairs; meals; nursing care; personal care; transport; social support and community engagement; and hoarding and squalor assistance.[13]

Funding

1.34 CHSP providers receive government funding through grant agreements to provide subsidised services to eligible older people.[14]

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[10] Department of Health, Disability and Ageing, About the Commonwealth Home Support Programme (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 25 November 2025).

[11] Department of Health, Disability and Ageing, About the Commonwealth Home Support Programme (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 25 November 2025).

[12] Department of Health, Disability and Ageing, About the Commonwealth Home Support Programme (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 25 November 2025).

[13] Department of Health, Disability and Ageing, Delivering services under the Commonwealth Home Support Program (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 4 March 2026).

[14] Department of Health, Disability and Ageing, About the Commonwealth Home Support Program (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 23 February 2025).

1.35 CHSP clients pay a contribution or fee (which varies between providers) towards the cost of their services. Clients are expected to contribute towards the cost of the services they receive, if they can afford to do so.[15]

1.36 Clients are not asked to cover the full cost of services, and any fees must be agreed between the client and the service provider before services start as part of their service agreement.[16]

1.37 Providers must have a publicly available client contribution policy that outlines how they determine their fees.[17]

1.38 Clients are not denied services if they are unable to contribute to the cost of the services. Each provider has their own arrangement for protecting those least able to contribute towards the cost of their care.[18]

Aged Care Act 2024

1.39 In late 2019, during the Royal Commission into Aged Care Quality and Safety, the Australian Government announced it would move toward a single, unified in-home aged care program to replace both CHSP and Home Care Packages. After delays to the broader reform timetable and the design of the SAH Program, the Australian Government later decided to defer the integration of CHSP into the new program to no earlier than 1 July 2027.[19]

1.40 From 1 November 2025, the CHSP came under the Aged Care Act and the Aged Care Rules 2025 (the Rules).

1.41 Since 1 November 2025 and the commencement of the Act, there have been changes to the way CHSP services are regulated and delivered. These changes include (amongst others):

- All recipients must be registered with My Aged Care and must have had an aged care assessment conducted by 31 October 2025;

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15 Department of Health, Disability and Ageing, About the Commonwealth Home Support Program (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 23 February 2025).

16 Department of Health, Disability and Ageing, About the Commonwealth Home Support Program (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 23 February 2025).

17 Department of Health, Disability and Ageing, About the Commonwealth Home Support Program (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 23 February 2025).

18 Department of Health, Disability and Ageing, About the Commonwealth Home Support Program (CHSP) | Australian Government Department of Health, Disability and Ageing, (accessed 23 February 2025).

19 Australian Community Transport Association, *Submission 3*, p. 2.

- If a recipient booked an assessment before 1 November 2025, but it was unable to be conducted in time, they may be eligible to have their approval backdated. This will depend on their circumstances at the time of assessment.
- If recipients chose or choose not to be assessed or register with My Aged Care, they are not eligible for government funded aged care services and will need to pay the full price of care.
- Eligibility for CHSP services is restricted to the following categories of people:
  - aged 65 years and over; or
  - Aboriginal or Torres Strait Islander and aged 50 years or over; or
  - homeless or at risk of homelessness and aged 50 years or over; or
  - existing clients who were approved for aged care before 1 November 2025.[20]

1.42 CHSP recipients aged between 45 and 49 who are also Aboriginal or Torres Strait Islander will only continue to be eligible if they registered with My Aged Care and were assessed by 31 October 2025.[21]

1.43 The Australian Government has also committed to the transition of the CHSP into the SAH Program no earlier than 1 July 2027.[22]

Funding

1.44 The Australian Government has invested in the extension of the CHSP through to 1 July 2027 pending its final decision on its transition into the SAH Program.[23]

1.45 The total funding for the CHSP over 2025–27 is $7.2 billion, supporting approximately 835,000 older Australians.[24]

1.46 The CHSP funds approximately 1,300 government, non-government and not-for-profit providers to deliver services across 74 Aged Care Planning Regions.[25]

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[20] Department of Health, Disability and Ageing, Commonwealth Home Support Program (CHSP) changes from 1 November 2025 – information for clients | Australian Government Department of Health, Disability and Ageing, (accessed 3 February 2026).

[21] Department of Health, Disability and Ageing, Commonwealth Home Support Program (CHSP) changes from 1 November 2025 – information for clients | Australian Government Department of Health, Disability and Ageing, (accessed 3 February 2026).

[22] Department of Health, Disability and Ageing, *Submission 39*, p. 3.

[23] Department of Health, Disability and Ageing, *Submission 39*, p. 4.

[24] Department of Health, Disability and Ageing, *Submission 39*, p. 4.

[25] Department of Health, Disability and Ageing, *Submission 39*, p. 4. The Australian Government uses Aged Care Planning Regions to plan aged care services across Australia. The determinations for the current 2018 Aged Care Planning Regions were signed in April 2018, 2018 Aged Care Planning

1.47 The Department of Health, Disability and Ageing told the committee that the 2025–27 CHSP grant agreements are in effect from 1 July 2025 to 30 June 2027. Further:

> Block funding, payments to providers in arrears based on a National Unit Price Range for most service types will continue to apply during the grant period.[26]

1.48 Client contribution arrangements continue to apply during this extension period with CHSP clients required to contribute to the cost of services where they can afford to do so.[27]

Region maps | Australian Government Department of Health, Disability and Ageing, (accessed 23 February 2026).

26 Department of Health, Disability and Ageing, *Submission 39*, p. 4.

27 Department of Health, Disability and Ageing, *Submission 39*, p. 4.

Chapter 2
Successes and challenges

> CHSP is the critical foundational level of our aged-care system, and it currently supports well over 800,000 people. It is the largest component of Commonwealth funded aged care and dwarfs both residential care and Support at Home in terms of the number of people that it provides services to every day. For many it is the difference between remaining safely at home and entering more intensive and costly parts of either the aged-care or the hospital system.[1]

2.1 This chapter explores the evidence received in relation to the value and success of the Commonwealth Home Support Program (CHSP) over forty years. It also examines the evidence in relation to challenges which affect service provision and sustainability.

2.2 This chapter also provides an overview of the performance audit conducted by the Australian National Audit Office into the effectiveness of the CHSP.

CHSP successes

2.3 The CHSP largely funds: not-for-profit community aged care providers such as Meals on Wheels, and community transport; state and local government services such as neighbourhood centres and community nursing; social connection services such as digital skill support and internet access; support for older people in engaging with government agencies; and access to food/showers/laundry services for older homeless people. In addition to direct services, the CHSP also funds a network of sector support and development workers who play a critical role in assisting CHSP providers build capacity, support volunteers and improve quality.[2] Randwick Community Transport submitted:

> The CHSP stands as the most successful and impactful program within the aged care sector, distinguished by significant strengths: scalability, flexibility, and community responsiveness. It delivers in-home care to almost one million Australians at a fraction of the cost of individualised budget programs. This efficiency stems largely from a sense of community responsibility. Social capital forms the foundational asset of the CHSP, strengthening outcomes for older Australians, improving system efficiency, and delivering long-term public value.[3]

2.4 The importance of CHSP services in the lives of older Australians was emphasised in evidence – in particular, the role of the CHSP as a readily

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1 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 1.

2 CHSP Alliance, *Submission 124*, p. 3.

3 Randwick Community Transport, *Submission 37*, [p. 1].

accessible program providing entry-level, reablement and preventive services reducing premature entry to residential aged care. The CHSP was described as having 'historically provided more straightforward and timely access to services, including for older people assessed as eligible and waiting an allocation of a home care package'.[4] Mr Tom Symondson, Chief Executive Officer, Ageing Australia, also noted:

> … [the] CHSP is the one part of the system that provides supports to a huge number of people that would otherwise probably not have access to supports at all. It should also be acknowledged it is the only part of the system designed around a reablement focus as opposed to the other parts of the system.[5]

2.5 Ms Carolyn Bell, Executive Director, Aged Care, Silverchain, similarly stated that the:

> CHSP works because it's simple, trusted and easy to access. It provides help early. It's often the first time someone accepts support. It prevents decline, avoids hospitalisations and helps carer burnout.[6]

2.6 This was echoed by Ms Diane Lynch, Chief Executive Officer, Kirinari Community Services, who described the CHSP as 'fabulous' and told the committee that the CHSP allows for providers to be 'super responsive' to increasing or decreasing the services a recipient may require.[7]

2.7 Mr Joel Reading, Acting Chief Executive Officer, Ozcare, told the committee that 'the CHSP is one of the most effective and best-value investments that we have in the Australian aged-care system'. Mr Reading stated:

> It's light touch. It's preventive. It helps people remain independent, maintain their wellbeing and, in particular, avoid premature entry into the higher cost streams of the system. This preventive focus is essential because early intervention improves outcomes for our recipients and reduces pressure across the broader system.[8]

2.8 The committee heard evidence from those with lived experience of receiving CHSP services. Robin, a recipient of care from two organisations in Victoria, told the committee that she has 'been hugely impressed with every aspect of the service' she has received, and these services 'have been lifechanging'. Robin

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4 Older Persons Advocacy Network, *Submission 107*, p. 9.

5 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 1.

6 Ms Carolyn Bell, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, p. 12. See also Armidale Uralla Meals on Wheels Inc, *Submission 31*, p. 2.

7 Ms Diane Lynch, Kirinari Community Service, *Committee Hansard*, Brisbane, 16 February 2026, p. 26.

8 Mr Joel Reading, Ozcare, *Committee Hansard*, Brisbane, 16 February 2026, p. 13. See also Community Culture, *Submission 77*, p. 5.

explained that as a result of the services she is 'safer and more confident living alone'. Robin also noted:

> People value locally based services delivered by local CHSP organisations employing local people. They are an essential part of the fabric of the community and its economy. They are usually trusted. We found, in rural and isolated New South Wales, large corporate providers based in regional centres are not acceptable to many people and cause some to refuse services. Obviously, service refusal leads to the risk of adverse outcomes, including future institutionalisation.[9]

2.9 Another witness, Jen, told the committee that when receiving care under the CHSP in 2023, she found the process of assessment 'collaborative and respectful' and the provider was 'empathetic'. Jen stated that she 'felt relieved knowing there was local support to help' care for her husband in their own home. Jen also noted, 'our contribution was $20 an hour for domestic assistance, $11.50 an hour for respite and $35 an hour for gardening, annual window cleaning and annual gutter cleaning'. Jen contrasted her experiences of the CHSP with that of receiving care under the SAH Program and stated:

> CHSP enabled us to access services in community without elongated wait periods. Our fully managed package on Support at Home now charges $120 an hour for domestic assistance and home maintenance. Essential gardening is $110 an hour, and respite is $120 an hour.[10]

2.10 Professor Kathy Eagar AM told the committee that the CHSP is 'the only part of the aged care system that has consistently performed well over the last four decades, with the only criticisms ever being that it is underfunded and neglected by successive governments'.[11] Similarly, the City of Salisbury submitted:

> CHSP is the only part of the aged care system which has consistently performed well over the last four decades for people to stay longer in their own homes and generating significant additional benefits at the same time by imbedding social approaches, wellness approaches, volunteer workforce, community-based networks and supporting the diverse special needs groups. A loss of such program will have adverse impact to the Australian health care system.[12]

2.11 The Inspector-General of Aged Care (Inspector-General) described the CHSP as 'the Australian Government's primary vehicle for preventing acute ageing,

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9 Robin, *Committee Hansard*, Brisbane, 16 February 2026, p. 11.

10 Jen, *Committee Hansard*, Brisbane, 16 February 2026, p. 10.

11 Professor Kathy Eagar AM, *Submission 15*, p. 2.

12 City of Salisbury, *Submission 68*, p. 21.

supporting older people's preferences to age in place and keeping people out of higher cost and more intensive tertiary aged care and hospitals'.[13]

2.12 The Australian Association of Gerontology similarly told the committee that 'early and foundational supports do considerable "heavy lifting". For example, early intervention and social connectivity contribute to slowing or preventing decline and delaying the need for additional supports'. The Association noted that 'this is currently largely provided through CHSP'.[14]

Comparative cost to government

2.13 The committee received evidence of the comparative cost of older Australians receiving care through the CHSP, SAH Program and Residential Care Facilities (RCFs) which demonstrate the 'relative effectiveness and cost benefit of the current CHSP program'.[15] Professor Michael Fine, Honorary Professor at Macquarie University, submitted that:

- **CHSP funded** services currently support 60 per cent of all aged care recipients, despite Australian Government expenditure of less than 10 per cent of aged care funding. The average cost per recipient is $70 per week.
- **SAH Program** services (Home Care Packages prior to 1 November 2025) assist around 16 per cent of all recipients, at an average cost of $432 per week to the Australian Government. This represents approximately six times the cost of the CHSP per client. The funding required was approximately 25 per cent of Australian Government funding in 2024.
- **RCFs**, the most intensive and costly form of provision, support 16.2 per cent of clients but required almost 66.1 per cent of all Australian Government funding. The cost per person is approximately 25 times higher than the CHSP.[16]

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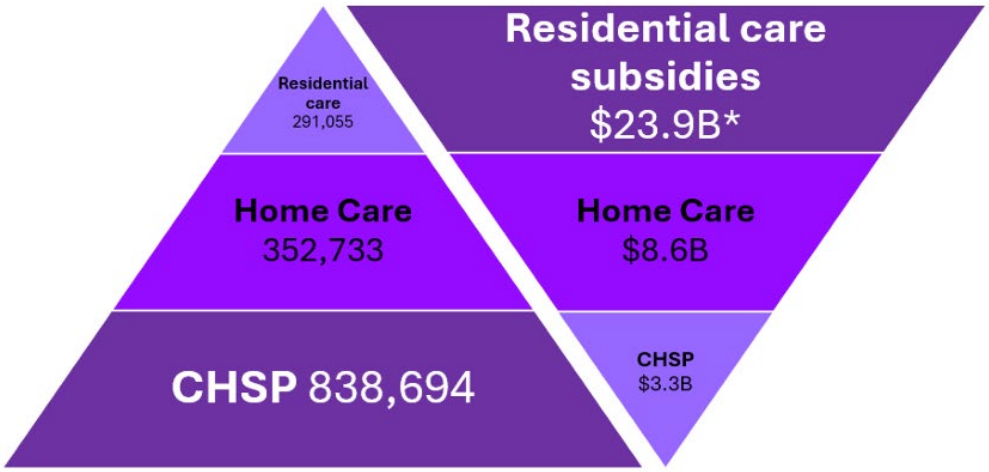
13 Inspector-General of Aged Care, *Submission 26*, p. 1. See also Australian Association of Gerontology, *Submission 122*, p. 8.

14 Australian Association of Gerontology, *Submission 122*, p. 8.

15 Professor Michael Fine, *Submission 35*, pp. 2–3. See also Older Persons Advocacy Network, *Submission 107*, pp. 8–9.

16 Professor Michael Fine, *Submission 35*, p. 3. See also Inspector-General of Aged Care, *Submission 26*, p. 1.

Figure 2.1 Aged care clients compared with Commonwealth expenditure on aged care services, 2024-25 financial year



Source: Inspector-General of Aged Care, Submission 26, p. 10

**Figures are formatted as billions. Source material expenditure tables are formatted as thousands, with the underlying values representing actual dollars. Residential care subsidies administered by the Department of Health, Disability and Ageing and the Department of Veterans' Affairs have been combined. Figures exclude other client and expenditure types, specifically for clients of the transition care and short-term restorative care programs, which comprise a much smaller proportion of clients.*

2.14 The Inspector-General similarly stated that 'simply put, residential aged care is monumentally more expensive than entry-level home support, with entry level services potentially able to deliver significant savings to the aged care budget'.[17]

Affordability

2.15 The Older Persons Advocacy Network (OPAN) told the committee that CHSP services are 'generally affordable for most older people, and the program enables providers to reduce or waive fees to readily enact the core principle that no older person will be denied access to services due to inability to pay'.[18] Mr Tim Hicks, Executive General Manager, Policy and External Relations, Bolton Clarke told the committee:

> One of the attractive things about CHSP is that there's quite a lot of discretion for providers to waive co-contributions for individual clients. It's a lot easier than applying for a hardship application to government. I think, more broadly, one of the benefits of CHSP is that it leaves a lot of the discretion about service delivery at the local level rather than making it with an administrative decision-maker. It's really on a case-by-case basis, but we do generally charge the nominal co-contribution that's in the guide for each of our services.[19]

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17 Inspector-General of Aged Care, *Submission 26*, p. 10.

18 Older Persons Advocacy Network, *Submission 107*, p. 9.

19 Mr Tim Hicks, Bolton Clarke, *Committee Hansard*, Canberra, 16 February 2026, p. 17.

2.16 The Department of Health, Disability and Ageing (the Department) provided the committee with an overview on how fees for CHSP clients are calculated. Ms Julia Atkinson, Assistant Secretary, Home Support Operations Branch, Access and Home Support Division, told the committee that CHSP clients are not subject to a means test. Instead, providers 'work closely with clients around what is affordable for them to pay for services, and the government provides a recommended reasonable range of consumer contribution to providers according to each service type'. The CHSP also has 'hardship arrangements, however these are managed by CHSP providers'. Ms Atkinson stated:

> CHSP providers are required to have a hardship policy. That policy must be published, and they must undertake to provide reasonable hardship arrangements for older people if they cannot afford to pay a contribution, as was previously agreed. A provider cannot charge a consumer contribution in CHSP without first having that rate agreed with the older person. Since the new Aged Care Act has come into place, that is now consistent with the Support at Home program and is expected to be contained in the older person's service agreement.[20]

2.17 The committee also heard that the CHSP is 'affordable for clients, by design'. The Older Women's Network NSW explained that 'government grants cover the bulk of service delivery costs, and client contributions are meant to be low and flexible'. It stated:

> The program manual suggests providers request contributions where possible, but no one must be refused service if they cannot pay. In practice, many CHSP clients pay a token fee or a donation per service.[21]

2.18 The Older Women's Network NSW stated that the affordability of services under the CHSP is 'not an accidental side-benefit', rather, it is core to the 'CHSP's mission of supporting "frail older people … who may be experiencing financial disadvantage" to remain at home'. It noted that providers have the discretion to waive or reduce fees, and that by 'ensuring that cost is not a barrier', it has 'been able to reach deeply into communities of disadvantaged seniors'.[22]

2.19 The CHSP has also 'historically provided more straightforward and timely access to services'. OPAN noted that in the past, older people and their carers could access services directly through a CHSP service provider, and this

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[20] Ms Julia Atkinson, Department of Health, Disability and Ageing, *Committee Hansard*, Canberra, 6 February 2026, p. 39.

[21] Older Women's Network NSW, *Submission 97*, [p. 9].

[22] Older Women's Network NSW, *Submission 97*, [p. 10].

enhanced access for diverse groups, including people experiencing disadvantage.[23]

Communities with specific needs

2.20 The CHSP was noted as being particularly successful in delivering services to communities with specific needs. For example, Ms Diane Lynch, Chief Executive Officer, Kirinari Community Services, told the committee that the program is well suited to providing services to regional communities, Aboriginal and Torres Strait Islander communities, and Culturally and Linguistically Diverse (CALD) communities. Ms Lynch noted that 'one of the really fabulous things about that program is the number of services that happen more in community than in home'.[24]

2.21 The committee heard that the success of the CHSP 'is particularly evident in Aboriginal and Torres Strait Islander communities, where community-based, block-funded CHSP providers have demonstrated their ability to reach Elders and older people who would otherwise fall through the gaps of the mainstream aged care system'. OPAN told the committee that 'for Aboriginal and Torres Strait Islander communities, the CHSP is not simply a service – it is cultural infrastructure'. It stated:

> Block funding under CHSP allows Aboriginal Community Controlled Organisations (ACCOs) to provide holistic care that sustains Elders' connection to Country, language, and community. This enables intergenerational learning and strengthens social cohesion.[25]

2.22 Mrs Kim Whiteley, Chief Executive Officer, National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) told the committee that for Aboriginal and Torres Strait Islander communities the 'CHSP functions as a critical safety net that fills gaps created by long assessment delays, workforce shortages, thin or failing markets, digital exclusion and limited access to culturally safe assessment pathways'. Mrs Whiteley stated:

> In many communities, CHSP is the only thing preventing complete withdrawal of support. We heard from a remote provider supporting an elder who waited for over a year for assessment. During that time, CHSP meals, transport and home support were the only things keeping them out of hospital.[26]

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23 Older Persons Advocacy Network, *Submission 107*, p. 9. See also Older Women's Network NSW, *Submission 97*, [p. 9].

24 Ms Diane Lynch, Kirinari, *Committee Hansard*, Brisbane, 16 February 2026, p. 25.

25 Older Persons Advocacy Network, *Submission 107*, p. 11.

26 Mrs Kim Whiteley, National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Committee Hansard*, Canberra, 6 February 2026, p. 21.

2.23 The National Aboriginal Community Controlled Health Organisation (NACCHO) told the committee that the block funded model allows Aboriginal Community Controlled Health Organisations (ACCHOs) 'the flexibility to support their clients according to their individual and collective needs and priorities'. Ms Monica Barolits-McCabe, Executive Director, NACCHO, explained:

> Under the CHSP, ACCHO's have certainty of service provision, meaning they can do long-term planning and provide secure employment opportunities for staff. Providers are able to use funding flexibly—for example, to support social programs for elders to bring them into community day centres for needed social and emotional support as well as healthcare checks and meals. The CHSP model means that people can get into the system straight away.[27]

2.24 The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) similarly told the committee that across Australia, the CHSP provides services to 68 per cent of the almost 35,000 Aboriginal and Torres Strait Islander people that receive a form of aged care support services. It noted that the CHSP provides 'a recurrent, stable funding base that is essential for ACCOs [Aboriginal Community Controlled Organisations] with limited economies of scale operating in culturally thin markets, enabling them to cover fixed costs'.[28]

2.25 VACCHO explained that ACCOs provide an evidence-based, best practice model of care for Elders that is 'culturally safe and combined with wrap-around social services'. Further, by being a 'one-stop-shop' for all health and wellbeing needs, ACCOs are able to ensure that there is 'no wrong door to access support'. VACCHO stated:

> This unique model of care means that when an Elder receives in-home support, their health and wellbeing needs are assessed proactively and on an ongoing basis, with a direct pathway for follow-up in a culturally safe, trusted environment.[29]

2.26 Mrs Kim Whiteley, NATSIAACC told the committee that:

> In some remote and very remote communities, an Aboriginal community controlled provider may be the only provider of service. An Aboriginal community controlled provider provides services not only in ageing and aged care but across the domain of health, from primary healthcare services to chronic disease management, child health and wellbeing, healing and plenty of other areas as well.[30]

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27 Ms Monica Barolits-McCabe, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Brisbane, 16 February 2026, p. 42.

28 Victorian Aboriginal Community Controlled Health Organisation, *Submission 116*, p. 7.

29 Victorian Aboriginal Community Controlled Health Organisation, *Submission 116*, p. 7.

30 Mrs Kim Whiteley, National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Committee Hansard*, Canberra, 6 February 2026.

2.27 For older people from CALD communities, the CHSP is similarly able to provide 'stable, trusted community-based service delivery, especially via ethno-specific individual and group social support'. OPAN noted that this type of specialist support often constitutes a thin market'.[31] The Older Women's Network NSW noted that CHSP services for cultural or gender-specific groups provide 'not only practical help but also social connection, information in first languages, and trust'.[32] Ms Jessica McAdam, Chief Operating Officer, Federation of Ethnic Communities Council of Australia (FECCA) told the committee:

> CHSP … is a critical program for supporting older people to remain independent in their own home for longer. It plays a vital role in early intervention, and this preventive function is especially important for older people who may otherwise disengage from the aged-care system altogether, noting this is of a higher risk for people from a CALD background.[33]

2.28 Dr Lisa Ward, Chief Executive Officer, Ethnic Communities Council of Queensland, similarly told the committee:

> Low-intensity supports, particularly social connection programs are associated with delayed functional decline and reduced hospital use. This is supported by established public health and ageing research. Our consultations consistently show that CHSP is the most culturally safe and accessible entry point into aged care … Without CHSP, some CALD seniors may delay engagement until crisis, which aligns with broader evidence, linking delayed early intervention into higher acuity presentations.[34]

2.29 LGBTQI+ Health Australia also noted the importance of group-based social support programs provided by the CHSP for LGBTQI+ older adults. It told the committee that ensuring the sustainable wellbeing of older Australians through such programs has a range of benefits including:

- reducing loneliness and social isolation;
- increasing mental health and cognitive wellbeing;
- enhanced and more frequent physical activity;
- community participation; and
- culturally safe and inclusive environments for diverse communities.[35]

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31 Older Persons Advocacy Network, *Submission 107*, pp. 11–12.

32 Older Women's Network NSW, *Submission 97*, [p. 12].

33 Ms Jessica McAdam, Federation of Ethnic Communities Council of Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 34. See also, Multicultural Communities Council of South Australia Inc, *Submission 30*; La Trobe University, *Submission 50*, p. 4.

34 Dr Lisa Ward, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 16 February 2026, p. 34. See also Ethnic Communities Council of Queensland, *Submission 53*, p. 1.

35 LGBTQI+ Health Australia, *Submission 111*, p. 2.

Challenges

2.30 In acknowledging the importance of the CHSP in facilitating older Australians to age-in-place, submitters also acknowledged the challenges with the program. This includes: capacity pressures experienced by providers resulting in new clients being unable to access services; and providers operating over their actual capacity; and insufficient provider availability in rural and remote areas.[36]

2.31 Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, told the committee that the CHSP is 'a highly cherished program', however the 'demand for CHSP greatly exceeds supply at the moment'.[37]

2.32 Mr Ian Yates AM, former acting Inspector-General of Aged Care told the committee that the CHSP has been 'in a "set and forget" situation in terms of its design and funding for a decade'. Mr Yates stated that the Australian Government has effectively 'capped' funding, with 'occasional one-off funding increases' that has not 'kept up with either indexation … or population growth'. Mr Yates submitted:

> So services have effectively been cut. Volumes have remained fairly constant because volume is measuring supply rather than need. Many services have their books closed, others have long waiting lists. For the last few years CHSP providers have been having to deal with the human tragedies created by the government's continued calculated denial of service to people they have assessed as needing support and care through SAH. As a result CHSP has been and is in crisis.[38]

2.33 Similarly, Ms Claudia Odello, Chief Executive Officer, Meals on Wheels New South Wales, described the CHSP as the 'poor cousin' in the aged care sector. Ms Odello stated that the CHSP has been 'under-reviewed and underinvested in for years despite carrying the large share of day-to-day in-home support'. Further, 'there's no contemporary funding model, with many providers arguing the funding model hasn't had a major modern review in over a decade despite rising costs, compliance expectations and demand'.[39]

2.34 Dr Lisa Ward, Ethnic Communities Council of Queensland, acknowledged that the 'CHSP is not perfect'. Dr Ward stated:

> It requires refinement. Rigid output allocations across regions and service types can leave people waiting, even where funding technically exists elsewhere in the system. Allocation settings must better reflect the communities age, and the demand shifts in practice. CHSP must also be

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36 Aged Rights Advocacy Service, *Submission 104*, p. 4.

37 Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, *Committee Hansard*, Canberra, 6 February 2026, p. 27.

38 Mr Ian Yates, *Submission 110*, p. 9.

39 Ms Claudia Odello, Meals on Wheels New South Wales, *Committee Hansard*, Canberra, 6 February 2026, p. 2.

> supported by adequate and sustainable funding. Funding growth has not consistently kept pace with demographic changes in raising demand and that places pressures on providers in some of the regions.[40]

2.35 It was noted that despite a 37 per cent increase in the number of Australians aged 65 and older since 2015, the number of participants in the CHSP has comparatively only increased 6.63 per cent. The Municipal Association of Victoria argued that this, coupled with anecdotal evidence of significant, decentralised waitlists for CHSP services such as domestic assistance, indicate that the CHSP is not achieving its full potential, and individuals are missing out on timely access to care.[41]

2.36 The Inspector-General similarly told the committee that the block funding arrangements in place limit the provision of CHSP services, and constrain program growth. In addition, these arrangements appear to have 'capped participant numbers well below previous levels of utilisation proportionate to the number of older people in Australia over the age of 65'. The Inspector-General suggested that this is:

> … likely to have driven an increasing number of older people into higher cost and more intensive models of care, as can be partially seen by the exponential growth of the former Home Care Packages program over the same period.[42]

2.37 The committee heard that there has been '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'. OPAN told the committee that:

> CHSP services that were most unavailable in local areas were home maintenance (e.g. gardening and gutter cleaning), home cleaning, transport and allied health services, in particular, lack of occupational therapists (OTs), affecting older peoples' access to assistive technology (AT).[43]

2.38 NACCHO told the committee that member services have reported that CHSP providers have either 'closed their books to new clients, or no longer provide services at all'. As such, it falls to Aboriginal Community Controlled Health Organisations (ACCHOs) and ACCOs to provide support. NACCHO submitted that:

> However, ACCHOs/ACCOs that deliver aged care services report being overburdened and are unable to meet the high demand for services from their communities. … Another ACCHO outlined that their CHSP program

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40 Dr Lisa Ward, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 16 February 2026, p. 34.

41 Municipal Association of Victoria, *Submission 108*, p. 7.

42 Inspector-General of Aged Care, *Submission 26*, p. 11.

43 Older Persons Advocacy Network, *Submission 107*, pp. 6–7.

> is oversubscribed by 300%, but their Board had made a decision that they are unwilling to refuse care to anyone who needs it. This requires the ACCHO to crossfund CHSP using other funding streams.
>
> It is unclear whether there has been a reduction in total CHSP funding, and what is being done with CHSP funding once a provider no longer operates CHSP services – whether it is reallocated to another provider in the area or not.[44]

2.39 Local Government NSW told the committee that due to chronic under-resourcing and rising compliance costs, some councils have already exited the CHSP, even where they were the primary or sole service provider in the area. For example, Wollongong City Council has elected to transition out of the CHSP transferring social support and community transport to non-government providers in response to changes in aged care legislation and funding. Local Government NSW explained that it expects more NSW councils to withdraw from CHSP service provision 'if the system becomes more complex and operational expenditure increases without commensurate funding'.[45]

2.40 OPAN noted that 'the lack of availability of CHSP services contributes to older people feeling reluctant to raise concerns and complaints with their CHSP providers'. It stated, 'the lack of alternatives also means older people can be forced to accept low quality and highly irregular, and infrequent services by their CHSP provider'.[46] Mr Craig Gear, Chief Executive Officer, OPAN, told the committee:

> The CHSP is providing that foundational community aged-care infrastructure, but it's currently stretched to breaking point. We're calling for greater access and equity of access and greater quality and oversight of CHSP services. Our advocates report that the availability and the nature of the CHSP services you just previously heard means that people are just not being able to find access to those services and those who are accessing services don't want to speak up because they're feeling that some service is better than nothing.[47]

2.41 OPAN stated that people have lost trust and confidence in what was once a 'highly valued' community-based service due to variability in access, a lack of increased funding to meet increased demand, and a lack of real-time information and assistance for older people and their carers to find available

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44 National Aboriginal Community Controlled Health Organisation, *Submission 118*, pp. 10–11.

45 Local Government NSW, *Submission 112*, p. 12.

46 Older Persons Advocacy Network, *Submission 107*, p. 7.

47 Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, Canberra, 6 February 2026, p. 8.

services.[48] The Aged Rights Advocacy Service described 'a system driven by supply shortages rather than assessed need'. It told the committee that:

> … many clients report that they are either self-funding services or seeking to transition to Support at Home, often unnecessarily and prematurely, because of the challenges with the accessibility and availability of CHSP services.[49]

2.42 As such, 'it is imperative that measures are implemented now to manage supply and demand challenges, which are likely to worsen closer to 1 July 2027'.[50] The Municipal Association of Victoria told the committee that 'transitioning to a new program model does not automatically address the ongoing problems of the previous one'. It stated that 'weaknesses in current administration of the CHSP, including insufficient funding and data collection, must be addressed to support provider readiness'.[51]

2.43 The committee heard that waiting periods for the receipt of care under the CHSP are leading to older Australians deteriorating while waiting for care, and in some cases service providers are providing unfunded care to some recipients. Ms Claudia Odello, Meals on Wheels New South Wales, told the committee:

> With Commonwealth home support, there's probably an average wait time at the moment, from being registered to being assessed to being referred by the RAS team or the assessment team, of anywhere between three and eight months. During that time, they get unwell. They haven't been looked after and they haven't been serviced, so obviously they're past the Commonwealth home support and they're now escalated to SAH.[52]

2.44 Mrs Leanne Wright, Service Manager, Blayney Meals on Wheels and Social Support Services, told the committee that in her region seven per cent of her clients are currently on waiting lists and Meals on Wheels is absorbing the cost of service provision.[53]

2.45 Community Options, a long-standing community organisation, withdrew from providing CHSP-funded services in the Australian Capital Territory in July 2024, 'due to long-term structural underfunding, escalating workforce pressures, and the increasing financial risk placed on providers'. It submitted:

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48 Older Persons Advocacy Network, *Submission 107*, p. 8.

49 Aged Rights Advocacy Service, *Submission 104*, p. 4.

50 Aged Rights Advocacy Service, *Submission 104*, p. 4.

51 Municipal Association of Victoria, *Submission 108*, p. 6.

52 Ms Claudia Odello, Meals on Wheels New South Wales, *Committee Hansard*, Canberra, 6 February 2026, p. 3.

53 Mrs Leanne Wright, Blayney Meals on Wheels and Social Support Services, *Committee Hansard*, Canberra, 6 February 2026, p. 3.

> A central challenge was that CHSP was designed and funded as an entry-level, low-intensity support program, despite the reality that many older people presented with complex needs, disability, chronic illness, cognitive impairment, or limited informal supports. Providers were increasingly expected to deliver case management, care coordination, and crisis support functions essential for client safety and continuity of care but these activities were not funded under CHSP. As a result, Community Options absorbed significant unfunded labour to prevent service gaps, deterioration, or hospitalisation for vulnerable clients.[54]

Audit of performance

2.46 On 14 May the Australian National Audit Office (ANAO) tabled the *Effectiveness of the Commonwealth Home Support Program* report in both Houses of Parliament. This audit examined the CHSP to determine if: the program meets people's needs; whether services are delivered effectively; and if the program is meeting its objectives. The audit examined the Department's records and data and met with departmental staff; and sought feedback from recipients, aged care service staff, and organisations representing older people and service providers.[55]

2.47 The audit reached the following conclusions:

- Despite being one of Australia's largest grants programs, the Department is unable to clearly demonstrate that the CHSP is meeting community demand or the program's objectives. There are accessibility barriers to CHSP services and the Department lacks assurance that CHSP services are being delivered effectively, to eligible people, according to need, and in a timely manner. The CHSP is partly effective due to these deficiencies in the administration of the program.[56]
- The Department will need to obtain more robust assurance over eligibility, unmet demand, provider sustainability, service delivery quality, and the achievement of objectives to effectively support the CHSP's transition to SAH Program.[57]
- The CHSP is partly effective at meeting community need. While the Department provides advice to government about supply and demand pressures to support additional funding, it does not have an established

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54 Community Options, *Submission 32*, p. 4.

55 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 5, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

56 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 5, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

57 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 5, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

methodology for measuring and monitoring unmet demand for CHSP services. Research conducted during the audit also found that significant proportions of CHSP providers, peak bodies and CHSP clients perceive there to be accessibility barriers for CHSP services.[58]

- In relation to readiness for transition to the SAH Program after 1 July 2027, forecasting of both demand and supply is limited. Engagement with CHSP providers about demand pressures and supply constraints is limited. The Department's ability to determine if CHSP services are being provided to eligible people according to need in a timely manner is constrained by:
  - controls that are still developing to ensure CHSP services are provided to those who have been assessed as needing them;
  - system and data limitations that do not capture information about timeliness of service provision across the entire client journey; and
  - a lack of monitoring.[59]
- While the audit's survey of more than 10,000 CHSP clients found that the majority were satisfied with their overall experience, the Department's assurance arrangements have focused on service provider reconciliation of grant funds rather than the quality of service delivery.[60]
- The Department obtains some information about service quality through delivery partners but does not have assurance over the quality of CHSP service delivery for the majority of providers. The Department has not analysed complaints or identified lessons learnt from the CHSP to inform its transition to the SAH Program.[61]
- The Department has not demonstrated, through performance reporting or evaluation, that the CHSP is meeting its objectives (which comprise, for clients: better quality of life, delaying admission to residential aged care,

[58] Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 5, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

[59] Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 6, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

[60] Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 6, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

[61] Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 6, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

greater social connectivity, improved or maintained emotional and physical wellbeing, and greater independence).[62]

2.48 The ANAO also made a number of findings, including:

- There is no robust planning framework for the CHSP and there is an absence of methodologies to calculate current demand or forecast future demand. A demand forecasting methodology is under development for the SAH program. Some work has been done on understanding and forecasting workforce trends, however the Department has no documented methodology for forecasting the supplier market, either nationally or for specific geographic regions, cohorts or service types. In addition, there is limited engagement with providers regarding demand and supply pressures despite ANAO research and other evidence suggesting there are demand and supply pressures.[63]
- Upon commencement of the *Aged Care Act 2024* on 1 November 2025, CHSP services were being provided to over 100,000 clients without a clear understanding of their needs as they have never been assessed for aged care services.[64]
- Analysis of all aged care assessments shows that time elapsed between applying for an aged care assessment and completing the assessment increased from 12 days in 2017–18 to 27 days in 2024–25 at the 50th percentile. At the 90th percentile, the number of days increased from 67 to 172. For CHSP clients specifically, the elapsed time between referral to an assessment organisation and a completed assessment in 2024–25 was 21 days at the 50th percentile and 103 days at the 90th percentile.[65]
- There is a lack of performance measurement, monitoring and reporting of program quality, outcomes or efficiency and the Department cannot demonstrate the CHSP is meeting the program's objectives.[66]

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62 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 6, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

63 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 6, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

64 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 7, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

65 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 7, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

66 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 8, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

- There is little available research that examines the impact of the CHSP or the extent to which the CHSP's objectives are being met. Available data on the impact of in-home aged care services more generally indicates a downward trend in the use of residential aged care (a CHSP objective), however there is a lack of longitudinal data that would help establish causality. ANAO research suggests that a majority of stakeholders believe that most objectives are being met.[67]

2.49 The ANAO concluded that:

> The Commonwealth Home Support Program is delivering services to more than 800,000 people and people who get the services are generally satisfied with them. However, people have trouble getting the services when they want them. The department does not collect enough information and use it to check whether the program is being delivered well. The department does not collect enough information and use it to check whether people who are eligible for the program are able to get the services they need when they need them. It will need to do a better job of collecting this kind of information and checking and acting on these things before the Commonwealth Home Support Program combines with the Support at Home program.[68]

2.50 As such, the ANAO made nine recommendations to establish, and improve the Department's measurement, monitoring, stakeholder engagement, and reporting frameworks and processes for the CHSP. This includes for example, measuring and monitoring demand and supply pressures, quantifying unregistered clients and establishing a plan for registration, establishing monitoring arrangements and benchmarks for service delivery, and developing a stakeholder engagement plan.[69]

2.51 The Department agreed to all recommendations, and stated that its implementation of these will reflect any decisions of government regarding the future direction and management of the CHSP.[70]

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67 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 8, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

68 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, Report at a Glance, [p. 2], Effectiveness of the Commonwealth Home Support Program, (accessed 19 May 2026).

69 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 9, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

70 Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 11, https://www.anao.gov.au/sites/default/files/2026-05/Auditor-General_Report_2025-26_31.pdf, (accessed 19 May 2026).

Chapter 3
The future of the CHSP

> The first are people like me who just say, 'Don't do it.' The second group of people say, 'Call it integration, integrate the two but keep grant funding for CHSP,' which is a very polite way of saying, 'Don't do it.' The third group of submissions are saying, 'Integrate the two, keep block funding, and don't do it until support at home is working well,' which puts it off onto the long finger.[1]

3.1 The committee received a diversity of evidence in relation to what the future of the Commonwealth Home Support Program (CHSP) should look like. Some inquiry participants expressed strong opposition to the proposed transition of the program to the Support at Home Program (SAH Program) whilst others made suggestions to ensure a successful transition.

3.2 The committee also received evidence in relation to the benefits of the current block-funding model, challenges which arise out of fee-for-service and co-contribution funding models, and the need for thin-market specific funding to ensure the viability of certain services and markets.

Opposition to transition

3.3 The committee received considerable evidence in opposition to the proposition of transitioning the CHSP into the SAH Program. This opposition included concerns about the SAH Program's operation, assessment processes and funding model (these issues will also be explored in a later chapter), and the need for a distinct, better funded program that offers all the benefits of the current CHSP. Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, stated:

> The proposal is to merge it into Support at Home, which, from my perspective, is a program that is predictably bearing out serious problems in practice. Why would we merge these two programs before we've ironed out the issues with Support at Home? My inbox is becoming flooded with some of the problems we are now seeing, as predicted, with the impact of co-payments. I don't understand why we're undertaking the transition at all.[2]

3.4 The Inspector-General told the committee that she 'remains unconvinced' that transitioning the CHSP to the SAH Program realises the intent of the

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1 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 46.

2 Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, *Committee Hansard*, Canberra, 6 February 2026, p. 26. See also Flexi Care, *Submission 41*, [p. 2].

recommendations of the Royal Commission into Aged Care Quality and Safety. However, if the transition is to proceed then it is:

> … vital that the government embed core principles of the CHSP in Support at Home – enabling flexible and equitable access to entry-level non-clinical services, prioritising preventative interventions that support older people to remain living independently, and honouring the intent of the Royal Commission. Making CHSP subject to current Support at Home co-contributions is likely to put this at risk.[3]

3.5 Allied Health Professionals Australia argued that the CHSP should not transition to the SAH Program unless the CHSP is fully evaluated and all of the transition implications are assessed for consistency with the recommendations of the Royal Commission into Aged Care Quality and Safety.[4]

3.6 Professor Diane Gibson, Distinguished Professor in Health and Ageing at the University of Canberra and Co-Director of the Centre for Ageing and Research Translation submitted:

> … the transition of CHSP to the SAH program should be carefully re-considered, and either abandoned entirely in its current form or else further delayed pending re-design of the proposed transition. In the meantime, the apparent decline in CHSP funding relative to the older population … should be arrested and reversed.[5]

3.7 Mr Ian Yates AM, former Acting Inspector-General of Aged Care, similarly told the committee that 'turning [the] CHSP into the current form of SAH is not a solution' to any of the issues which currently affect its operation. In fact, 'putting the two programs together is most likely to lose or cripple the best aspects of CHSP while not solving any of its issues'.[6]

3.8 Mr Adrian Morgan, General Manager, Flexi Care, told the committee that:

> Absorbing CHSP into Support at Home as it exists would involve significant disruption to hundreds of thousands of people, as well as to the systems that are essentially working well, without a clear rationale other than being able to say that we have one home-care program. If CHSP is rolled into Support at Home, older people will be paying more and receiving less, and the cost to the Commonwealth will likely be greater. CHSP's operations and funding can and should be improved, but it certainly should not be abandoned.[7]

3.9 Mr Morgan also stated, 'the idea of bringing 800,000-plus people into an individual funding model is extremely concerning'. Mr Morgan concluded, 'I can't see, from a practical point of view, how we would get it done without years

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3 Inspector-General of Aged Care, *Submission 26*, p. 11.

4 Allied Health Professionals Australia, *Submission 52*, p. 5.

5 Professor Diane Gibson, *Submission 40*, p. 2.

6 Mr Ian Yates, *Submission 110*, p. 6.

7 Mr Adrian Morgan, Flexi Care, *Committee Hansard*, Brisbane, 16 February 2026, p. 12.

and years of work, and I don't know what benefit it would deliver'.[8] Similarly Maroochy Home Maintenance and Care Association Trading as Maroochy Home Assist submitted:

> I strongly oppose the transition of the Commonwealth Home Support Program (CHSP) into the Support at Home (SaH) Program (no earlier than 1 July 2027). The staged reforms to in home aged care, while well-intentioned, are already producing longer waiting periods resulting in consumer and carer stress, market instability, and provider readiness concerns under SaH Stage 1 (commenced 1 November 2025).[9]

3.10 Flexi Care submitted that the 'CHSP should not be rolled into Support at Home'. It explained:

> This is because we consider CHSP has significant strengths that are worth retaining and that Support at Home is a significantly flawed program in its current state. At this stage integration would be detrimental to the hundreds of thousands of people who are being supported by it and the community that benefits through its positive outcomes.[10]

3.11 Ms Carolyn Bell, Executive Director, Aged Care, Silverchain, told the committee that 'it is too early in the transition of support at home, and the stabilisation of support at home, to be confident that support at home is the right program and suitable for the CHSP'.[11]

3.12 Professor Kathy Eagar AM, strongly criticised the proposal to transition the CHSP to the SAH Program saying that it is 'a ridiculous idea to move from a cost-efficient program to an inefficient program'.[12] Access Sydney Transport similarly told the committee that:

> The proposed transition to SAH poses significant risks to service viability, continuity of care, and equitable access — especially for infrastructure-dependent services such as transport. Without stable grant funding, realistic reform timelines, and an understanding of the true cost of service delivery, older people risk losing essential supports that safeguard their health, wellbeing, and participation in community life.[13]

3.13 The Sydney Multicultural Community Services (SMCS) submitted that it 'strongly advocates for the continuation and strengthening' of the CHSP, 'including the preservation of block-funded, community-based supports. It explained:

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8 Mr Adrian Morgan, Flexi Care, *Committee Hansard*, Brisbane, 16 February 2026, p. 13.

9 Maroochy Home Maintenance and Care Association Trading as Maroochy Home Assist, *Submission 8*, [p. 1].

10 Flexi Care, *Submission 41*, p. 1.

11 Ms Carolyn Bell, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, p. 14.

12 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 46.

13 Access Sydney Community Transport, *Submission 70*, p. 5–6.

> If the transition proceeds as currently designed, SMCS — like many CALD-specialised providers — will most likely be unable to continue delivering aged care services. The administrative, financial, and technological requirements of the SAH model are incompatible with the operating realities of small, community-based multicultural organisations. The likely closure of SMCS's aged care programs would leave many CALD older people without culturally safe support, and there are not enough mainstream providers with the capability or willingness to fill this gap.[14]

Block funding

3.14 There are a number of different government funding models utilised in the aged care sector. The CHSP is funded through grant agreements which provide funds directly to service providers – this is known as 'block funding'. The SAH Program however provides each care recipient with a funding amount that can be utilised to pay for an array of services as required.

3.15 The committee heard that 'block funding provides stability, flexibility, and efficiency, especially in low-density or 'thin' markets and in certain service types where individualised, per-service pricing models often fail due to irregular demand'.[15] Ms Diane Lynch, Chief Executive Officer, Kirinari Community Service, told the committee that in delivering services across regional Australia the flexibility provisions of the CHSP achieved through block funding allows the delivery of service 'very quickly across a large geographical area. Ms Lynch noted, 'we have something like 6,000 customers under CHSP across regional Australia, and the part of CHSP that is so beautiful for delivering services in large regional areas is that ability to be highly flexible.'[16]

3.16 Providers of CHSP services such as meals, community transport and cottage respite all told the committee that the continuation of the 'block funding' (grant funding) model that the CHSP currently utilises is essential. The committee heard that block funding 'gives providers predictable revenue streams, allowing them to spread fixed costs like infrastructure maintenance and staffing' and ensure that services can be 'accessed flexibly and quickly when needed'.[17] For example, Ms Claudia Odello, Chief Executive Officer, Meals on Wheels New South Wales noted that:

> Receiving that block funding allows these services to open their doors in the communities that they support, and it allows them to provide quick support. You can't wait months to be assessed to get a meal. That's when you'll lose them. They'll end up in hospital or even worse. So having that block funding

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14 Sydney Multicultural Community Services, *Submission 47*, p. 2.

15 Australian Association of Gerontology, *Submission 122*, p. 8.

16 Ms Diane Lynch, Chief Executive Officer, Kirinari Community Services, *Committee Hansard*, Brisbane, 16 February 2026, p. 24.

17 HammondCare, *Submission 1*, p. 2.

> in advance allows those Meals on Wheels services to do what they do best, which is provide that support to people when they need it, as they need it.[18]

3.17 Mr Tom Symondson, Chief Executive Officer, Ageing Australia, highlighted that the block funding and pooled funding arrangements of the CHSP allow providers the 'freedom' to be based within a community and respond to the needs of the community as required. Mr Symondson said that providers are able to pool funding which allows this freedom of responsiveness, and lowers the hour-by-hour cost of service.[19]

3.18 The Australian Community Transport Association (ACTA) noted that its members have highlighted that CHSP funding arrangements have 'historically provided a level of stability through block funding, which has supported service continuity in communities where markets have low-density populations'.[20] It recommended that the CHSP be maintained as a 'separate, block-funded program operating alongside Support at Home'.[21]

3.19 The Australian Association of Gerontology (AAG) told the committee that it recommends:

> … the system retain block funded elements to provide flexible and responsive supports, safeguard equity, maintain community service infrastructure, prevent provider closures, and ensure older people can continue to access the right support at the right time.[22]

Fee-for-service funding and co-contributions

3.20 While the Australian Government has not provided detail on the transition of the CHSP, much of the opposition to the proposal to transition the CHSP arises because of the risk of a 'less flexible and more expensive "fee-for-service" co-contribution model for basic entry-level support services aimed at preventing or delaying acute ageing' being introduced.[23]

3.21 The Inspector-General expressed concern that the introduction of a co-contribution model for CHSP services seriously risks the significant 'increase in service costs, resulting in older people, particularly those who face the greatest vulnerability, foregoing necessary care when they need it in order to afford other basic essentials'. The Inspector-General stated:

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18 Ms Claudia Odello, Meals on Wheels New South Wales, *Committee Hansard*, Canberra, 6 February 2026, p. 3.

19 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 2.

20 Australian Community Transport Association, *Submission 3*, p. 7.

21 Australian Community Transport Association, *Submission 3*, p. 5.

22 Australian Association of Gerontology, *Submission 122*, p. 8.

23 Inspector-General of Aged Care, *Submission 26*,p. 8

> This in turn would entirely undermine the preventative intent of the CHSP by further accelerating cognitive and physical deterioration, driving older people into higher cost and more intensive models of care and hindering independence.[24]

3.22 The Inspector-General also reiterated her position that the new SAH Program's co-contribution model is inconsistent with the Royal Commission into Aged Care Quality and Safety's vision, and 'may undermine existing policy to promote people ageing in place, connected to their community and kin'.[25]

3.23 Mr Tim Hicks, Executive General Manager, Policy and External Relations, Bolton Clarke, told the committee that the Australian Government 'should not proceed' with 'introducing individualised budgets or individualised plans for everyone on CHSP'. Mr Hicks described this as 'contrary to everyone's interests – …even the government's'.[26]

3.24 The AAG submitted that a client contribution model would provide an additional barrier to access due to its complexity, and direct financial cost. This would delay commencement of care for many older people and is likely to heighten inequalities.[27] The Older Women's Network NSW told the committee that a shift from grant-based funding significantly increases administrative workload for providers and payment-processing requirements for government'. It noted that:

> Providers require additional systems, staff time, and compliance infrastructure to manage individualised billing and debt collection. These higher transaction costs mean that, for any given funding envelope, fewer hours of direct care can be delivered, or costs are passed on to consumers through higher fees.[28]

3.25 The committee heard that home care workers are already reporting behavioural changes by SAH Program participants as a result of the individualised funding and co-contribution model. The United Workers Union stated:

> …there have been concerns that older people will begin giving up certain services to avoid paying for them. These include personal care support such as showering, and everyday living supports such as cleaning, gardening, and food purchases.
>
> Home care workers are already reporting this behaviour from clients. A member in South Australia told us her clients have begun relinquishing domestic services (e.g., light cleaning and shopping support) because they fear their care packages will be consumed by the new fees.

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24 Inspector-General of Aged Care, *Submission 26*, p. 8

25 Inspector-General of Aged Care, *Submission 26*, p. 7.

26 Mr Tim Hicks, Bolton Clarke, *Committee Hansard*, Canberra, 6 February 2026, p. 15.

27 Australian Association of Gerontology, *Submission 122*, p. 8.

28 Older Women's Network NSW, *Submission 97*, [p. 11].

3.26 Dementia Australia also raised significant concerns regarding co-contributions as implemented by the SAH Program. It told the committee that such a model disproportionately affects older Australians with dementia. It stated:

> The means-testing basis of the SAH co-contributions means costs will vary depending on types of services you receive and your means. This disproportionally disadvantages people living with dementia given higher co-contribution rates for independence (e.g. social support, transport and personal care) and everyday living services (e.g. domestic assistance, meal preparation and shopping) which are key to maintaining wellbeing and independence for people living with dementia and have been shown to have a therapeutic effect.[29]

3.27 Submitters also argued that the funding of CHSP services through individualised agreements will result in recipients rationing their access to services. For example, the Community Transport Company argued that where transport is funded through individual funding agreements, 'rationing becomes inevitable'. It submitted that:

> People are forced to limit trips, prioritise only the most critical appointments and make impossible choices between essential activities such as medical care, food shopping and social connection.[30]

3.28 The Community Transport Company noted that a loss of accessible transport leads to 'missed appointments, deteriorating health and increased isolation' which in turn leads to a 'higher use of hospitals, emergency departments and residential aged care'. It argued that CHSP-funded transport prevents these downstream costs by enabling early intervention, social participation and continued independence'.[31]

3.29 It was contended that the different fee and funding structures between CHSP and the SAH Program create financial disincentives for older people to move from CHSP services to packaged care as their needs change. Indeed, there are perverse incentives for part pensioners and non-pensioners to remain with CHSP, where providers can exercise discretion over fees charged rather than undergoing a Services Australia assessment of income and assets.[32]

3.30 The City of Salisbury submitted that providers who deliver both CHSP and SAH services are indicating that clients are choosing not to receive services under the SAH Program because 'they feel the co-contributions are too high'. This poses 'significant risks for providers, as providers remain responsible for managing

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29 Dementia Australia, *Submission 115*, p. 3.

30 The Community Transport Company, *Submission 6*, [p. 2].

31 The Community Transport Company, *Submission 6*, [p. 4].

32 Older Persons Advocacy Network, *Submission 107*, p. 16. See also Benetas, *Submission 34*.

their increasing care needs while the clients rely solely on CHSP funding'.[33] Ms Bronwyn Perry, Executive Director, Strategic Communications, Silverchain, stated:

> We've seen clients that are on CHSP choose not to take up the Support at Home package when it was released, and that is continuing. It's not all CHSP clients who receive a Support at Home allocation, but it is some.[34]

3.31 Mr Adrian Morgan, General Manager, Flexi Care similarly stated that 'we have a significant number of participants who have made that decision within the last few months when faced with either the size of their co-contributions and/or a loss of services'. Mr Morgan explained:

> They say, 'I'm not interested in taking up Support at Home.' The other thing that's a player here is the 60 per cent allocation for Support at Home places. That means a lot of people have access to fewer services than they already do under the CHSP. It's an added problem at the moment.[35]

3.32 The Municipal Association of Victoria stated that 'this points to a considerable risk that more care clients will refuse care due to cost if Support at Home were to become the only aged care program'.[36]

3.33 Mr Yates AM, former Acting Inspector-General of Aged Care, also told the committee that because the CHSP is being used by older Australians who should be recipients of care under the SAH Program, those who need CHSP services are not able to access them. Mr Yates stated:

> Those people then deteriorate and need an HCP. When this is denied them, despite being assessed as eligible, they often deteriorate and end up in hospital (avoidably) or end up avoidably or prematurely in residential care, reducing access to those whose need was not as easily preventable.[37]

3.34 Some witnesses called for an alignment in co-contributions between the CHSP and the SAH Program.[38]

3.35 The committee heard evidence that the negative impact of the SAH Program's compulsory co-contributions is disproportionately experienced by Aboriginal and Torres Strait Islander communities. NACCHO submitted that:

> The Commonwealth Home Support Program does not require service providers to have complex conversations about budgets and co-contributions. With the Support at Home Program, care providers are now responsible for educating their care recipients a complex system of fees and

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33 City of Salisbury, *Submission 68*, p. 23.

34 Ms Bronwyn Perry, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, p. 18.

35 Mr Adrian Morgan, Flexi Care, *Committee Hansard*, Brisbane, 16 February 2026, p. 18.

36 Municipal Association of Victoria, *Submission 108*, p. 14.

37 Mr Ian Yates, *Submission 110*, p. 9.

38 Mr Tim Hicks, Bolton Clarke, *Committee Hansard*, Canberra, 6 February 2026, p. 15.

> exception forms. For ACCHO service providers, explaining to care recipients who did not previously pay for services that they will now have to contribute is very difficult and risks undermining trust in their service.[39]

3.36 Ms Monica Barolits-McCabe, Executive Director, NACCHO, also noted that the hardship application process in place for older Australians to apply for exemptions to co-contributions 'is quite difficult'. Ms Barolits-McCabe stated:

> What we're hearing from our services is that the hardship application process is quite difficult. We're also hearing that almost all of the hardship applications so far have been denied. So there are two things. They're put off going through the hardship application process because it's complex and then, if it's denied, they're not wanting to continue to put people through that whole process again.[40]

3.37 Submitters such as NACCHO and the Municipal Association of Victoria called for the removal of compulsory co-payments for all services delivered by ACCOs. The Municipal Association of Victoria submitted that 'it is critical that ACCOs are empowered by the future system to provide culturally safe and appropriate care to Elders. Equity cannot be achieved through a one-size-fits-all system'.[41]

Box 3.1 Case study – impact of co-contributions[42]

We have heard from one ACCHO aged care service provider that is already transitioning patients to Support at Home, that having to charge a co-contribution for services such as cleaning is highly stressful for both the service recipient and the worker. Charging care recipients who are already financially disadvantaged can mean clients will have less money for essentials such as rent and food.

Having to explain this fee repeatedly to service recipients with cognitive conditions is distressing for workers.

The ACCHO has transitioned some care recipients to the Support at Home Program, and initially asked care recipients for co-contributions. When asked for a co-contribution, some service recipients decided to decline

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39 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 7. See also Ms Monica Barolits-McCabe, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Brisbane, 16 February 2026, pp. 42–43.

40 Ms Monica Barolits-McCabe, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Brisbane, 16 February 2026, p. 44. See also Aboriginal Health and Medical Research Council of NSW, *Submission 22*, [p. 3].

41 Municipal Association of Victoria, *Submission 108*, pp. 14–15. See also National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 9.

42 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 8.

service entirely. The ACCHO has now chosen to cover the co-contribution themselves, however this is not financially sustainable.

The ACCHO noted that if service provision continued to be financially unsustainable (with the ACCHO having to cover co-payments), they may need to stop providing aged care entirely, which would have huge consequences for service recipients. The ACCHO is the only Aboriginal organisation in the area that delivers aged care services and is the preferred provider for local community. Mainstream organisations in the area do not have capacity to take on the ACCHO's client load if they were to stop services.

3.38 Concern was expressed that a shift towards individualised funding under the SAH Program also 'presents serious risks to the financial viability of services with high fixed costs that provide important social infrastructure'. This includes community transport, centre-based respite, and cottage respite. Services in rural and remote and other thin markets, and small, specialised and community-based organisations are particularly vulnerable under such a shift in funding models.[43] The AAG told the committee the loss of such providers would 'erode critical community infrastructure, remove local capacity, reduce choice for older people, and leave entire regions or communities without essential services'.[44]

3.39 ACTA similarly argued that the SAH 'merger risks applying the wrong funding model to community transport' services offered through the CHSP. It recommended that the Australian Government 'maintain CHSP as a distinct, block-funded program to deliver entry-level, preventive and reablement services, while Support at Home addresses higher and more complex care needs'.[45] It explained:

> If CHSP is merged into Support at Home, ACTA is concerned community transport could be funded primarily through individualised "per-service" pricing, rather than the Royal Commission's recommended approach for a single program with five service categories, where Social Supports (including meals and transport), Respite Supports, and Assistive Technology & Home Modifications are funded through a mix of block and activity-based funding to ensure coverage and equity, while Care at Home is individually funded.[46]

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43 Australian Association of Gerontology, *Submission 122*, p. 8. See also Australia and New Zealand Society for Geriatric Medicine, *Submission 24*, pp. 4–5.

44 Australian Association of Gerontology, *Submission 122*, p. 8.

45 Australian Community Transport Association, *Submission 3*, p. 4. See also The Community Transport Company, *Submission 6*, [p. 4].

46 Australian Community Transport Association, *Submission 3*, p. 7.

3.40 The Community Transport Company similarly highlighted that if 'community transport services are funded solely through individualised packages, market behaviour shifts in predictable ways'. It explained:

> Providers are incentivised to prioritise short, simple, high-volume trips and to avoid longer-distance, lower-volume or higher-complexity journeys. Services in rural, regional, and outer-urban areas become less viable, and clients with mobility, cognitive or social complexity are deprioritised over more 'profitable' individuals.
>
> This leads to selective service provision rather than universal access.[47]

3.41 The Community Transport Company also noted that the result of selective service provision in thin markets arising from individualised funding includes 'reduced availability, longer wait times or outright refusal of service'. Further, the 'human consequence is increased isolation, withdrawal from community life and declining wellbeing'. It concluded that 'these outcomes directly contradict the Royal Commission's findings on dignity, social connection and the importance of participation in healthy ageing'.[48]

3.42 ACTA told the committee that 'moving from CHSP-style block funding … risks destabilising community-based providers by failing to cover essential fixed "infrastructure" costs (fleet, insurance, compliance, scheduling/dispatch, workforce/volunteer coordination, training, quality and safety)'.[49] The Community Transport Hub explained that community transport is 'an asset-heavy, capacity-based service', and as such, 'the majority of costs are incurred before a single trip is delivered'. Further:

> Providers must maintain accredited vehicle fleets, including wheelchair accessible vehicles; recruit, train and screen drivers; operate safety, insurance and accreditation systems; and maintain allocation, scheduling and dispatch infrastructure. These costs exist regardless of daily fluctuations in demand.[50]

3.43 It was argued that CHSP block funding plays a critical system function by underwriting the standing capacity of operators. Block funding ensures that services exist before people need them. However, once base funding is removed, capacity is lost and cannot be readily rebuilt. While individualised funding models assume service capacity already exists, once it disappears due to base funding cuts, it does not return.[51]

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47 The Community Transport Company, *Submission 6*, [p. 2].

48 The Community Transport Company, *Submission 6*, [p. 2].

49 Australian Community Transport Association, *Submission 3*, p. 7. See also Australian Association of Gerontology, *Submission 122*, p. 8.

50 The Community Transport Company, *Submission 6*, [p. 3].

51 The Community Transport Company, *Submission 6*, [p. 3].

3.44 The Community Transport Hub noted that the Royal Commission into Aged Care Quality and Safety 'cautioned against reforms that assume markets will self-correct. Applying an individualised funding model to an asset-heavy service like community transport risks exactly that failure'.[52]

Thin-market funding

3.45 As noted above, thin markets including rural and remote communities and specialised cohorts such as CALD and Aboriginal and Torres Strait Islander communities, face high service delivery costs, workforce shortages, and limited provider competition for both SAH and CHSP services.

3.46 The below sections examine the evidence received in relation to the need for thin-market specific funding, and the possible consequences to service provision in the absence of funding that recognises the unique challenges of these markets.

3.47 Thin markets are characterised by: limited provider choice; high workforce turnover; a reliance on outreach, fly-in-fly-out, or visiting service models; and a reduced capacity to absorb unfunded reform and transition costs. North and West Remote Health told the committee that:

> Without explicit market sustainability measures, the transition to the SAH Program risks accelerating provider withdrawal from marginal markets and further entrenching inequities in access for older people living outside metropolitan and regional centres.[53]

3.48 Remote and very remote aged care markets are inherently thin, driven by geographical disparity, small and dispersed populations, workforce shortages and the inability to achieve economies of scale. Across many of these locations, particularly in very remote settings, there is no functional aged care market, with only two to three eligible clients at any given time. In a fee-for-service funding model, this level of demand is insufficient to support sustainable service delivery without additional viability measures.[54]

3.49 The City of Greater Geelong noted the introduction of the *Support at Home Thin Market Grants Program* which saw a second round of funding for Support at Home providers close in January 2026. It noted that 'these grants provide flexible funding to providers in rural, remote (Modified Monash MM3–7[55]), and

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52 The Community Transport Company, *Submission 6*, [p. 3].

53 North and West Remote Health, *Submission 121*, [p. 6]. See also Tamworth Meals on Wheels, *Submission 48*, pp. 3–4.

54 North and West Remote Health, *Submission 121*, [p. 6].

55 The Modified Monash Model (MMM) is how the Australian Government defines whether a location is metropolitan, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote. Department of Health, Disability and Ageing,

specialised cohorts to maintain service viability and ensure older Australians can access affordable, high-quality care'.[56] The Aged Rights Advocacy Service (ARAS) noted that 'it is unclear whether there is any intention to also enable CHSP providers to access similar thin market grants'.[57]

3.50 The City of Greater Geelong submitted that multi-year thin-market grants provide long-term funding stability for providers operating in rural, remote or specialised cohorts where service delivery costs are often high, and client volumes are low. Multi-year arrangements allow providers to plan effectively, recruit and retain staff, and maintain essential services. This is in contrast to short-term grants which create uncertainty and discourage investment.[58]

3.51 Maroochy Home Maintenance Care and Association trading as Maroochy Home Assist however noted that 'prior rounds [of grant funding] were oversubscribed and short term'. It concluded that 'CHSP's local networks are at risk if SAH entry requires cost structures [that] thin market providers cannot bear'. It suggested that in the event of the CHSP being transitioned to the SAH Program, 'multi-year thin-market loadings and earlier price-cap protections for critical services in rural/remote and specialised cohorts' and 'transparent travel loadings' must be implemented.[59]

3.52 HammondCare was also critical of the current grant-based process of accessing thin-market funding. It described the process as placing an unnecessary administrative burden on providers' and stated that it 'fails to deliver long-term certainty. HammondCare recommended the implementation of 'automatic thin-market funding via direct subsidy payments for eligible providers'. It noted that under the AN-ACC funding model, residential aged care facilities in MM4–7 regions are automatically granted a higher tier of funding due to geographic location and associated market conditions.[60]

3.53 The Australian Nursing and Midwifery Federation stated that 'short term grants and pilot programs do not address … structural conditions' including 'persistent service gaps in outer regional and remote areas, particularly for specialised and culturally safe services'. As such, 'where markets fail to deliver

https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en, (accessed 3 March 2026).

56 City of Greater Geelong, *Submission 9*, p. 7.

57 Aged Rights Advocacy Service, *Submission 104*, p. 4.

58 City of Greater Geelong, *Submission 9*, p. 7. See also Sydney Multicultural Community Services, *Submission 47*, p. 5.

59 Maroochy Home Maintenance and Care Association Trading as Maroochy Home Assist, *Submission 8*, [pp. 2–3].

60 HammondCare, *Submission 1*, p. 4. See also North and West Remote Health, *Submission 121*, [p. 6].

essential care, governments must intervene directly to ensure continuity and equity of access in aged care'.[61]

3.54 The City of Greater Geelong provided a number of recommendations to the committee in relation to funding for CHSP services in thin markets, including:

- Maintain block funding models for local government to guarantee service continuity where market-based approaches fail.
- Continue and expand Thin Markets Grants with multi-year, flexible operating expense support (pricing offsets, travel loadings, workforce incentives, brokerage where necessary).[62]

3.55 ARAS recommended that access to thin market grants or other viability measures must be provided to CHSP providers during any transition phase, to assist with the viability of service providers in rural and remote areas.[63]

Modernised program

3.56 The committee heard calls for the CHSP to be 'maintained and expanded as the primary preventative and early intervention tier of the aged care system'.[64] As such, the Australian Government should make a strong policy statement about its commitment to an early-entry, easy-access program available 'at the beginning of ageing'.[65]

3.57 First, the CHSP should act as a support system for people with low-level needs (less than six hours a week), and people should be able to be directly referred without having to go through a My Aged Care assessment. Professor Kathy Eagar noted that currently some 40 to 50 per cent of referrals for services under the CHSP come from hospitals and general practitioners.[66]

3.58 Second, the CHSP should be recognised as a support program for people with higher levels of need who are awaiting a SAH Program package. Professor Eagar noted that that while the CHSP is 'doing as good a job as possible' it is not receiving extra funding for these participants.[67]

3.59 Mrs Natalie Siegel-Brown, Inspector-General of Aged Care told the committee:

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61 Australian Nursing and Midwifery Federation, *Submission 113*, p. 7. See also Hornsby Ku-ring-gai Community Aged/Disabled Transport Service Inc, *Submission 18*, [p. 2].

62 City of Greater Geelong, *Submission 9*, p. 8.

63 Aged Rights Advocacy Service, *Submission 104*, pp. 4–5.

64 CHSP Alliance, *Submission 124*, pp. 1–2. See also Randwick Community Transport, *Submission 37*, [p. 3].

65 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 48. See also CHSP Alliance, *Submission 124*, p. 3.

66 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 48.

67 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 48.

> … if we take a chance to strengthen the preventive impact of CHSP, we could make the finite aged-care funding bucket that we've got go further, by slowing the growth in the number of people coming into higher cost care. If we get it right, it's literally the most immediate means that the government has to realise the Act's promise of helping people remain independent, connected and well for longer.[68]

3.60 The Municipal Association of Victoria stated that it sees a 'clear opportunity to evolve and adequately fund the CHSP to continue delivering care that is responsive, flexible, preventive, and person-centred, ultimately reducing pressure on Support at Home, residential aged care, and health systems'.[69]

3.61 As such, the Municipal Association of Victoria called for the 'continuation of the CHSP, or a CHSP-like program, to support the almost one million Australians who require less intensive, lower-cost services to keep them safe at home and connected to their communities'.[70] Similarly, Local Government NSW urged the Australian 'Government to retain and modernise the CHSP rather than absorb it into Support at Home'. It recommended:

> That the Australian Government retain the CHSP as a permanent, separate and predominantly grant funded, entry level program and defer any transition of CHSP clients into Support at Home until key design, assessment and funding issues with Support at Home are resolved.[71]

3.62 Dr Lisa Ward, Chief Executive Officer, Ethnic Communities Council of Queensland, recommended that the CHSP 'be retained as a distinct and strengthened program alongside Support at Home'.[72] Dr Ward explained:

> CHSP is not a duplication; it functions as the system's low-intensity preventative tier. CHSP is designed to deliver early intervention and prevention. If it is absorbed into Support at Home, the system weakens its mechanism for intervention before need escalates. Transition may increase hospital demand, residential aged care entry and long-term public expenditure. For culturally and linguistically diverse older Australians, it's likely to result in a later engagement and higher acuity at first presentation.[73]

3.63 Mr Murray Coates, Chief Executive Officer, ACTA, recommended that the Australian Government:

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[68] Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, *Committee Hansard*, 6 February 2026, p. 26.

[69] Municipal Association of Victoria, *Submission 108*, p. 5.

[70] Municipal Association of Victoria, *Submission 108*, p. 5.

[71] Local Government NSW, *Submission 112*, p. 9.

[72] Dr Lisa Ward, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 16 February 2026, p. 34. See also Ethnic Communities Council of Queensland, *Submission 53*, p. 8.

[73] Dr Lisa Ward, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 16 February 2026, p. 34.

> … take the good bits of CHSP and have a distinct program running alongside Support at Home but separate from Support at Home, and then let's use this as an opportunity to improve it. We really don't care what it's called. We're not hung up on CHSP. The important thing for us is that it's sustainable and it's delivering really good services…[74]

3.64 Ms Claudia Odello, Chief Executive Officer, Meals on Wheels New South Wales, similarly recommended:

> The government should commit now to retain and expand CHSP beyond 2027 as a separate program that complements Support at Home. That commitment must be backed by growth funding, a funding model review and thin-market protections, and we need immediate action now to funded targets.[75]

3.65 The Older Women's Network NSW also recommended the retention of the CHSP as a 'distinct, ongoing program, not merely a transition pathway into' the SAH Program. It also made a range of recommendations to strengthen the CHSP including recognising the CHSP as a 'preventative public good, not a discretionary add-on' and indexing 'CHSP funding to population ageing and demand to ensure sustainability'.[76]

3.66 Access Sydney Community Transport advocated for the establishment of a 'prevention-focused, entry-level aged care program that guarantees access to essential services for older Australians'. It further called for the retention of 'block or activity-based grant funding models for CHSP, recognising that infrastructure-dependent services such as transport cannot be sustainably delivered through individualised budgets'.[77]

3.67 HammondCare argued that the funding model adopted after the transition 'must reflect the true operational costs of delivering' services to 'support provider viability and client accessibility'.[78]

Mixed-funding model

3.68 The committee also received suggestions that the transition to the SAH Program should not result in older people only having access to individualised funding. Rather, there should be a single in-home program incorporating both block-

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74 Mr Murray Coates, Australian Community Transport Association, *Committee Hansard*, Brisbane, 16 February 2026, p. 30.

75 Ms Claudia Odello, Meals on Wheels New South Wales, *Committee Hansard*, Canberra, 6 February 2026, p. 3.

76 Older Women's Network NSW, *Submission 97*, [p. 2].

77 Access Sydney Community Transport, *Submission 70*, p. 4. See also Mr Adrian Coates, Chief Executive Officer, Australian Community Transport Association, *Committee Hansard*, Brisbane, 16 February 2026, p. 28.

78 HammondCare, *Submission 1*, pp. 2–3.

funded services and individualised budgets, with older people having access to both, according to their needs.[79]

3.69 The Older Persons Advocacy Network (OPAN) pointed to significant issues arising from the implementation of the National Disability Insurance Scheme 'where individual funding plans have become the "only show in town", with the associated lack of "foundational supports" for people with disability, their families and carers'. Instead, it offered its support for:

> … a future single aged care program with different sub-components that work together to enable all older people to be able to engage with services and access the support they need, when they need it.[80]

3.70 OPAN suggested that this mixed funding model would allow for older people to 'layer individualised services and community-based support services together in the way that best suits their, and their carer's needs'.[81]

3.71 The City of Salisbury suggested that the Australian Government should fully adopt the implementation of Recommendation 117 of the Royal Commission into Aged Care Quality and Safety. It stated that this would deliver grant funding for support services through a mix of block and activity-based funding. It stated that:

> Maintaining CHSP as an independent care stream with a strong foundation in block funding, would enable CHSP to effectively complement the SAHP and continue to meet the diverse needs of older Australians requiring early-intervention and short-term support.[82]

3.72 The Australian Human Rights Commission proposed that the CHSP be transformed into a new Foundational Supports for Older People at Home Program that 'would preserve its existing strengths, maintain flexible services that reflect older people's needs and preferences, and safeguard its essential focus on social connection and independence especially at the local level'. It also suggested that the program should comprise three elements:

- two clearly defined streams of funded activities – social supports, and living supports;
- a commission-based funding model; and
- eligibility for funding limited to not-for-profit and local government providers.[83]

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79 Older Persons Advocacy Network, *Submission 107*, p. 15.

80 Older Persons Advocacy Network, *Submission 107*, p. 15. See also Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, Canberra, p. 8.

81 Older Persons Advocacy Network, *Submission 107*, p. 15.

82 City of Salisbury, *Submission 68*, p. 23.

83 Australian Human Rights Commission, *Submission 75*, pp. 2–3.

3.73 The Australian Human Rights Commission also called for the Australian Government to apply 'active market stewardship in thin markets, using commissioning, block funding, and collaborative commissioning models rather than relying solely on transactional purchasing'.[84]

3.74 COTA Australia also called for a mixed funding model with a variety of contracting or commissioning approaches adopted to create a 'base load capacity within the aged care system for entry level and high capital growth services'. It suggested that these approaches could include 'national tenders, regional commissioning, grants to support low-density populations, volume or unit price contracts, standing panels, outcome linked contracts, regional alliances'.[85]

3.75 COTA Australia suggested that some CHSP services may be better suited to a 'targeted grants model where government funding is tied to service outputs at a lower unit cost, recognising the significant capital expenses required to deliver those services' while others may not require such an approach. COTA Australia also submitted that 'program design should determine which services will provide better outcomes for older people with block funding and which with individualised approaches'.[86] Life Care suggested that services such as clinical supports, independent living support, and every day living supports such as gardening and home maintenance should move to the SAH Program while community transport and social services including group based services should be retained by the CHSP.[87]

3.76 COTA Australia also suggested that 'blended funding approaches and greater investment are needed to remove the postcode lottery by equalising access to services'.[88]

3.77 Ageing Australia recommended that the Australian Government undertake a comprehensive assessment of funding models.[89] Ms Julia Atkinson, Assistant Secretary, Home Support Operations Branch, Access and Home Support Division, the Department, told the committee:

> The royal commission advised or recommended two things to government. One was that there be a single in-home support program. They also recommended that some of the services under that program be funded through block funding. At the time that the government responded to that

84 Australian Human Rights Commission, *Submission 75*, pp. 3–4.

85 COTA Australia, *Submission 120*, p. 21.

86 COTA Australia, *Submission 120*, p. 22.

87 Life Care, *Submission 98*, [p. 4].

88 COTA Australia, *Submission 120*, p. 22. See also Ms Patricia Sparrow, COTA Australia, *Committee Hansard*, Canberra, 6 February 2026, p. 11.

89 Ageing Australia, *Submission 21*, pp. 12–13.

> royal commission, the government undertook to continue to consult and consider what that final funding model may look like. The government of today continues to do that.[90]

New funding model

3.78 While the CHSP Alliance called for the immediate retention of the CHSP as a distinct program from the SAH Program, it also proposed that in the medium to longer term the Australian Government could design a 'revamped CHSP' that is 'fit for the next 20 years'.[91] This new funding model would separately fund the fixed and variable costs of delivering CHSP services in the community. It submitted that:

> While block funding has served CHSP well until now, it is not a suitable funding model for the future. The history of CHSP demonstrates too clearly that block funded services quickly become 'set and forget' in the minds of policy and funding bodies. Also, block funding models are not nimble enough to respond to changing population need and demand.[92]

3.79 The CHSP Alliance proposed a new funding model based on the Australian National Aged Care Classification (AN-ACC) funding model utilised for residential aged care. This model would recognise that the CHSP, like residential aged care, has two separate sets of costs:

- Fixed infrastructure costs necessary to establish a service and grant it the capacity to deliver its services. These costs are affected by the size, location and role of the service. These costs can be calculated and funding delivered each year, providing organisations the cash flow required to begin and plan each year.
- Variable activity costs which relate directly to the delivery of service to an individual. Activity costs are based only on the needs of the recipient and the nature of the service they receive, and can be funded prospectively based on the anticipated need of the person, or retrospectively based on the service received. These costs do not vary according to the location or size of the service provider.[93]

3.80 Professor Kathy Eagar explained:

> There are a set of fixed costs to deliver services, and CHSP services should be funded—get a block grant—to pay for their fixed costs. Then they should have a price and volume contract that says: 'We want you to deliver a thousand units of activity plus or minus 10 per cent at this quantum of money, and, if you deliver a thousand and it's within the volume tolerance

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90 Ms Julia Atkinson, Department of Health, Disability and Ageing, *Committee Hansard*, Canberra, 6 February 2026, p. 36.

91 CHSP Alliance, *Submission 124*, p. 1. See also Professor Michael Fine, *Submission 35*, p. 8.

92 CHSP Alliance, *Submission 124*, p. 7.

93 CHSP Alliance, *Submission 124*, p. 7. See also Dr Anna Howe, *Submission 11*, p. 3.

band'—as it's technically called—'of between 900 and 1,100 units, we square off for the year. If it's less than 900 then we will reduce your activity the following year. If it's more than that, we will grow your budget. If you don't have a mechanism to grow the budget in proportion to demand, you grow it at the marginal rate, not at the full average rate.'[94]

[94] Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 49.

Chapter 4
Transition readiness

> We are very, very worried that another transition of a program of the scale of CHSP, if rushed in the same way as the reform so far to Support at Home, will be catastrophic for those 800,000-plus people and also providers that provide those services. We don't oppose reform; we oppose reform done badly that does not make things better. The strain on Support at Home providers is extremely noticeable.[1]

4.1 This chapter examines the evidence received in relation to the aged care sector's readiness for the Commonwealth Home Support Program (CHSP) to be transitioned to the Support at Home Program (SAH Program). This includes evidence in relation to consultation and information provision by the Department of Health, Disability and Ageing (the Department); workforce readiness; the need for modelling and data collection; and roll out proposals.

Information and consultation

4.2 Aged care providers expressed concern about a lack of information and clarity regarding the transition timeline, and how to prepare their services and clients for a transition to the SAH Program. There is also significant confusion in the community regarding access to services.[2] The Municipal Association of Victoria told the committee that 'it is challenging to comment on the timeline for transition…due to an ongoing lack of detail' provided by the Australian Government.[3] Ms Claudia Odello, Chief Executive Officer, Meals on Wheels New South Wales, told the committee:

> There's been very little in terms of any clarity of what's going to happen in the next 18 months. We keep hearing that CHSP will fold into Support at Home no sooner than 1 July 2027. That's what we've heard. We've written to the department, spoken to the department, on multiple occasions for clarity, and we get very vague and ambiguous responses, so we have no clarity.[4]

4.3 Mrs Julie Stacey, General Manager, Maroochy Home Assist, told the committee:

> The government has indicated that CHSP will transition no earlier than 1 July 2027, yet there is still no clear plan and there are no implementation

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1 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 1.

2 Australian Association of Gerontology, *Submission 122*, p. 7.

3 Municipal Association of Victoria, *Submission 108*, p. 6.

4 Ms Claudia Odello, Meals on Wheels New South Wales, *Committee Hansard*, Canberra, 6 February 2026, p. 4.

> milestones and no answers to the myriad 'How?' questions providers have been asking for years, and no meaningful safeguards, to my knowledge.[5]

4.4 The Inspector-General of Aged Care (Inspector-General) told the committee that since November 2023 when the Australian Government announced the two stages of the SAH Program, 'there has been a distinct lack of clear information regarding the detail and timeline around the transition of CHSP'. Further, 'the language of 'no earlier than' with respect to the tentative transition date of 1 July 2027 has created additional distress and confusion, while also leaving open-ended the suggestion that this date may again be changed'. The Inspector-General stated that this is 'preventing existing CHSP providers from forward planning and providing certainty to their workforce'.[6] Mrs Natalie Siegel-Brown, Inspector-General, stated:

> I've received nothing about timelines or rationale. I really want to emphasise that, before the transition can even be planned or orchestrated, we need public information on the rationale and modelling assumptions for that transition decision. I literally have no details about what the transition will look like, and it scares me that, less than 18 months out from the drop-dead date, we have no idea about really simple stuff, like how it will be staged and how it will be achieved without consulting older people in the sector on the implications. You could say to me, 'Look, it's all yet to come.' But it's so late in the piece, and we know how much consultation needs to happen. My concern is that, if we don't have that information soon enough, that consultation will end up being consultation on a foregone conclusion.[7]

4.5 Ms Bronwyn Perry, Executive Director, Strategic Communications, Silverchain, told the committee, 'we haven't received any information relating to the transition of CHSP'. Ms Perry noted:

> There's obviously been information received about what is happening to CHSP under the new Aged Care Act, for example, and the strength and quality standards, but there's been no information about the transition of CHSP.[8]

4.6 It was noted that despite the Australian Government committing to integrate the CHSP after 1 July 2027, it has not 'published a transition plan' and that 'transition details were "still to be confirmed"'.[9] Mr Chris Grice, Chief Executive Officer, National Seniors Australia, told the committee:

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5 Mrs Julie Stacey, Maroochy Home Assist, *Committee Hansard*, Brisbane, 16 February 2026, p. 29.

6 Inspector-General of Aged Care, *Submission 26*, p. 3.

7 Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, *Committee Hansard*, Canberra, 6 February 2026, p. 26.

8 Ms Bronwyn Perry, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, p. 16. See also Hornsby Ku-ring-gai Community Aged/Disabled Transport Service Ince, *Submission 18*, [p. 3].

9 Local Government NSW, *Submission 112*, p. 7.

> … there is no comprehensive, transparent transition framework that clearly outlines how current CHSP clients will be mapped into the Support at Home classifications, what funding levels will apply and how co-contributions will operate, particularly given the 18-month timeline for the transition. Second, there is insufficient clarity around system readiness, particularly regarding specific assessment capacity, workforce supply, IT functionality and thin market risks, all of which directly impact continuity of care.[10]

4.7 The Local Government Association of South Australia (LGASA) told the committee that 'the extended, and continually shifting, timeline for transitioning from the CHSP to SAH is creating significant uncertainty for providers, clients, and local government decision-makers'. It submitted:

> There is no clear date for when CHSP will fully transition. Emerging commentary suggests that the outcomes of the current inquiry may lead to further delays beyond 2027, leaving providers unable to plan with confidence.
>
> Repeated changes to the transition timeline have become a major source of stress and anxiety for both council staff and clients, who are unsure about future program arrangements and eligibility.[11]

Modelling and data collection

4.8 The committee heard that before further reforms are considered for the CHSP, the lack of data collection, modelling and reporting in relation to the program must be remedied. For example, the Inspector-General told the committee that the Australian Government must 'provide greater clarity and transparency on the evidence base and modelling assumptions underpinning the proposed CHSP transition, and facilitate meaningful engagement with the sector and broader community at the earliest possible opportunity'.[12]

4.9 The Inspector-General noted that there is only 'limited publicly available information relating to the evidence base underpinning decision making around the transition'. The Inspector-General also stated that 'nor is there clarity around what, if any, modelling has been undertaken to support the notion that the tentative transition timeline is practical, or possible, for the majority of CHSP providers and clients'. The Inspector-General concluded that 'this lack of information makes it impossible to accurately assess the adequacy of the transition timeline or the readiness of impacted aged care providers'.[13]

4.10 The Inspector-General recommended the Australian Government commission an independent cost-benefit analysis of the CHSP. This analysis should weigh:

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10 Mr Chris Grice, National Seniors Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 2.

11 Local Government Association of South Australia, *Submission 109*, p. 16.

12 Inspector-General of Aged Care, *Submission 26*, p. 2.

13 Inspector-General of Aged Care, *Submission 26*, p. 3.

> … the potential benefits of expanding CHSP against the cost of delivering higher level care at the tertiary end of the system if the delivery of entry-level home care supports is further constrained. The final report of this analysis should be made public.[14]

4.11 The Australian Association of Gerontology (AAG) similarly told the committee that its 'strongest recommendation' is that the redesign of the aged care system 'needs to incorporate a comprehensive, coordinated and adequately resourced research, monitoring and data collection strategy'. It submitted:

> This strategy should span government investment, real care cost monitoring, assessment times and efficacy, service delivery gaps and innovations, care pathways and disconnections, workforce growth and attrition, as well as older people's overall satisfaction with care. We believe this is lacking from the current approach to the transition; despite the implementation of several pilot projects to gather data (e.g. Aged Care Quality and Safety Commission, 2024; Australian Healthcare Associates, 2024), and the National Aged Care Data Clearinghouse, there remain many untested assumptions informing the transition to SAH and the wider reforms.[15]

4.12 Submitters argued that there are significant national data gaps particularly in relation to 'who is receiving CHSP support, who is missing out, and who is waiting for services'. The AAG submitted that:

> Much of the broad population-level data focuses on service use. This is not an adequate proxy for evidence about service needs. Differences in service use may arise from barriers to access rather than differences in need. Relying on service use as a proxy for need risks conflating access, availability, and uptake with actual demand. This may obscure unmet needs and structural barriers to access.[16]

4.13 The AAG also argued that 'population-based modelling may be obscuring service deserts in some areas, such as outer metropolitan areas and regional centres'. Further:

> Gaps in available data and modelling limit a comprehensive understanding of needs, preferences, service usage, and outcomes under both the existing CHSP and the emerging SAH model. These evidence gaps constrain the ability of any government to design, implement, and evaluate the aged care system, or guide the transition in a way that is evidence-based.[17]

4.14 The AAG suggested that the following research and monitoring is required:

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[14] Inspector-General of Aged Care, *Submission 26*, p. 11. See also Hornsby Ku-ring-gai Community Aged/Disabled Transport Service Inc, *Submission 18*, [p. 7].

[15] Australian Association of Gerontology, *Submission 122*, p. 2.

[16] Australian Association of Gerontology, *Submission 122*, p. 6. See also Municipal Association of Victoria, *Submission 108*, p. 7.

[17] Australian Association of Gerontology, *Submission 122*, p. 6.

- Data mapping of the level of support needs in the Australian population; local level service provider capacity and population commensurability.
- Data, transparency and early warning systems to identify and respond before markets/ providers fail; and increase data collection capabilities to inform planning and prevent 'service deserts'.
- Region-based environmental scans of available supports (beyond Commonwealth funded aged care), as well as cost-benefit analyses which include spending on health, levels of unpaid carer contributions and quality of life measures for older people.[18]

4.15 The Municipal Association of Victoria similarly stated that 'before the transition begins, the Department must gather reliable, transparent data on unmet needs and waitlists and share it with the sector to inform funding allocations and provider planning'.[19]

4.16 The Department told the committee that it has undertaken modelling in relation to the SAH Program and the CHSP but that this is not publicly available. It has not however conducted a recent cost-benefit analysis but that is on the department's forward work plan.[20]

Consultation

4.17 The committee heard calls for the Australian Government to implement consultation mechanisms in order to understand emerging concerns since the introduction of the SAH Program.[21] Ageing Australia submitted:

> 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.[22]

4.18 The United Workers Union (UWU) told the committee that home care workers are observing their clients 'giving up certain services to avoid paying for them'. Home care workers are also reporting that they are undertaking this work

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18 Australian Association of Gerontology, *Submission 122*, p. 7. See also Municipal Association of Victoria, *Submission 108*, p. 7; Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, Canberra, 6 February 2026, p. 8; Wyndham City Council, *Submission 19*, p. 9.

19 Municipal Association of Victoria, *Submission 108*, p. 7.

20 Mr Greg Pugh, First Assistant Secretary, Access and Home Support Division, Department of Health, Disability and Ageing, *Committee Hansard*, Canberra, 6 February 2026, p. 33.

21 See for example, Your Side Australia, *Submission 14*, p. 1. See also Council of Elders, *Submission 46*, p. 1.

22 Ageing Australia, *Submission 21*, p. 7. See also Indigo, *Submission 51*, p. 5.

'unofficially', either after a 'request from the client themselves or because they are concerned about the risk to the client's physical and psychological wellbeing from leaving these tasks unattended'.[23]

4.19 The UWU stated that 'home care workers are uniquely placed to identify what is working, what is failing, and what will place older people at risk. Their insights must be central to the implementation, monitoring, and improvement of the new system'. As such, it recommended that:

> The Federal Government should have a structured consultation specifically with home care workers, through their unions, to learn from those workers about what is happening on the ground with the move to SAH, and what can be done to improve the quality of care.[24]

4.20 The Municipal Association of Victoria also told the committee that the Department should establish a CHSP Transition Advisory Group with representation from peak bodies, and a range of providers representing diverse service provision. Regular, detailed communication and consultation with the broader sector and community should be prioritised by this group.[25]

4.21 Ms Bronwyn Perry, Executive Director, Strategic Communications, Silverchain, told the committee that co-design of any new program is required. Ms Perry stated:

> Our view is that co-design is needed with providers who are delivering the care and understand the broad experience of clients across Australia and multiple different types of client experience. Of course, that's not singular, and it's not unanimous, so we're mindful of that. Co-design is also needed with older people. As my colleague mentioned earlier, there are several services available in CHSP that are not available in support at home. We wouldn't want to see those lost to the in-home aged-care system, and they're very important supports.[26]

4.22 This was echoed by Mr Murray Coates, Chief Executive Officer, Australian Community Transport Association, who told the committee that 'it's imperative that any new model is co-designed, with adequate sector resourcing to ensure genuine participation from providers, consumers and sector experts'. Mr Coates explained:

> There are a lot of practical, well-informed and intelligent people in the sector. Tap into them. Ask for their suggestions. Ask them to share their

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23 United Workers Union, *Submission 114*, p. 3.

24 United Workers Union, *Submission 114*, p. 4.

25 Municipal Association of Victoria, *Submission 108*, p. 12.

26 Ms Bronwyn Perry, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, pp. 14–15. See also Sutherland Food Services, *Submission 16*, [p. 4].

> experience. Test their ideas. We'll end up with a better model of CHSP going forward.[27]

4.23 The Department told the committee that 'there has been and continues to be consultation, particularly with the advisory council and the council of elders, around the transition of this program…'[28]

Provider readiness

4.24 The committee heard evidence that a majority of CHSP providers have expressed a lack of confidence in their readiness for a transition of the program and that there is significant danger of these providers exiting the market. Mrs Natalie Siegel-Brown, Inspector-General, stated:

> Right now, providers, workers and consumers are facing profound uncertainty about the transition of CHSP into Support at Home. They have no certainty about the timeframes and no certainty of its core strengths, and that uncertainty right now, 18 months out from July 2027, is already constraining availability. People are wondering what the viability of their service is. Issues like unclear end-of-life arrangements, capped home-modification funding and a potential to shift to a rigid co-contributions fee-for-service model—all of this could end up driving people prematurely into residential aged care.[29]

4.25 The committee also heard that the lack of information available regarding the program's future is undermining service providers' confidence. In the absence of a well-planned and communicated transition plan, the committee heard that providers may pre-emptively exit the system.[30] Mr Tom Symondson, Ageing Australia, stated:

> We are definitely not ready, and I am very concerned about CHSP rolling into Support at Home, firstly, whilst we have the problems that we have with Support at Home, but, secondly, whilst we have no idea what the program design is. The government announcement is 'no sooner than 1 July 2027'. That's good because it doesn't tie us to a specific date. But we need to know what is going to be fixed and by when before that date is fixed.[31]

4.26 Mr Symondson, also told the committee that the cost of moving to the 'compliance heavy' SAH Program is 'going to bury a lot of those providers'. Mr Symondson stated:

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[27] Mr Murray Coates, Australian Community Transport Association, *Committee Hansard*, Brisbane, 16 February 2026, p. 28. See also Queensland Health, *Submission 10*, p. 6.

[28] Ms Sonja Stewart, Deputy Secretary, Ageing and Aged Care Group, Department of Health, Disability and Ageing, *Committee Hansard*, Canberra, 6 February 2026, p. 32.

[29] Mrs Natalie Siegel-Brown, Inspector-General of Aged Care, *Committee Hansard*, Canberra, 6 February 2026, p. 26.

[30] Municipal Association of Victoria, *Submission 108*, pp. 7–8.

[31] Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 4.

> Don't just think this is an easy process and all these organisations will just cope. I think many of them won't, and some of them, where they deliver more than just aged care, are going to go, 'We'll just do the other things.' Most CHSP providers are not-for-profits or charities and are often delivering early childhood services or homelessness services, saying: 'We'll just do those things. We won't do aged care anymore because it's too hard.' That would be an absolutely devastating blow, particularly to small communities.[32]

4.27 Meals on Wheels Australia also told the committee that the 'uncertainty is already doing damage'. Ms Odello, Meals on Wheels New South Wales, elaborated:

> Ongoing uncertainty about CHSP beyond 2027 is destabilising organisations like Meals on Wheels. Services can't confidently recruit, invest or plan for demand and innovation when the future setting is so unclear. We support reforms that strengthen rights, transparency and quality in aged care, but we're very concerned about the abolition of CHSP and the rolling of it into Support at Home after 1 July 2027. The risks are foreseeable. They're also avoidable.[33]

4.28 Ms Mary-Ann Geronimo, Chief Executive Officer, Federation of Ethnic Communities Council (FECCA), noted that workers have also exited the market due to uncertainty regarding their future employment. Ms Geronimo stated:

> We have seen people who are in the CHSP program who have left the program because there's no certainty in their jobs. We have seen them get out of that whole sector. There is no clarity in how they will become a part of home based care. But, obviously, if they're working with a bigger organisation, that's going to be something that the organisation would look into, and they would not want to lose that kind of expertise. But, for smaller organisations, that's something: funding lost; people lost. We need to be very cognisant of that.[34]

4.29 Professor Kathy Eagar AM similarly told the committee that while there are a 'lot of very skilled providers … who are absolutely committed to what they do' they are experiencing uncertainty. Professor Eagar noted:

> … they have mortgages, they've got kids to put through school and they need job security. I know a lot of them. People are saying to me: 'I'm going to have to leave. We want to buy a new house, and we won't get a mortgage, because I'm now on 12-month contracts.' So government's put CHSP on 12-month contracts, and there's no job security.[35]

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[32] Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 3. See also Ageing Australia, *Submission 21*, p. 8.

[33] Ms Claudia Odello, Meals on Wheels New South Wales, *Committee Hansard*, Canberra, 6 February 2026, p. 1.

[34] Ms Mary-Ann Geronimo, Federation of Ethnic Communities Council of Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 40.

[35] Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 51.

4.30 Professor Eagar further noted that 'over the past decade the CHP has been the one part of the aged-care system that has not had problems attracting and retaining its workforce but I'm starting to hear that those problems are emerging because of job insecurity'.[36]

4.31 The LGASA told the committee that there is a lack of information available regarding whether CHSP providers will automatically transition to SAH Program providers, and how clients will be informed and supported through the transition.[37]

4.32 National Seniors Australia also pointed to anxiety about the scheduled end of existing funding on 30 June 2027. It stated that 'if funding arrangements are not extended or clarified ahead of this date, providers and recipients may face uncertainty that effectively forces a transition by default'. It described this as 'undermining the Government's stated timeline and increasing the risk of a rushed transition or inadequate rollout of funding'.[38]

4.33 In addition to information and guidance, there is a significant need for additional support to ensure workforce, administrative and technological readiness for the transition. The committee heard that the transition support available during the transition to the SAH Program, and the introduction of the new *Aged Care Act 2024*, fell short of provider expectations. Service providers 'are absorbing high, unfunded costs across their workforces, systems, IT, administrative capacity, and compliance work'. In addition, 'frontline teams are being stretched to breaking point because there is no funding to adequately resource these significant changes'.[39] Mr Tom Symondson, Chief Executive Officer, Ageing Australia told the committee:

> The strain on Support at Home providers is extremely noticeable. The important thing to remember about the context difference between Support at Home providers and CHSP providers is most CHSP providers are much smaller. So, if you saw turmoil with Support at Home, the same rushed process will have a much greater impact on the average CHSP provider, which is why doing this properly is so much more important.[40]

4.34 Mr Symondson noted the significant negative impact that the introduction of the SAH Program has had on the sector workforce. Mr Symondson stated:

> Our sector is exhausted. We are seeing executives, middle managers and frontline staff leaving, unfortunately, in droves. We've seen a number of

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36 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 51.

37 Local Government Association of South Australia, *Submission 109*, p. 26.

38 National Seniors Australia, *Submission 87*, p. 3.

39 Municipal Association of Victoria, *Submission 108*, p. 8.

40 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 1. See also Uniting Communities, *Submission 33*.

> CEOs of organisations announce resignations in the last two months, the highest number I've ever seen in a short period of time, and a lot of that is because of burnout. So, whatever we do, we have to recognise that this is not a system full of robots. Any change will take huge organisational and individual effort. Let's not pile that on top of a whole heap of other things that are not yet fixed.[41]

4.35 The Australian Nursing and Midwifery Federation (ANMF) told the committee that the transition of the CHSP 'must not proceed unless and until system readiness is established'. This must be 'evidenced through measurable indicators relating to workforce supply and skill mix, assessment capacity, provider viability, and materially reduced waiting times'. The ANMF noted that 'the Royal Commission into Aged Care Quality and Safety concluded that chronic understaffing was a primary cause of substandard care and warned that reform without sufficient workforce capacity would fail to deliver improved outcomes'.[42]

4.36 The ANMF argued that aged care reform has proceeded on 'assumptions of workforce availability, skill mix, and surge capacity that are not supported by current labour market conditions'. It noted that national workforce projections indicate that the aged care sector requires at least 17,000 additional direct care workers each year to meet existing demand, before accounting for growth associated with reform and population ageing'.[43]

4.37 When workforce capacity is insufficient, individual workers face excessive workloads, unpaid labour, and accountability for failures arising from system design rather than professional conduct. This in turn increases psychosocial hazards for workers, and results in accelerated workforce attrition.[44]

4.38 The ANMF recommended that the transition commencement description of 'no earlier than 1 July 2027' should operate as a safety threshold, not an assumed start dated. It stated:

> Transition should occur only once government can demonstrate that workforce demand and supply gaps have materially narrowed at national and regional levels, that assessment capacity can deliver timely access within clinically appropriate timeframes, and that provider viability is not dependent on insecure employment practices or service withdrawal.[45]

4.39 Ms Rebecca Sharkie MP, Federal Member for Mayo, expressed concern that adding a large cohort of CHSP recipients to the SAH Program would 'require

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41 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 5.

42 Australian Nursing and Midwifery Federation, *Submission 113*, p. 4.

43 Australian Nursing and Midwifery Federation, *Submission 113*, p. 4.

44 Australian Nursing and Midwifery Federation, *Submission 113*, p. 4.

45 Australian Nursing and Midwifery Federation, *Submission 113*, p. 5.

growth in workforce capacity for e.g. aged care workers, and navigators/aged care specialist officers to support people through this change'. Ms Sharkie also stated:

> Workforce and other strategies must be developed well in advance to address the anticipated impact on waiting periods and workforce of increasing the number of SAH recipients fivefold. … additional dedicated Government resources and aged care navigators/support roles must also be allocated to support people in person and by phone with transition impacts. Existing online services are not accessible to everyone, and exclude some people from obtaining the assistance they require to access care in a reasonable timeframe.[46]

4.40 Many CHSP providers describe themselves as small, place-based organisations, often operating in rural, regional and remote areas or delivering specialist services. While the My Aged Care Service Finder may list multiple providers in these settings, in practice, CHSP providers are often the only service physically present in small townships and local communities. Further, while larger providers may indicate they service rural and regional areas, in reality such services are often delivered infrequently, limited to larger regional centres and are significantly more expensive due to travel and overheads.[47]

4.41 The Victorian Sector Support and Development Partnership told the committee that in this context, there is significant concern that there are market dynamics that will lead to CHSP exit and consolidation. In particular, by the time CHSP providers are required to transition, existing SAH 'providers will have had almost two years to establish themselves in the new program, build systems, refine pricing, stabilise workforces and secure market share'. Further, many CHSP providers report 'having limited resources to rapidly build the capability and capacity needed to compete in an established, highly competitive market'. The Victorian Sector Support and Development Partnership stated:

> Providers described this as creating an uneven playing field, where CHSP providers are expected to enter late, absorb risk quickly, and compete against Support at Home providers that have already had significant time to embed systems, navigate program complexity, invest in implementation, and shift their focus to client acquisition and growth.[48]

4.42 Providers in remote and very remote communities operate with smaller workforces, have limited administrative capacity and are experiencing 'cumulative reform fatigue arising from concurrent system changes, including the Single Assessment System and workforce reforms'. As such, 'without certainty, staged milestones and dedicated transition funding, there is a real risk

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46 Ms Rebecca Sharkie MP, *Submission 96*, p. 4.

47 Victorian Sector Support and Development Partnership, *Submission 69*, p. 31.

48 Victorian Sector Support and Development Partnership, *Submission 69*, p. 31.

of service withdrawal from already fragile markets'.[49] North and West Remote Health (NWRH) called for capacity building investment by the Australian Government to support a successful transition for remote providers. NWRH stated that this should include 'workforce training, digital systems upgrades and change management support'.[50]

Recipient readiness

4.43 The committee heard that older Australians are concerned about the transition of the CHSP, particularly their personal preparedness for the transition and the need for a realistic timeframe in which to understand and adjust to changes. Dementia Australia submitted that there is:

> … a clear consensus on the need for information about the program transition that was timely and clearly expressed in plain language that all older people and people with cognitive impairment and their families could understand.[51]

4.44 Professor Kathy Eagar told the committee that 'there are 850,000 people in this program, and many of them are extremely anxious about what's going to happen to them. They're reading these stories every day about what a disaster it is'.[52]

4.45 Submitters also pointed to the experience of the transition to the SAH Program and challenges which have been experienced by clients and service providers. For example, Dementia Australia provided the results of consultation it undertook with its clients that highlighted that:

- 53 per cent surveyed did not understand what the changes introduced on 1 November 2025 meant for them;
- 53 per cent did not feel confident they could access the aged care services they need; and
- 48 per cent did not expect to be able to afford the care services they need.[53]

4.46 Dementia Australia also told the committee that:

> Feedback also described confusion, lack of clear information, and reports that even providers and My Aged Care staff were unable to explain the changes. These findings underscore the importance of well-planned and timed transition underpinned by early and thorough consultation.[54]

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49 North and West Remote Health, *Submission 121*, [p. 2].

50 North and West Remote Health, *Submission 121*, [p. 2].

51 Dementia Australia, *Submission 115*, pp. 4–5.

52 Professor Kathy Eagar AM, *Committee Hansard*, Brisbane, 16 February 2026, p. 51. See also Kingsgrove Community Aid Centre, *Submission 13*, [p. 1].

53 Dementia Australia, *Submission 115*, p. 4.

54 Dementia Australia, *Submission 115*, p. 4.

4.47 Dementia Australia concluded that 'providers and clients will need significantly more time to understand…and prepare for the transition than was provided for SAH'.[55]

4.48 Similarly Mr Chris Grice, Chief Executive Officer, National Seniors Australia, told the committee that there is a 'real risk that vulnerable older Australians may experience service disruption during the transition if safeguards are not clearly defined and implemented'. Mr Grice noted:

> We have received reports that older Australians are facing significant challenges since the new act took effect on 1 November. They value certainty and need assurance that the support they depend on today will not be reduced, delayed or made more complicated in the future.[56]

4.49 Mr Grice argued that the 'success of the reform will depend on whether individuals feel secure, rather than uncertain, about the support they rely on'. Mr Grice stated, 'reform succeeds when consumers feel confident. The transition of CHSP must prioritise continuity, clarity and assurance for older Australians who depend on these services every day'.[57]

4.50 Mr Corey Irlam, Deputy Chief Executive Officer, COTA Australia, told the committee that the Department must learn from the roll-out of the SAH Program and proactively outline its plan for public education. Mr Irlam stated:

> It felt a little bit like an afterthought in the sequence of events of when things were handed out for older people, and still, today, sometimes they don't fully understand the new Support at Home, for example. We need to learn from that experience. We need to communicate it better. We need to strive for more level-9 plain English kind of standards and get that into the transition plan so that it's built in from the beginning, starting early, rather than, 'Oh my God, we're running out of time,' and just ramming it through, which feels like what happened this time around.[58]

Roll-out proposals

4.51 The committee received evidence arguing that if the Australian Government proceeds with integrating the CHSP into the SAH Program, then it should pursue a staged roll-out with sufficient time provided for planning, communication and implementation.[59] Mr Tom Symondson, Chief Executive Officer, Ageing Australia, told the committee that if the transition isn't managed

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55 Dementia Australia, *Submission 115*, p. 4.

56 Mr Chris Grice, National Seniors Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 2.

57 Mr Chris Grice, National Seniors Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 2.

58 Mr Corey Irlam, COTA Australia, *Committee Hansard*, Canberra, 6 February 2026, p. 13. See also Your Side Australia, *Submission 14*, p. 1.

59 Municipal Association of Victoria, *Submission 108*, p. 12. See also Australia and New Zealand Society for Geriatric Medicine, *Submission 24*, p. 3.

carefully then 'it will adversely affect the health and wellbeing of older people'. Mr Symondson explained that this:

> … runs completely counter to the objectives of the new Aged Care Act, which are supposed to recognise people's rights and make sure that they have access to the right care in the right place at the right time. Without adequate lead times and targeted support to providers, particularly given the small average size, we will not see better outcomes, and it will further risk the sustainability of the system as a whole.[60]

4.52 Mr Symondson detailed a number of conditions which should be met before the transition of the CHSP. These include the resolution of current SAH Program issues 'before we even consider changes to the CHSP; 'genuine co-design' with older people and with providers to ensure that 'what's proposed works or can work'; at least 12-months notice of any transition; and a review of CHSP funding levels and alignment with indexation rates'.[61]

4.53 COTA Australia told the committee that the Australian Government should:

> … publish a detailed, codesigned roadmap that is realistic about sequencing and dependencies, and clearly assigns accountability for actions across the Department, the assessor network and providers. A defined planning period and milestones with success measures and public reporting are necessary preconditions for integrating existing programs.[62]

4.54 It also suggested that a clear transition plan should:

> (a) State the clear consumer outcome/s Government is committed to delivering as part of each phase,
> (b) Identify measurable readiness conditions for both providers and government required to deliver each phase. These readiness conditions should be regularly reported on publicly …
> (c) Include clear timeframes for consultations, publishing of final design, IT build requirements completed, final rules and program guidelines being published and other implementation elements, and
> (d) At a minimum, identify quarterly milestones and six-monthly phases that maintain focus on Government progress to achieving its consumer outcomes that have been committed to.[63]

4.55 Mr Joel Reading, Acting Chief Executive Officer, Ozcare noted that if 1 July 2027 marks the beginning of the transition then the Australian Government must settle and finalise all processes and release guidance material 'no later than 1 December [2026]'. Mr Reading explained:

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60 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, pp. 1–2. See also Ageing Australia, *Submission 21*, p. 8.

61 Mr Tom Symondson, Ageing Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 2.

62 COTA Australia, *Submission 120*, p. 8. See also Indigo, *Submission 51*, p. 4.

63 COTA Australia, *Submission 120*, p. 24.

> The transition time to move the practices, IT systems et cetera is astronomical and, to be perfectly frank, when things didn't happen the first time around, we moved heaven and earth to get ready for the anticipated commencement date. We burnt a lot of staff goodwill and spent a great deal of money, and we do not want to go through that again.[64]

4.56 Submitters called for the release of 'detailed guidance' in order to 'begin workforce, budget, and service planning'.[65] The Australian Association of Gerontology told the committee that there is a need for a 'clearly staged road map, publicised well ahead of changes, to ensure providers and older people are adequately informed about how the changes will be rolled out and the likely impact of these changes'.[66]

4.57 Similarly, NWRH called for clear and finalised design parameters to be released at least 12 to 18 months prior to the transition of the CHSP, and the inclusion of 'explicit remote viability modelling'.[67]

4.58 Mr Joel Reading, Ozcare, and other witnesses including Mr Adrian Morgan, General Manager, Flexi Care, told the committee that finalising transition guidance material by 1 December 2026 would not give sufficient time for the genuine co-design of the program that they are seeking.[68]

Lessons from previous programs

4.59 The Municipal Association of Victoria noted the transition of the CHSP to the SAH Program will impact almost one million older Australians, and argued that 'lessons from previous transitions must be accounted for in future transition planning, or more Australians will lose access to these vital supports'.[69] Ms Georgina Watson, Head, Policy, UnitingCare Australia, similarly told the committee that:

> We advocate that this transition warrants a phased approach and must be underpinned by system readiness, a clear road map and guidelines from government, and consumer centred safeguards. If we take the current combined waitlist for Support at Home and the estimated number of people accessing the CHSP, even accounting for people that are both using the CHSP and on a waitlist for Support at Home, that's around a million people that will need to be transitioned onto Support at Home. Compare this to the

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64 Mr Joel Reading, Ozcare, *Committee Hansard*, 16 February 2026, p. 14.

65 Local Government Association of South Australia, *Submission 109*, p. 16.

66 Australian Association of Gerontology, *Submission 122*, p. 5.

67 North and West Remote Health, *Submission 121*, [p. 2].

68 Mr Joel Reading, Ozcare, *Committee Hansard*, Brisbane, 16 February 2026, pp. 15–16; Mr Adrian Morgan, Flexi Care, *Committee Hansard*, Brisbane, 16 February 2026, pp. 15–16.

69 Municipal Association of Victoria, *Submission 108*, p. 12.

> NDIS, which allowed four years for 364,000 people to become NDIS participants.[70]

4.60 This was also reflected by Mr Joel Reading, Acting Chief Executive Officer, Ozcare, who stated that:

> We also have to take constructive lessons from the reform process, including the recent transition to Support at Home. Large-scale transitions require all the rules and guidance to be provided well in advance so providers can plan their workforce systems and service delivery safely and also have an adequate transition funding scheme. We're talking about 830,000 clients and 1,200 providers here. This is exponentially larger than Support at Home was.[71]

4.61 It was argued that the national transition of the CHSP to the SAH Program should be phased by region over a three-year minimum period, mirroring the rollout of the National Disability Insurance Scheme (NDIS).[72] Such a transition would 'enable a feedback loop for continual improvement, allowing policy tweaks and course correction during transition avoiding market disruption'.[73] The Municipal Association of Victoria told the committee that a 'phased approach could also facilitate timely, targeted transition supports at a regional level to assist providers and older Australians'. This could include:

- Business and workforce training and resources
- Local targeted communications and supports for older Australians to understand the changes and make informed decisions about their service
- Access
- Outreach undertaken by the Department of Health, Disability and Ageing, the Aged Care Quality and Safety Commission, sector peaks, Older Persons' Advocacy Network, Sector Support and Development providers, through both regional in-person and online supports.[74]

4.62 Whiddon, a not for profit aged care provider, told the committee that:

> … a single transition date poses considerable risk, particularly for regional areas where service continuity relies on flexible funding arrangements. Feedback from our teams suggests providers are at differing stages of

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70 Ms Georgina Watson, UnitingCare Australia, *Committee Hansard*, Canberra, 6 February 2026, p. 14. See also UnitingCare Australia, *Submission 25*, p. 6; IRT, *Submission 28*, [p. 4].

71 Mr Joel Reading, Ozcare, *Committee Hansard*, 16 February 2026, p. 13.

72 UnitingCare Australia, *Submission 25*, p. 6. See also Municipal Association of Victoria, *Submission 108*, p. 12.

73 Municipal Association of Victoria, *Submission 108*, p. 12.

74 Municipal Association of Victoria, *Submission 108*, p. 12. See also Queensland Health, *Submission 10*, p. 4; Dr Anna Howe, *Submission 11*, p. 2.

> readiness, and a phased approach is essential to avoid destabilising current support arrangements.[75]

4.63 Ms Watson, UnitingCare Australia, also offered support for the proposed transition to be 'deferred until at least mid-2028 and then staged over two or three years so that the final rollout occurs no earlier than 2030. Ms Watson stated 'a staged approach will minimise administrative risk for providers and enable better outcomes for older Australians'.[76]

4.64 The Victorian Sector Support and Development Partnership similarly called for the Australian Government 'to pilot and test any proposed CHSP transition model before making any final transition decisions.' It suggested that:

> The Government should adopt a staged and adequately funded rollout approach to the national transition prioritising safety, continuity of care and system readiness.[77]

4.65 The ANMF told the committee that the NDIS rollout provided important lessons which should be regarded when transitioning the CHSP. The ANMF stated that the NDIS rollout 'demonstrates that entitlement expansion without coordinated workforce planning, system design, and effective oversight leads to fragmentation, administrative burden, and inconsistent quality'. It stated that the Australian Government 'must avoid repeating these failures by prioritising safety, workforce sustainability and system integrity over rollout speed'.[78]

4.66 The Australian Human Rights Commission also noted the implementation of the NDIS and submitted:

> … lessons from previous large-scale reforms, including the National Disability Insurance Scheme (NDIS), show that accelerated implementation can create service gaps, administrative complexity, and increased system strain. These lessons have particular relevance to the aged care sector where the availability of community-based aged care services is central to older people's wellbeing, especially when care is consistent, uninterrupted and built on trusted relationships.[79]

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75 Whiddon, *Submission 36*, p. 3.

76 Ms Georgina Watson, UnitingCare Australia, *Committee Hansard*, Canberra, 6 February 2026, pp. 14–15.

77 Victorian Sector Support and Development Partnership, *Submission 69*, p. 56.

78 Australian Nursing and Midwifery Federation, *Submission 113*, pp. 8–9.

79 Australian Human Rights Commission, *Submission 75*, p. 2.

Chapter 5
Support at Home Program

5.1 This chapter examines the evidence received in relation to the implementation of the Support at Home Program (SAH Program) and the Single Assessment System (SAS). This evidence provides an important overview of the challenges which may affect any transition of the Commonwealth Home Support Program (CHSP) into the SAH Program.

SAH Program challenges

5.2 The committee heard that before the CHSP is transitioned to the SAH Program, the SAH Program must be properly evaluated and any issues identified should be rectified. While this inquiry does not intend to replicate the work of the concurrent inquiry into the SAH Program also being undertaken by this committee, the experiences of older Australians and service providers since November 2025 provide important context when considering the transition of the CHSP. The committee heard that issues with the SAH Program include:

- concerns regarding consumer contributions, rising costs and financial barriers to accessing care;
- assessment and service receipt wait times;
- assessment outcomes including classifications and allocated support being insufficient to meet needs;
- system complexity and the need for navigation support to help understand information and options;
- concern regarding staff availability, turnover and qualifications; and
- the availability of services including respite.[1]

5.3 The committee also heard that a range of policy decisions are also leading to negative outcomes for SAH Program participants, and these include:

- the delay to being able to access multiple providers to deliver services with package funding;
- the decision to delay price caps; and
- the requirement for hardship applications to be made separately.[2]

5.4 Mrs Julie Stacey, General Manager, Maroochy Home Assist, told the committee that the SAH Program 'introduced new regulatory categories, major workforce obligations and a significantly heavier administrative burden, while, at the same time, requiring providers to absorb these administrative costs into an hourly

1 Dementia Australia, *Submission 115*, pp. 2–3. See also COTA Australia, *Submission 120*, pp. 18–20.

2 COTA Australia, *Submission 120*, pp. 20–21.

rate that does appear excessive when compared with market prices'. Mrs Stacey stated:

> What we have been seeing on the ground since stage 1 of Support at Home rolled out is deeply concerning: longer wait times; clients not understanding what their approvals mean; OTs being unsure of how or where to refer. And all this is escalating stress for consumers and carers. The system was clearly not ready for reform of this scale, nor has any evidence—to my knowledge—been presented to show that it delivers benefits.[3]

5.5 Mr Tim Hicks, Executive General Manager, Policy and External Relations, Bolton Clarke, similarly described the administrative requirements of the SAH Program as 'astronomical'. Mr Hicks stated:

> The administrative requirements for Support at Home and the level of reporting that's involved is astronomical. The level of detail we need to report on each individual service is crazy. Whilst it's useful for everyone to have more information, I don't think they need that much information, nor do I think they're necessarily getting the best quality information, because they're asking for more than people can reasonably provide.[4]

5.6 Ms Marcela Carrasco, Executive General Manager, Home Care, HammondCare, also told the committee that the 'compliance requirements' under the SAH Program are 'quite extensive' and that this 'burden is going just increase over time'.[5]

5.7 Mr Adrian Morgan, General Manager, Flexi Care described the SAH Program as a 'significantly flawed program which is unnecessarily pushing up costs, creating complexity and confusion for older people and providers, causing needless delays and being slow to respond to people's changing needs'. Mr Morgan also noted that 'it also encourages participants to concentrate unduly on the cost of services, and not on their quality or effectiveness'.[6]

5.8 Mr Morgan told the committee that services provided to recipients under the SAH Program cost 20–40 per cent more than those provided under the CHSP due to the administrative and oversight requirements.[7] This was echoed by Ms Carolyn Bell, Executive Director, Aged Care, Silverchain who stated:

> It does cost more to deliver under the Support at Home program. That's related to the administrative and systems oversight. There are a lot more compliance and data requirements under Support at Home. Also, when it comes to Support at Home, the complexity of the clients, the degree of care management and care navigation support and the amount of services in

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3 Ms Julie Stacey, Maroochy Home Assist, *Committee Hansard*, Brisbane, 16 February 2026, p. 29.

4 Mr Tim Hicks, Bolton Clarke, *Committee Hansard*, Canberra, 6 February 2026, p. 18.

5 Ms Marcela Carrasco, HammondCare, *Committee Hansard*, Canberra, 6 February 2026, p. 19.

6 Mr Adrian Morgan, Flexi Care, *Committee Hansard*, Brisbane, 16 February 2026, p. 12.

7 Mr Adrian Morgan, Flexi Care, *Committee Hansard*, Brisbane, 16 February 2026, p. 18.

> bringing together a comprehensive care plan for those clients make a higher administrative burden in the delivery of service.[8]

5.9 Ms Carolyn Bell, Executive Director, Aged Care, Silverchain, told the committee that the program 'has great potential, but it is still a work in progress'. Ms Bell stated, 'assessment systems are under strain. Government communication has been inadequate. The service list needs refinement, and the financial impacts on older people are not well understood'.[9]

5.10 The Victorian Sector Support Development Partnership submitted that providers have:

> … described the early stages of Support at Home as rocky, with delays in the release of practical guidance, unresolved IT and claiming issues, service-level impacts, and a level of administrative complexity that has not yet stabilised.[10]

Waiting periods

5.11 The proposed transition of the CHSP into the SAH Program, not earlier than 30 June 2027, is taking place in a system already characterised by lengthy assessment delays and extended waits for service commencement.[11] The City of Salisbury stated:

> There are already substantial wait times for clients accessing SAHP packages. If the Department is currently unable to open packages for all eligible clients under SAHP, it is difficult to see how the system will be able to absorb and service the entire CHSP cohort within the same framework.[12]

5.12 On 12 May 2026, the Department of Health, Disability and Ageing (the Department) released the *Aged Care Act 2024* Wait Times Report: Residential care and Support at Home report for the period 1 November 2025 to 31 March 2026. This report stated that the average number of days between the application for assistance and the commencement of SAH Program services is 364.[13]

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8 Ms Carolyn Bell, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, pp. 18–19.

9 Ms Carolyn Bell, Silverchain, *Committee Hansard*, Brisbane, 16 February 2026, p. 12.

10 Victorian Sector Support and Development Partnership, *Submission 69*, p. 34.

11 National Seniors Australia, *Submission 87*, p. 4.

12 City of Salisbury, *Submission 68*, p. 23.

13 Department of Health, Disability and Ageing, *Aged Care Act 2024* Wait Times Report: Residential care and Support at Home report, p. 16, Aged Care Act 2024 Wait Times Report, (accessed 22 May 2026).

5.13 As at 31 March 2026 364,723 people had an ongoing SAH Package (they were receiving care or considering the offer) and 100,191 people were waiting for an ongoing package.[14]

5.14 Concerns regarding the size and duration of aged care waiting lists for all types of care have been raised repeatedly in evidence – this includes the waiting list to receive an assessment for aged care, and the waiting list to receive care after assessment.[15] In considering the impact of the transition of the CHSP to the SAH Program, submitters expressed concern that existing waiting lists will increase in size and duration, and older Australians will be significantly negatively impacted.[16]

5.15 The Inspector-General of Aged Care (Inspector-General) noted the size of the waiting list for the SAH Program and stated 'it remains to be seen how quickly wait times for assessment will be reduced, particularly given the expected, exponentially growing demand for these services as Australia's population ages'.[17] The Australian Association of Gerontology also argued that any anticipated reduction in waiting times and greater individual support under the SAH Program are 'likely to be unequally distributed and heavily dependent on several factors'. It stated that:

> Many people will move from existing waiting lists into a system in transition. There will be a transition lag, as providers adapt to new systems, and there may be delays or temporary reductions in capacity. The net result is that people currently on waitlists, or those in CHSP needing more support, will continue to face long waits before services start under SAH. They may receive only interim, limited support for a prolonged period.[18]

5.16 It was noted that there are currently approximately 839,000 older Australians currently receiving CHSP services under block-funding arrangements which cannot be directly correlated to the SAH Program funding level. As such, the recipients may all be required to undergo some form of reassessment after transition.[19] The Aged Rights Advocacy Service (ARAS) told the committee that 'an expected influx of CHSP clients seeking reassessment in order to access the SAH system will also place pressure on already extensive SAH waitlists'. It argued that:

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14 Department of Health, Disability and Ageing, Assessment outcome: Support at Home | My Aged Care; (accessed

15 See for example, Whiddon, *Submission 36*, p. 2.

16 Aged Care Workforce Remote Accord, *Submission 45*, p. 4.

17 Inspector-General of Aged Care, *Submission 26*, p. 3.

18 Australian Association of Gerontology, *Submission 122*, p. 9.

19 Dementia Australia, *Submission 115*, p. 6.

> It is unclear whether the transition of CHSP into SaH will assist with availability and capacity challenges, as we may see an influx of clients transitioning from one program to the other.[20]

5.17 Dementia Australia submitted that in the event that CHSP recipients require reassessment then this would necessitate timely access to such a process facilitated by 'a large, appropriately trained reassessment workforce … with the ability and authority to apply clinical judgment to ensure appropriate outcomes'. It also submitted that:

> Assessors must have the opportunity to override the Integrated Assessment Tool (IAT) assessment outcome where necessary, to ensure people transitioning are not placed in an inappropriate level of care or denied access to care.[21]

5.18 Dementia Australia noted the 'current lengthy wait times for assessment' and suggested that 'a significantly expanded workforce must be in place before CHSP clients start to transition to avoid a further blow out of assessment wait times'.[22]

5.19 The Inspector-General similarly stated that 'additional delays would also be introduced if reassessment of existing clients is required, with further complications arising if older people receiving multiple CHSP services also need to be realigned to new Support at Home levels'. The Inspector-General stated:

> Delays inevitably impact an older person's rate of cognitive and physical decline. This prejudices their rights first and foremost, but from an economic perspective, increases the rate at which they require more intensive levels of care. Therefore, the government has both a human rights and a fiscal interest in reducing these delays to the maximum extent possible.[23]

5.20 The Inspector-General expressed serious concern that the proposed transition will 'negatively impact waiting periods for assessment and receipt of care'. The Inspector-General noted the lack of clarity regarding the transition and the 'tens of thousands awaiting an assessment and an unknown number of prospective CHSP clients currently waiting in limbo for services'.[24] Dementia Australia stated that if the 'CHSP is transitioned and access to the SAH Program is not significantly improved, the impacts will include additional physical, emotional, and financial challenges' for recipients.[25]

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20 Aged Rights Advocacy Service, *Submission 104*, p. 5.

21 Dementia Australia, *Submission 115*, p. 6.

22 Dementia Australia, *Submission 115*, p. 6.

23 Inspector-General of Aged Care, *Submission 26*, p. 4.

24 Inspector-General of Aged Care, *Submission 26*, p. 4.

25 Dementia Australia, *Submission 115*, p. 6.

5.21 The Australian Association of Gerontology (AAG) recommended that the Australian Government 'implement a targeted strategy to reduce the current backlog before the transition of CHSP recipients' into the SAH Program'. It stated that:

> This must include increasing assessor workforce capacity and using interim funding mechanisms more proactively. The Government should commit to sustained expansion of home support and care package availability, alongside targeted support to providers to assist with transition readiness, workforce development, and capacity expansion. Monitoring the supply–demand balance should be transparent and publicly reported.[26]

5.22 The Municipal Association of Victoria highlighted that the CHSP currently supports a significant number of older Australians who are awaiting assignment of a SAH Program package. It submitted that:

> It is unclear how integrating CHSP into the Support at Home model will relieve pressure on service demand or address the blown-out waiting periods for older people to be assessed for services and then wait for their Support at Home package allocation.[27]

Implementation and evaluation

5.23 Providers told the Victorian Sector Support Development Partnership that they are still waiting for key information needed to operate confidently under Support at Home'. This includes, 'clear guidance on claiming, evidence requirements and day-to-day implementation'. Providers are 'working through issues as they arise, often without timely clarity' which 'creates uncertainty for workforce planning, service delivery and financial sustainability'.[28]

5.24 The Victorian Sector Support and Development Partnership noted that there has not yet been time for a 'formal evaluation' of the SAH Program against the outcomes it was designed to deliver. Of note, there is an absence of evidence that the program: improves access to care; supports the timely delivery of services; works effectively in rural and regional areas; is culturally safe and appropriate; and is financially viable for small and community-based providers.[29]

5.25 The committee heard that any transition approach 'must allow problems in the current SAH settings to be fixed first' and the Australian Government should ensure that 'each phase only proceeds when readiness conditions have been met

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[26] Australian Association of Gerontology, *Submission 122*, p. 9. See also Aged Care Workforce Remote Accord, *Submission 45*, p. 4.

[27] Municipal Association of Victoria, *Submission 108*, p. 14.

[28] Victorian Sector Support and Development Partnership, *Submission 69*, p. 34.

[29] Victorian Sector Support and Development Partnership, *Submission 69*, p. 34.

and publicly evidenced'.[30] The Victorian Sector Support and Development Partnership told the committee that:

> Victorian CHSP providers expressed strong concern about making decisions on the final transition of CHSP to the Support at Home program, given that Support at Home has not yet been fully implemented, evaluated, or shown to be working as intended.[31]

5.26 Ms Rebecca Sharkie MP, Federal Member for Mayo, submitted that:

> Before moving more people into SAH, the Government needs to listen to deafening feedback that waiting times for SAH are already unacceptable, and the combination of the lack of price caps and exponential increases in recipient co-contributions for SAH independence services and everyday living assistance are placing older people in dire situations.[32]

5.27 The Victorian Sector Support and Development Partnership warned that 'transitioning the CHSP into a program … risks embedding problems across the aged care system'. Further, 'older people, particularly those in rural, regional and Aboriginal communities, would bear the consequences if the program does not perform as intended'.[33]

Single Assessment System

5.28 The introduction of the SAS represented a major shift in aged care assessments, combining the Integrated Assessment Tool (IAT), a unified assessment workforce, and new First Nations assessment organisations.[34] Under the current arrangements all recipients including those with low level needs must undergo a formal aged care assessment through the SAS. This represents a significant change for CHSP recipients, who were previously able to access services more quickly.[35]

5.29 However, the committee heard concerns regarding the SAS' readiness to support timely and accurate assessments for older Australians. In particular, systemic issues which have contributed to assessment delays for both SAH Program and CHSP participants. Access Sydney Community Transport told the committee that:

> Since the introduction of the single assessment system, CHSP referrals have fallen sharply. Many older people describe My Aged Care as complex and difficult to navigate even for basic services. As a result, older people are not accessing essential entry-level supports that maintain independence and

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30 COTA Australia, *Submission 120*, p. 8.

31 Victorian Sector Support and Development Partnership, *Submission 69*, p. 34.

32 Ms Rebecca Sharkie MP, *Submission 96*, p. 3.

33 Victorian Sector Support and Development Partnership, *Submission 69*, p. 35.

34 Catholic Health Australia, *Submission 93*, p. 22.

35 National Seniors Australia, *Submission 87*, p. 4.

> reduce the risk of preventable decline, increased high need supports and hospitalisation.[36]

5.30 The Victorian Sector Support and Development Partnership similarly told the committee that 'delays, inconsistent assessment quality and outcomes, limited local knowledge and a lack of cultural safety within the single assessment system are preventing timely access to care and placing older people at risk'.[37]

5.31 The committee heard that 'providers consistently report excessive delays for assessments and support plan reviews, with many older people waiting months for decisions'. Providers describe 'people becoming more unwell, losing confidence in the system and, in some cases, ending up in hospital because support was not put in place in time'. Providers were also clear that these delays 'have real consequences for older people and their families'.[38]

5.32 While a 'streamlined, accessible, and equitable assessment process is essential to ensure older people receive the right support at the right time', system challenges exist. The SAS 'introduces delays and rigid service codes, creating administrative bottlenecks that ultimately delay care'.[39] For example, Catholic Health Australia told the committee that:

> Providers have highlighted that these rigid coding requirements under the IAT are forcing unnecessary reassessments whenever a client's needs change. Under the new system, highly itemised service codes mean that even minor adjustments in care - such as moving from one type of allied health support to another - trigger a formal reassessment.[40]

5.33 Catholic Health Australia made recommendations in relation to the SAS, and the transition of the CHSP. Namely that the Australian Government should clearly and proactively communicate how CHSP clients will be treated during any transition in order for providers to prevent delays to care. It also recommended the introduction of an assessment tool designed specifically for referrals for low-level support (with appropriate safeguards) so that a full assessment is not required.[41] Access Sydney Community Transport similarly stated that 'access to entry level services should reflect these characteristics to ensure timely access to services and prevent clients' care needs from escalating while waiting for services'.[42]

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36 Access Sydney Community Transport, *Submission 70*, p. 3.

37 Victorian Sector Support and Development Partnership, *Submission 69*, p. 11.

38 Victorian Sector Support and Development Partnership, *Submission 69*, p. 24.

39 Catholic Health Australia, *Submission 93*, p. 22.

40 Catholic Health Australia, *Submission 93*, p. 22.

41 Catholic Health Australia, *Submission 93*, p. 22.

42 Access Sydney Community Transport, *Submission 70*, p. 3.

5.34 Mr Kieran McGregor, a social worker in a clinician role supporting older adults, also raised concerns regarding access to allied health supports for CHSP participants. Mr McGregor told the committee that under the SAS, no allied health services can be provided unless an assessment occurs and service codes are provided. Mr McGregor noted that under the previous arrangement, allied health clinicians could refer clients to each other as required, and clients 'could receive the service promptly. Mr McGregor noted the new requirements and stated:

> In practice, this means clients who previously would move relatively seamlessly between services, may now be subject to significant delays to access treatment or service or be financially impacted by needing to fund privately. With assessment delays now extending up to 12 months for some clients, this requirement is directly increasing preventable harm, leaving older Australians exposing them to unnecessary deterioration and risk while they wait.[43]

How assessments are conducted

5.35 The committee heard a range of concerns regarding the way in which assessments are conducted. This includes concerns that algorithms are not assigning correct levels of care; that assessments are being conducted remotely rather than face to face; and that assessors do not have appropriate clinical knowledge to make assessments.

5.36 The committee heard that the algorithms utilised by the SAS may be assigning lower levels of care to some older people than they require, and they are therefore waiting lengthy periods for reassessment, or are unable to leave hospital due to not having access to appropriate levels of care. For example, Mr McGregor stated:

> I have seen a client who has a serious neurodegenerative disorder who was assessed as a medium priority despite significant advocacy for a high priority Support at Home package. The Assessor agreed the client was high priority however the Algorithm assigned it as medium. The client is unable to return home as they currently have no CHSP services in place or available in their LGA, and there is no confirmed timeframe for their Support at Home package. As a result, they remain in a public hospital bed.[44]

5.37 Occupational Therapy Australia submitted that the IAT does not adequately incorporate the professional judgement and clinical observations of clinical assessors'. It explained:

> Assessors are currently unable to override automated assessment outcomes, even where those outcomes do not align with their observations of an older person's functional capacity, complexity, or clinical needs. This creates a risk

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43 Mr Kieran McGregor, *Submission 80*, [p. 2].

44 Mr Kieran McGregor, *Submission 80*, [p. 4].

> that assessment results do not accurately reflect the individual's circumstances or support requirements.[45]

5.38 The committee also heard concerns that assessments are being 'conducted by phone rather than face-to-face, even where people have complex needs, cognitive impairment, or are high risk'.[46] Assessments were also described as being 'carried out by inexperienced assessors, or by assessors located in a different state, with little understanding of local services, rural realities or community context'.[47] The committee heard that this is 'leading to inaccurate assessments and inappropriate support plans'.[48] Mrs Julie Stacey, General Manager, Maroochy Home Assist, told the committee:

> Phone based assessments are proving wholly inadequate. The insights gained during an in-person home visit are often far more accurate than what someone may disclose, or feel able to disclose, in a phone interview.[49]

5.39 In addition, providers are describing spending significant time 'correcting poor-quality reassessments and support plan reviews' and providing 'interim support without funding' because it is 'not safe to wait'. This was described as stressful for providers and confusing and distressing for older people and their families, who are often left unsure about what will happen next or when support will arrive'.[50]

5.40 Providers were clear that the current assessment system is not enabling access to care. Instead, it is acting as a barrier, placing older people at risk and undermining the preventative and responsive role that CHSP currently plays.[51]

Rural, remote and very remote areas

5.41 While assessment delays are recognised as a national issue, in remote and very remote contexts, 'these delays are compounded by distance, workforce scarcity, digital connectivity barriers and cultural and literacy considerations'.[52]

5.42 North and West Remote Health (NWRH) told the committee that in many remote regions, in-person allied health engagement is essential to accurately assess functional capacity, home environments and safety risks. Telehealth alone is insufficient due to connectivity limitations and the need for

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45 Occupational Therapy Australia, *Submission 43*, [p. 2].

46 Victorian Sector Support and Development Partnership, *Submission 69*, p. 24.

47 Victorian Sector Support and Development Partnership, *Submission 69*, p. 24.

48 Victorian Sector Support and Development Partnership, *Submission 69*, p. 24.

49 Mrs Julie Stacey, Maroochy Home Assist, *Committee Hansard*, Brisbane, 16 February 2026, p. 29.

50 Victorian Sector Support and Development Partnership, *Submission 69*, p. 24.

51 Victorian Sector Support and Development Partnership, *Submission 69*, p. 24.

52 North and West Remote Health, *Submission 121*, [p. 3].

environmental observation. However, travel time significantly reduces assessor availability. NWRH explained that, for example, an occupational therapy assessment in very remote locations may involve:

- several hours of travel each way;
- limited capacity to conduct more than one assessment per day; and
- hourly costs exceeding metropolitan averages due to travel, isolation and workforce scarcity.[53]

5.43 However, assessment algorithms and prescriptive care planning approaches 'significantly undermine the flexible, transdisciplinary allied health models that are essential for effective service delivery in remote and very remote communities'.[54]

5.44 NWRH explained that in order to respond to workforce shortages and limited discipline availability, adaptable models of care are utilised in remote areas. For example, an occupational therapist may deliver continence assessments and management in the absence of a continence nurse. It explained that 'these approaches are clinically appropriate, evidence-informed and delivered within professional scope. They are developed through shared decision-making between the client and provider, preserving choice and control while ensuring access to care'. However:

> Rigid, algorithm-driven care prescriptions that mandate specific disciplines or service types risk restricting access in thin markets where the "ideal" discipline may not exist. This would disproportionately disadvantage CHSP clients in remote settings who have historically benefited from discipline-agnostic allied health access and would reduce provider capacity to respond flexibly to client needs, workforce realities and cultural context.[55]

5.45 Murrindindi Shire Council submitted that:

> Assessments must be timely, culturally safe, and connected to local navigation, with clear hospital-to-home templates and authority for navigators to coordinate across boundaries. In rural settings, thin capacity can stall assessments and service activation; we recommend resourcing regional assessor pools, tele-assessments with in-home support, and rapid referral pathways…[56]

Assessments and culturally inappropriate practices

5.46 The application of rigid assessment protocols in the aged care system, particularly turnaround time requirements, have significant unintended consequences on very remote communities, and Aboriginal and Torres Strait

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53 North and West Remote Health, *Submission 121*, [p. 3].

54 North and West Remote Health, *Submission 121*, [p. 4].

55 North and West Remote Health, *Submission 121*, [p. 4].

56 Murrindindi Shire Council, *Submission 12*, p. 3.

Islander communities. NWRH stated that assessment processes are 'routinely disrupted' by factors that current performance indicators do not adequately accommodate. NWRH stated that for example in discrete Aboriginal communities, such as Doomadgee, these factors include:

- limited individual phone ownership and reliance on shared family devices;
- intermittent or absent phone credit;
- participants not answering calls due to low trust of government systems;
- extremely low literacy and health literacy, resulting in voicemail, text messages or written correspondence being ineffective; and
- English not being a first language, requiring supported or translated communication.[57]

5.47 NWRH told the committee that structural barriers are treated as client disengagement, and metropolitan assumptions are applied to very remote contexts. This 'disproportionately excludes older First Nations people who are most in need of in-home support'. Further:

> The outcome is that vulnerable clients who are unsafe at home, frail, or socially isolated are denied access to assessment and therefore denied access to services, whole community providers continue to provide informal unfunded support.[58]

5.48 NWRH concluded that without changes to assessment protocols and algorithms, the transition of the CHSP to the SAH Program risks entrenching inequity rather than improving access.[59]

5.49 The Victorian Sector Support and Development Partnership similarly told the committee that 'providers are especially concerned about the impact of the current assessment system on Aboriginal people'. It stated that 'mainstream assessment processes were described as not culturally appropriate, often rushed, impersonal and not conducive to building trust'. While providers noted that 'Indigenous assessment services are being rolled out', this work is still in its early stages' and 'these services are not yet available in most locations'. The Victorian Sector Support and Development Partnership told the committee that 'providers strongly emphasised that First Nations-specific assessment pathways must be fully implemented and accessible before any CHSP transition occurs'.[60]

5.50 The committee also heard that the assessment process is inappropriate for culturally and linguistically diverse older Australians too. Dr Lisa Ward, Chief Executive Officer, Ethnic Communities Council of Queensland, noted that during testing of the assessment process it was found that 'a lot of the questions

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57 North and West Remote Health, *Submission 121*, [p. 3].

58 North and West Remote Health, *Submission 121*, [p. 3].

59 North and West Remote Health, *Submission 121*, [p. 4].

60 Victorian Sector Support and Development Partnership, *Submission 69*, p. 25.

were not suitable for people of a First Nations background nor a CALD background'. Dr Ward noted that some older people from these communities would not answer certain questions or 'refrain from responding appropriately' 'due to embarrassment'.[61] This was echoed by Ms Mary-Ann Geronimo, Chief Executive Officer, Federation of Ethnic Communities Councils of Australia, who told the committee that assessors have also raised concerns:

> … we had some consultations where I got to speak to some assessors. They themselves are from a CALD background. They did say that the way the questions have been put together feels like it does not give them the answers that they think people should be saying. They're also limited by the number of cases that they have to process within a day or a week. There's usually not much of a chance to go deeper into the questions. That's the kind of challenge that we are facing at the moment, in terms of making sure people are really putting forward information that should help assessors understand their situations better.[62]

[61] Dr Lisa Ward, Ethnic Communities Council of Queensland, *Committee Hansard*, Brisbane, 16 February 2026, p. 38.

[62] Ms Mary-Ann Geronimo, Federation of Ethnic Communities Councils of Australia, *Committee Hansard*, Brisbane, 16 February 2026, p. 38.

Chapter 6
Assistive technology, home modifications, and the End-of-Life Pathway

6.1 This chapter examines the evidence received in relation to the adequacy and appropriateness of the funding parameters for home modifications and assistive technology under the Assistive Technology and Home Modifications (AT-HM) scheme available to Support at Home (SAH) Program participants, and the time and funding limits which apply to accessing the End-of-Life (EOL) Pathway.

6.2 As noted in Chapter 1, the *Aged care service delivery* inquiry conducted in 2025 recommended that the committee re-examine these programs.

6.3 Submitters also noted that the Commonwealth Home Support Program (CHSP) currently provides funding for assistive technology and home modifications, however it applies different funding caps to the AT-HM scheme. There is concern that this lack of alignment between programs will result in reduced funding for older Australians if the CHSP is transitioned to the SAH Program.

Assistive technology and home modifications

6.4 Under the *Aged Care Act 2024*, the AT-HM scheme gives SAH Program participants separate funding for assistive technology and home modifications.[1]

6.5 Older people are assessed for the AT-HM scheme as part of their aged care assessment. If needed, participants are approved for a suitable funding tier. Assessors may approve:

- an assistive technology funding tier;
- a home modifications funding tier; or
- both.[2]

6.6 Home modifications (HM) include changes to a participant's home environment to make it safer and more accessible. Home modifications can include:

- grab rails in the shower or bathroom
- internal and external handrails
- ramps and stair lifts
- bathroom redesign (e.g. changing the layout to improve accessibility)

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1 Department of Health, Disability and Ageing, Assistive Technology and Home Modifications (AT-HM) scheme | Australian Government Department of Health, Disability and Ageing, (accessed 4 March 2026).

2 Department of Health, Disability and Ageing, Assistive Technology and Home Modifications (AT-HM) scheme | Australian Government Department of Health, Disability and Ageing, (accessed 4 March 2026).

- widening doorways and passages (e.g. to allow for wheelchair access).[3]

6.7 The HM funding tiers are Low (under $500), Medium (up to $2000) and High (up to $15,000). Funds are allocated for 12 months, though providers can apply for an extension for an additional 12 months for high tier home modifications if evidence is provided to the department of progress. Evidence of progress may include invoices, planning documents, letters of council approval, or building contracts.[4]

6.8 Funding for High tier home modifications is subject to a $15,000 lifetime cap. Older people who have already accessed and used a HM high tier may access HM low or medium tiers if they have a change in need or require additional home modifications to support them to stay safely at home.[5]

6.9 For SAH Program participants approved for the AT-HM scheme and who live in a Modified Monash Model 6 or 7 area[6], an additional 50 per cent of allocated funding is provided. For example, a participant with a High tier allocation living in a Modified Monash (MM) 6 or 7 area would have a lifetime cap of $22, 500 for home modifications in this tier.

6.10 Assistive technology (AT) includes items, pieces of equipment or products that help a participant to do things more easily and/or complete activities they can no longer do independently. Examples of assistive technology include:

- mobility equipment, such as walking sticks, walking frames and wheelchairs
- toileting supports, such as bedpans and commodes
- bathing devices, such as shower chairs and bath boards.[7]

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3 Department of Health, Disability and Ageing, Assistive Technology and Home Modifications (AT-HM) scheme | Australian Government Department of Health, Disability and Ageing, (accessed 4 March 2026).

4 Department of Health, Disability and Ageing, AT-HM scheme guidelines, pp. 25–26, (accessed 4 March 2026).

5 Department of Health, Disability and Ageing, AT-HM scheme guidelines, p. 25, (accessed 4 March 2026).

6 The Modified Monash Model is used by the Department of Health, Ageing and Disability to define whether a location is metropolitan, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote. Department of Health, Ageing and Disability, https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm, (accessed 11 May 2026).

7 Department of Health, Disability and Ageing, Assistive Technology and Home Modifications (AT-HM) scheme | Australian Government Department of Health, Disability and Ageing, (accessed 13 May 2025).

6.11 AT funding tiers are Low (under $500), Medium (up to $2000) and High (up to $15,000). Participants are able to access funding over $15,000 if required to meet their assessed needs.[8]

Criticism of $15,000 lifetime cap on home modifications

6.12 Home modifications are critical for older Australians wishing to age at home. Such modifications contribute to reducing hospitalisations and delaying or preventing residential aged care entry. Accessible housing also promotes quality of life, productivity, and reduces care costs for people with disability and mobility impairments.[9] Evidence shows that:

> Well-designed modifications reduce falls and related injuries, support functional independence in daily activities, improve quality of life and confidence, and reduce caregiver burden by decreasing the level of physical assistance and supervision required. These outcomes matter directly to social participation and dignity, because safer homes help people maintain routines, remain connected to community, and avoid preventable decline.[10]

6.13 Assistive Technology Suppliers Australia (ATSA) told the committee that 'the strongest outcomes occur when home modifications are needs-based and personalised'. Further, 'effectiveness depends on matching the intervention to an individual's physical and cognitive characteristics and the realities of their living environment'. ATSA noted that:

> Ongoing maintenance and timely adjustments are also important, because needs change over time, particularly for people with progressive conditions or fluctuating functional capacity.[11]

6.14 The committee heard that the lifetime cap on home modifications is counterproductive to the goal of ageing in place. Rather than supporting people to remain living in their homes and communities as their needs change, the cap risks cutting off access to essential supports when they are most needed. The committee was warned that this could result in older people being left in unsafe housing, experiencing preventable falls, or being forced into residential care earlier than necessary.[12] Mrs Julie Stacey, General Manager, Maroochy Home Assist, told the committee:

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8 Department of Health, Disability and Ageing, Assistive Technology and Home Modifications (AT-HM) scheme | Australian Government Department of Health, Disability and Ageing, (accessed 13 May 2025).

9 Australian Association of Gerontology, *Submission 122*, p. 10. See also Kirinari, *Submission 23*, [p. 4]

10 Assistive Technology Suppliers Australia, *Submission 103*, p. 12.

11 Assistive Technology Suppliers Australia, *Submission 103*, p. 12.

12 Victorian Sector Support and Development Partnership, *Submission 69*, p. 40. See also Tasmanian Department of Health, *Submission 42*, p. 2. See also Australian Rehabilitation and Assistive Technology Association, *Submission 78*, [p. 2.].

> I … strongly advocate for the removal of the $15,000 lifetime cap on home modifications and a move to a needs based, clinical model. The proposed $15,000 lifetime cap on home modifications is a critical risk. Many older Australians need staged modifications over time as their conditions progress. A single bathroom renovation can exhaust the entire cap, leaving people without access to ramps, rails or stair solutions later in life—ultimately, pushing them prematurely into residential care.[13]

6.15 The committee heard concerns regarding the flow-on impacts for the broader health and aged care system. Where home modifications cannot be accessed in a timely and adequate way, there is increased pressure on hospitals and residential aged care, including longer hospital stays due to unsafe discharge environments and delayed discharge while patients await access to residential care.[14]

6.16 Further, the lifetime cap on home modifications under the SAH Program 'risks limiting access to appropriate supports over time, particularly for people with progressive conditions or complex needs and where there may be greater wear and tear due to environmental factors.[15]

6.17 The cap also introduces new inequities for particular cohorts including:

- those with progressive or degenerative conditions who require multiple stages of modifications;
- those in older and lower-cost housing that require major structural or remediation work to support modifications;
- low-income households; and
- multigenerational households that need to accommodate the safety and functional requirements for multiple members of the household.[16]

6.18 The Australian Nursing and Midwifery Federation (ANMF) told the committee that the 'lifetime cap on high-tier home modifications presents foreseeable equity and safety risks'. It submitted:

> Ageing-in-place involves cumulative and progressive needs, particularly for people with frailty or degenerative conditions. A significant proportion of older Australians reside in housing constructed prior to contemporary accessibility standards, increasing the likelihood that multiple modifications

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13 Mrs Julie Stacey, General Manager, Maroochy Home Assist, *Committee Hansard*, Brisbane, 16 February 2026, p. 29.

14 Victorian Sector Support and Development Partnership, *Submission 69*, p. 40.

15 Northern Territory Government, *Submission 2*, p. 1. See also Local Government NSW, *Submission 112*, p. 10.

16 Australian Association of Gerontology, *Submission 122*, p. 10. See also Occupational Therapy Australia, *Submission 43*, p. 5; IRT, *Submission 28*, p. 2.

> will be required over time (Australian Bureau of Statistics housing stock data, 2021).[17]

6.19 ATSA similarly told the committee that 'arbitrary lifetime limits and narrow definitions risk shifting costs rather than reducing them'. ATSA explained:

> When essential modifications cannot be completed or must be rationed, the likely downstream impacts include increased falls, greater reliance on formal services and unpaid carers, avoidable hospital presentations, and earlier transition to residential care.[18]

6.20 ATSA contrasted this approach with needs-based funding which 'can cover major modifications, follow-up adjustments, and maintenance' which is 'more likely to deliver the intended outcomes and reduce whole-of-systems costs'.[19]

6.21 Submitters expressed concern regarding the wellbeing of older Australians who expend their funding on home modifications, but require additional modifications as they age or as their health changes. For example, the National Aboriginal Community Controlled Health Organisation (NACCHO) noted that:

> A person might need a certain modification (e.g. railings) now, and then further modifications (e.g. ramps) as their mobility declines with age. If a person no longer has scope or budget to make further modifications, they may be pushed towards residential aged care before they require it, increasing cost to the aged care system.[20]

6.22 The Federation of Ethnic Communities' Councils of Australia (FECCA) noted that a survey of home modification professionals found that more than 10 per cent of projects exceed $15,000, particularly where structural changes are required. Further, providers report that major structural works frequently exceed $15,000, often costing $30,000–$50,000 or more.[21] Similarly, Juniper Aged Care submitted:

> Based on our experience, the true cost of delivering effective, safe home modifications is closer to $50,000, particularly for people with complex needs.[22]

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17 Australian Nursing and Midwifery Federation, *Submission 113*, p. 6.

18 Assistive Technology Suppliers Australia, *Submission 103*, p. 13.

19 Assistive Technology Suppliers Australia, *Submission 103*, p. 13.

20 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 11. See also Aged Rights Advocacy Service, *Submission 104*, p. 5; Assistive Technology Suppliers Australia, *Submission 103*, p. 12.

21 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 15. See also Ms Rebecca Sharkie MP, *Submission 96*, pp. 4–5; Ethnic Communities Council of NSW – SSD Coalition, *Submission 55*, p. 14; Mount Alexander Shire Council, *Submission 29*, p. 2; Queensland Health, *Submission 10*, p. 7.

22 Juniper Aged Care, *Submission 54*, p. 10.

6.23 Dementia Australia highlighted that 'the needs of people with dementia can change rapidly and unpredictably'. As such, 'access to a range of home modifications over time must reflect these changing and progressing needs, including safety equipment, bathroom modifications, mobility supports, sensor technology, and environmental adaptations'. Of concern, the cumulative costs of such modifications over time would exceed $15,000, 'particularly given that authorised suppliers often charge more than private providers'.[23]

6.24 The Australian Association of Gerontology (AAG) also noted lengthy waiting times for occupational therapist assessments for home modifications, and stated that 'long waiting times may mean needs become more urgent or more complex, raising costs and accelerating cap exhaustion'. It also raised concern that:

> It is unclear how people are supported when the cap is reached, introducing the real risk that individuals will dangerously delay or avoid modifications that are necessary for their safety and wellbeing.[24]

6.25 The ANMF argued that the lifetime cap 'incentivises delay in essential modifications, increasing falls risk, injury, and functional decline, while shifting costs to hospitals and emergency services'. It noted that 'falls remain one of the leading causes of preventable injury-related hospitalisations among older Australians, and delayed environmental modification is a recognised contributor to this risk'.[25] Juniper Aged Care noted that:

> … according to the Australian Institute of Health and Welfare, falls are the leading cause of hospitalised injuries and injury deaths among older Australians, making up 77% of all injury hospitalisations and 71% of injury deaths in this age group.
>
> In 2019–20, falls among people aged 65 and over resulted in:
>
> - 133,000 hospitalisations; 3,228 per 100,000 population
> - 5,000 deaths; 122 per 100,000 population
> - 2 in 3 falls hospitalisations were for females.[26]

Regional and remote communities

6.26 The committee heard that the lifetime cap is particularly unsuited for service provision in regional, remote and very remote communities. Mr John Cain, Chief Executive Officer, North and West Remote Health (NWRH), told the committee that $15,000 'will be exhausted at the drop of a hat for anything to do with home modifications in any sector in rural and remote areas'. Mr Cain expressed concern that older Australians will be unable to do so. Mr Cain stated:

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23 Dementia Australia, *Submission 115*, p. 8.

24 Australian Association of Gerontology, *Submission 122*, p. 10.

25 Australian Nursing and Midwifery Federation, *Submission 113*, p. 6.

26 Juniper Aged Care, *Submission 54*, p. 11.

> Whatever the cap, if a person needs a home modification and the building or renovation costs come in at $20,000—and they're expected to pay the $5,000 to achieve that—the likelihood of them achieving that is probably next to zero; they'll fall out of it for sure. They need that money for food—bread and milk—and electricity and all the other costs associated with general living. They'll do without the care they need and they'll end up back in hospital for sure.[27]

6.27 NWRH, a not-for-profit community health organisation delivering primary health, allied health and in-home aged care services across remote and very remote Australia, raised particular concern about the impact of the cap on clients in remote and very remote regions. It submitted that for clients in MM 6 or 7 areas the cap does not account for issues such as:

- high allied health assessment costs, including extensive travel times and expense to attend clients in remote locations;
- multiple assessment iterations required to balance clinical need with restrictive funding limits;
- freight costs for large equipment, which can reach several thousand dollars per item; and
- the condition of remote housing stock, which is often older and unsuitable and therefore requires more extensive modification.[28]

Box 6.1 Remote costs case study

An Occupational Therapy assessment for a client living several hours from town, such as a Birdsville client serviced from Mount Isa, may involve a full day of travel, assessment and reporting at rates exceeding $300 per hour. When combined with freight and installation costs, the $15,000 cap may be exhausted before future decline, progression of frailty or additional safety needs are addressed.[29]

6.28 The National Aboriginal Community Controlled Health Organisation (NACCHO) also argued that the remoteness supplement of 50 per cent is also insufficient to meet the increased costs of building in regional and remote areas.[30]

6.29 NACCHO explained that 'housing repair and maintenance activities in remote areas cost between 1.4 to 4.5 times the equivalent activity in mainstream public

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[27] Mr John Cain, North and West Remote Health, *Committee Hansard*, Brisbane, 16 February 2026, p. 26.

[28] North and West Remote Health, *Submission 121*, [p. 5]. See also Local Government NSW, *Submission 112*, pp. 11.

[29] North and West Remote Health, *Submission 121*, [p. 5].

[30] National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 11.

housing – but specific items can be up to 47 times higher in remote communities'. NACCHO explained that this is due to:

- increased cost of materials due to distance from manufacturers/sources;
- high costs of transporting materials to remote building sites – including long distances, crossing bodies of water and/or other difficulties;
- a shortage of local trades people and high costs of external labour. In some parts of Australia, labour costs are also affected by having only a 6-7 month construction season due to climate issues;
- a lack of competition; and
- greater costs of infrastructure – there is poor economy of scale in purchasing as costs must be divided across a relatively low number of residents compared with urban and regional centres.[31]

6.30 The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) described this as the 'remote tax'. It stated that the transport of building materials, travel and accommodation for specialised trades, and project management costs can consume between 40 and 60 per cent of the available budget before any construction work commences.[32]

6.31 NACCHO also noted that:

> The Australian Bureau of Statistics has calculated that from September quarter 2020 and June quarter 2024, the price of building construction increased by 31%. It appears as though the lifetime cap will not increase with the cost of building.[33]

6.32 The Aboriginal Health Council of South Australia (AHCSA) told the committee that the lifetime 'cap will disproportionately impact older Aboriginal and Torres Strait Islander people, who make up a significant proportion of residents in remote and very remote areas living with housing insecurity'. AHCSA noted that due to the thin market for trades in remote and very remote areas, government funded projects are 'often charged at much higher rates than normal work'. It also submitted that:

> The wait times to access these services often mean that people pass away by the time home modification projects have been approved; these wait times will be exacerbated by the additional administrative work required to secure supplementary funding.[34]

6.33 NATSIAACC also noted that many Elders and Older People live in multi-generational and kinship households where modifications must be more robust, durable, and fit for shared use'. As a result, 'modifications often require greater

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31 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 11.

32 National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Submission 27*, p. 13.

33 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 11.

34 Aboriginal Health Council of South Australia, *Submission 94*, pp. 5–8.

scale, high-quality materials, and in some cases, repeated intervention over time'. It submitted:

> The observed consequence of this policy setting is that Elders and Older People are left in unsafe or unsuitable housing or are forced to consider premature entry into Residential Aged Care, not because of clinical need, but because their home environment cannot be made safe within funding constraints. This outcome directly contradicts the stated objectives of the SaH reform, including prevention, independence, and ageing in place.[35]

6.34 The Aboriginal Health Council of South Australia (AHCSA) told the committee that where people are unable to remain at home due to insufficient funding for home modifications, many are forced into assisted living or residential care facilities that are not culturally safe for Aboriginal and Torres Strait Islander people. It submitted that 'this is a devastating and avoidable outcome for many Elders who would prefer to remain on Country, closely connected to their family and community'.[36]

6.35 The Northern Territory Government also noted that it has experienced an increase in demand for assistive technology and home modifications. It submitted that this is placing pressure on its Northern Territory Health Equipment Loans Program, which often 'acts as a provider of last resort when there are market gaps or service delivery limitations'. It concluded:

> There is a significant risk that introducing lifetime caps may increase pressure on hospitals and the need to access residential care services, as it does not support older people to age at home over time.[37]

Renters

6.36 The committee heard that the lifetime cap on home modifications is likely to have a significant impact on older Australians who live in privately rented properties. The Housing for the Aged Action Group (HAAG) explained that its research shows that:

> 77.6% of people in mortgaged households have lived in their current homes for 5 or more years, while only 39.9% of participants in private renter households have stayed that long, with 60% having moved in within the last 5 years, reflecting greater residential mobility.[38]

6.37 For older Australians who are homeowners, modifications such as grab rails, ramps and accessible bathrooms are usually a one-time investment likely to benefit them throughout their remaining years. For renters, all home modifications are lost when a tenancy ends – an older person could spend their

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35 National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Submission 27*, p. 14.

36 Aboriginal Health Council of South Australia, *Submission 94*, p. 8.

37 Northern Territory Government, *Submission 2*, p. 1.

38 Housing for the Aged Action Group, *Submission 117*, [p. 7].

entire $15,000 lifetime modification budget on a rental property but lose access if the landlord decides to sell or end the tenancy agreement.[39]

6.38 Anglicare Australia told the committee that:

> Renters often face barriers to installing permanent modifications and may need to repeat or adjust modifications if they move, through no choice of their own. Applying a lifetime cap in these circumstances effectively penalises people for housing insecurity and increases the risk that they will be unable to age safely at home.[40]

6.39 Older Australians who have to relocate will require the same modifications and under the lifetime cap, will either have to 'live in unsafe and unsuitable housing, or pay out of their own pocket for home modifications if they are able'.[41]

6.40 HAAG reported that it 'encounters many older renters who are already reluctant to request modifications because they fear increases or eviction'. It noted that:

> With limited housing options that are accessible and affordable across the country for people with disability and older people, there is stiff competition for the small number of houses that are accessible, close to amenities and are affordable. Many older people are struggling to find housing that meets their growing accessibility needs in the private rental market.[42]

6.41 HAAG argued that the lifetime cap will 'result in older renters living in unsafe properties, having knock-on effects for their health and wellbeing and likely resulting in injury or premature admission to residential age care'.[43]

Culturally and Linguistically Diverse Communities

6.42 The committee heard that the detrimental impact of the lifetime cap is likely to be felt disproportionately by the culturally and linguistically diverse (CALD) communities. FECCA told the committee that 'CALD older Australians are more likely to have lower superannuation balances, lower rates of home ownership and reduced financial resilience'. Providers have reported that CALD clients are 'far less able to self-fund beyond the cap and are therefore more likely to decline recommended works, even where risks of falls, injury or deterioration are high'. FECCA stated that:

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39 Housing for the Aged Action Group, *Submission 117*, [p. 7]. See also Uniting Communities, *Submission 33*, p. 4

40 Anglicare Australia, *Submission 62*, p. 7.

41 Housing for the Aged Action Group, *Submission 117*, [p. 7].

42 Housing for the Aged Action Group, *Submission 117*, [p. 7].

43 Housing for the Aged Action Group, *Submission 117*, [p. 7].

> In practice, the cap operates as a financial gatekeeper: those with means can adapt their homes and remain safely at home, while those without face unsafe living conditions or premature entry into residential care.[44]

6.43 FECCA told the committee that the impact of the lifetime cap is intensified in cultural and household contexts. Multigenerational living arrangements are common in many CALD communities and are 'often protective, enabling family care, cultural continuity and ageing in place'. However, modifications to shared spaces such as bathrooms, kitchens, doorways and common areas frequently exceed the $15,000 limit. Providers have reported that 'culturally normative living arrangements are effectively penalised, forcing households to absorb costs or forgo essential safety works'. FECCA argued that a 'funding rule that appears neutral embeds assumptions about nuclear households, disadvantaging culturally normative collective living arrangements'.[45]

6.44 Labour and market constraints further compound the inequitable impact of the cap on CALD communities. CALD-specialist providers have reported difficulties 'securing home modification professionals who can work effectively with culturally diverse households, particularly where understanding of spatial use, privacy, gender norms or religious practices is required'. FECCA noted that:

> Where culturally appropriate designs are not achieved at first assessment, redesigns and repeated assessments create implementation delays. Providers noted that these delays frequently undermine client confidence in recommended works, increasing the likelihood that modifications are deferred or abandoned altogether, especially where households are already facing financial constraints and uncertainty about exceeding the cap.[46]

6.45 FECCA concluded that the lifetime 'cap operates not as a neutral budget control, but as a structural barrier to safety, dignity and choice'.[47]

Concerns with the SAH Program

6.46 The committee heard concerns that the transition of the CHSP to the SAH Program may result in reduced practical access to assistive technology and home modifications due to the differences between the two programs.

6.47 National Seniors Australia (NSA) stated that 'the lifetime caps under SAH compare unfavourably with CHSP, which currently allows up to $15,000 per year for home modifications under the "Home Adjustments" category'. NSA submitted that:

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44 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 15. See also Ethnic Communities' Council of Victoria, *Submission* 57, p. 9.

45 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 16.

46 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 16.

47 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 16.

> There is a saliant question about what will happen to CHSP clients access to home modifications if CHSP is integrated into SaH. NSA is concerned that moving to a lifetime cap will increase consumer contributions and may deter older Australians from undertaking necessary home modifications.[48]

6.48 ATSA similarly raised concern that if Tier 1 is treated as the default pathway for entry on to the SAH Program for CHSP participants then the $500 annual cap on assistive technology 'may not provide continuity with current CHSP access settings' and 'may require people to delay purchases, ration essential items, or seek escalation to higher tiers for commonplace supports'.[49]

6.49 ATSA also highlighted the importance of older people not experiencing any disruption in their ability to access aids, equipment and assistive technology due to the safety-critical and time sensitive nature of such supports. As such, the transition of the CHSP to the SAH Program must 'include clear continuity arrangements for all existing CHSP participants'. ATSA argued that:

> Older people should not be required to wait for a full Support at Home package allocation, navigate new administrative processes, or undergo unnecessary reassessment simply to maintain access to essential equipment.[50]

6.50 Anglicare Australia told the committee that its concerns regarding the lifetime cap are compounded by new settings limiting the accumulation of unspent funds to $1000 or 10 per cent of a participant's quarterly budget. It stated that 'these restrictions, when combined with a lifetime cap, significantly reduce flexibility and limit the effectiveness of home modification supports'.[51]

6.51 Community Industry Group also noted reports from providers who have advised that some AT-HM Scheme clients are only offered interim funding (a minimum service offer) at only 60 per cent of a client's assessed classification, which is often less care than staying on their previous transitioned Home Care Package level or remaining with CHSP.[52]

6.52 Community Industry Group similarly expressed concern regarding limitations with the assessment and funding systems which are contributing to delays in care delivery under the AT-HM Scheme. It stated that:

> Across the sector, it is increasingly reported that clients are being approved and assigned AT-HM funding while their Support at Home Level is still

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48 National Seniors Australia, *Submission 87*, p. 5.

49 Assistive Technology Suppliers Australia, *Submission 103*, p. 7. See also Advance Ageing Western Australia, *Submission 89*, pp. 9–10.

50 Assistive Technology Suppliers Australia, *Submission 103*, pp. 7–8.

51 Anglicare Australia, *Submission 64*, pp. 7–8. See also Community Industry Group, *Submission 59*, p. 11.

52 Community Industry Group, *Submission 59*, p. 12.

> pending. This creates untenable situations for providers, who must either choose to decline these clients, leaving our vulnerable older Australians without approved essential home modifications or assistive technology, or accept these clients without an assigned Support at Home level, causing the provider to absorb ongoing onboarding and implementation costs for the client's care.[53]

6.53 Anglicare Australia also expressed concern regarding what it called 'emerging delays in the approval processes'. It submitted that while the intent of the AT-HM Scheme 'is to improve efficiency and consistency, delays in approvals are already creating challenges for participants and providers'. Further, without action to streamline processes, increased demand following the transition of the CHSP to the SAH Program 'risks exacerbating bottlenecks and further delaying access to essential modifications'.[54]

6.54 The committee also heard concerns regarding the impact of means-tested client contributions required under the AT-HM Scheme. Whiddon, a not-for-profit aged care organisation with almost 80 years of experience supporting older Australians across metropolitan, regional and remote NSW and QLD, told the committee that, under the SAH Program, assistive technology and home modifications are delivered through capped funding tiers and generally attract a means-tested client contribution for the independence component, while clinical assessment and prescription services are fully government-funded. It explained that:

> This represents a material shift from the previous Home Care Packages arrangements, where contributions were primarily based on income and paid at a daily rate, and where equipment and home modifications were usually funded from the person's package budget without a separate per-item co-payment. The new approach also introduces a higher lifetime cap on non-clinical contributions, increasing potential out-of-pocket costs over time for people entering the system under the new arrangements.[55]

6.55 Whiddon explained that 'in practice, this means some clients, including full Age Pension recipients, may now be required to make a direct financial contribution toward essential home modifications'. It submitted:

> The contribution ranges from five to fifty per cent, dependent upon the client circumstances. In reality, a fifteen thousand dollar home modification or piece of equipment will result in a client paying anywhere from seven hundred and fifty dollars to seven thousand five hundred dollars. This may be simply out of reach for many clients leading some to decline support … Under the former Home Care Packages model, the same items were commonly funded from available package balances, with no upfront

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53 Community Industry Group, *Submission 59*, p. 11.

54 Anglicare Australia, *Submission 64*, p. 8.

55 Whiddon, *Submission 36*, p. 3.

> payment or co-contribution required at the point of installation when funds were available.[56]

Recommendations

6.56 The committee heard a range of recommendations in relation to the AT-HM Scheme. These are outlined below.

6.57 The City of Greater Geelong recommended that the AT-HM lifetime cap on home modifications be modified. It submitted that the Australian Government should introduce 'clinical needs-based extensions (with credentialed prescribing and quality controls), and regional price loadings to reflect higher delivery costs'.[57] NWRH similarly recommended the cap be geographically adjusted with an index for remoteness, and an exemption from the cap for assessment, travel and freight costs.[58]

6.58 Likewise, the Local Government Association of South Australia called for the adoption of:

> A flexible, needs-based funding model for home modifications - with increased or removed caps, hardship exemptions, and indexation - to ensure all older people can access the essential home adjustments required to live safely at home.[59]

6.59 The ANMF offered its support for 'replacing rigid lifetime caps with a clinically led, needs-based access model supported by clear guardrails, independent clinical review, and periodic reassessment'.[60]

6.60 The AAG argued that 'funding allocations and eligibility should be independent of when someone enters the aged care system. Needs, not location or dwelling-type, should determine the level of home modifications support available'. It also submitted:

> We recommend that the CHSP and SAH home modifications schemes be reviewed, and the modelling underpinning the allocation of the $15 000 lifetime cap under SAH be compared for adequacy and efficiency against data examining regional and case specific budget differentials.[61]

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56 Whiddon, *Submission 36*, pp. 3–4.

57 City of Greater Geelong, *Submission 9*, p. 7. See also Local Government NSW, *Submission 112*, p. 11.

58 North and West Remote Health, *Submission 121*, [p. 5].

59 Local Government Association of South Australia, *Submission 109*, p. 19. See also Australian Rehabilitation and Assistive Technology Association, *Submission 78*, p. 2; Anglicare Australia, *Submission 64*, p. 8.

60 Australian Nursing and Midwifery Federation, *Submission 113*, p. 6. See also RSL Australia, *Submission 81*, p. 3; Access Sydney Community Transport, *Submission 70*, p. 3; North and West Remote Health, *Submission 121*, [p. 5]; Victorian Sector Support and Development Partnership, *Submission 69*, p. 53; Australian College of Nurse Practitioners, *Submission 44*, [p. 4].

61 Australian Association of Gerontology, *Submission 122*, p. 10.

6.61 NACCHO argued that the lifetime cap on home modification costs should be 'abolished'.[62]

6.62 HAAG called for the lifetime cap to be removed for people in rental accommodation, or modify it to be a per-dwelling cap that resets if a person moves. HAAG also called for the establishment of a 'mechanism to transfer modifications (such as portable ramps) or compensate older renters for modifications they funded out of pocket when tenancies end'.[63]

6.63 ATSA made a series of recommendations in relation to reforming the AT-HM Scheme and these include:

- that the Australian Government provide clear national guidance on how low-cost assistive technology will be delivered through the AT-HM Scheme, including seamless integration of CHSP aids and equipment, appropriate product coverage, funding for wrap-around supports, and safeguards to ensure timely, needs-based access;[64]
- that all existing CHSP clients should retain uninterrupted access to aids and equipment during the transition to the SAH Program, through automatic eligibility under the mid-cost tier of the AT-HM Scheme, with no requirement to wait for package allocation or operate under a separate legacy stream;[65] and
- the abolition of the $15,000 lifetime cap on home modifications, and the establishment of a new funding framework for home modifications that is more responsive to individual needs and circumstances.[66]

6.64 Anglicare Australia similarly recommended that, prior to the transition of the CHSP to the SAH Program, the AT-HM Scheme should be 'reviewed and streamlined' to 'account for increased demand and reduce the risk of approval delays'.[67]

6.65 The Western Sydney Community Forum recommended that the $10,000 annual subsidy provided through the CHSP should be retained, rather than $15,000 under the SAH lifetime cap.[68]

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62 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 11.

63 Housing for the Aged Action Group, *Submission 117*, [p. 7].

64 Assistive Technology Suppliers Australia, *Submission 103*, p. 7. See also NovaCare Nursing, *Submission 4*, p. 33.

65 Assistive Technology Suppliers Australia, *Submission 103*, p. 8.

66 Assistive Technology Suppliers Australia, *Submission 103*, p. 13.

67 Anglicare Australia, *Submission 64*, p. 8.

68 Western Sydney Community Forum, *Submission 65*, p. 14. See also Ageing Australia, *Submission 21*, p. 10.

End-of-Life Pathway

6.66 The End-of-Life (EOL) Pathway is a short-term pathway under the Support at Home (SAH) Program. It supports participants who have been diagnosed with three months or less to live and wish to remain at home, by providing more funding to access in-home aged care services.[69]

6.67 On the EOL Pathway, an older person will have access to a budget of $25,000 over 12 weeks. If the older person requires services beyond 12 weeks, an urgent Support Plan Review can be undertaken to transfer the participant to an ongoing Support at Home classification.[70]

6.68 If funds remain after 12 weeks, these can be used up to the 16-week mark to support continuity of care.[71]

6.69 An older person is eligible to access the EOL Pathway if they meet the following criteria:

- a doctor or nurse practitioner advises estimated life expectancy of 3 months or less to live; and
- an Australian-modified Karnofsky Performance Status (AKPS) score[72] (mobility/frailty indicator) of 40 or less.[73]

6.70 Participants are also required to meet general entry criteria for accessing funded aged care services, including being aged 65 or over (age 50 or over for an Aboriginal or Torres Strait Islander person, or homeless, or at risk of homelessness).[74]

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69 Department of Health, Disability and Ageing, End-of-Life Pathway – fact sheet for doctors and nurse practitioners, (accessed 25 March 2026).

70 Department of Health, Disability and Ageing, End-of-Life Pathway – fact sheet for doctors and nurse practitioners, (accessed 25 March 2026).

71 Department of Health, Disability and Ageing, End-of-Life Pathway – fact sheet for doctors and nurse practitioners, (accessed 25 March 2026).

72 The AKPS score is a measure of an individual's overall performance status or ability to perform their daily activities. It is a single score assigned by a clinician based on observations of a patient's ability to perform common tasks relating to activity, work and self-care. An AKPS score of 100 signifies normal physical abilities with no evidence of disease. Decreasing numbers indicate a reduced ability to perform activities of daily living.

73 Department of Health, Disability and Ageing, End-of-Life Pathway – fact sheet for doctors and nurse practitioners, (accessed 25 March 2026).

74 Department of Health, Disability and Ageing, End-of-Life Pathway – fact sheet for doctors and nurse practitioners, (accessed 25 March 2026).

6.71 The EOL Pathway is designed to complement services received through states and territories, including palliative care services.[75]

Time limit and funding cap

6.72 The parameters of the EOL Pathway available under the SAH Program were widely criticised in evidence. In particular, it was argued that the time limit of 12 weeks (16 where funding permits), and the funding cap of $25,000 do not adequately recognise that end of life is complex and unpredictable. For example, the AAG submitted that:

> The EOL Pathway assumes a linear and predictable dying trajectory. The time window fails to reflect the complex and unpredictable EOL trajectories that many experience. People with unpredictable or slowly declining conditions may have care unnecessarily delayed or may outlive the 3-month window, resulting in loss of continuity of services.[76]

6.73 The fixed time limits for the EOL Pathway were described as 'inhumane, arbitrary and traumatising for both clients and frontline workers, with some CHSP providers characterising the approach as creating "funding deadlines to die by"'.[77]

6.74 End of life care needs and time limits are particularly unpredictable for people living with dementia as disease trajectory and symptomatology is variable. Dementia Australia noted that:

> Large cohort evidence shows that clinicians are reasonably accurate at identifying people with dementia who are imminently dying or likely to live more than a year but are poor at predicting intermediate survival of weeks to months.[78]

6.75 Dementia Australia concluded that the rigid time limits and capped funding of the EOL Pathway 'risk penalising individuals who outlive expected timeframes'.[79] The ANMF similarly noted that time or funding-limited end-of-life pathways risk service discontinuity, unsafe discharge, crisis escalation, and avoidable hospitalisation. It submitted that:

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[75] Department of Health, Disability and Ageing, End-of-Life Pathway – fact sheet for doctors and nurse practitioners, (accessed 25 March 2026).

[76] Australian Association of Gerontology, *Submission 122*, p. 11. See also Mount Alexander Shire Council, *Submission 29*, p. 4.

[77] Ethnic Communities Council of NSW – SSD Coalition, *Submission 55*, p. 15.

[78] Dementia Australia, *Submission 115*, p. 8. See also Australian and New Zealand Society for Geriatric Medicine, *Submission 24*, p. 4.

[79] Dementia Australia, *Submission 115*, p. 8.

> The ANMF has consistently advocated for holistic, person-centred end-of-life care that recognises clinical, psychosocial, cultural, and spiritual needs as inseparable components of safety and quality.[80]

6.76 The Inspector-General of Aged Care (Inspector-General) similarly noted that 'diagnosing dying is complex, prognoses are not always accurate and patient response is not always well understood'. As such, the:

> … small, but expected number of people receiving end-of-life care who outlive the 12-16 week prognosis should not be penalised in their last days of life. This is a process that requires medical supervision, not policy-imposed eligibility criteria.[81]

6.77 Some submitters outlined concerns regarding the impact of having to seek reassessment on older Australians and their families after outliving initial prognosis. NACCHO described the parameters of the EOL Pathway as 'unnecessarily cruel to those at the end of their life who live beyond the 16-week mark. It is unclear what is meant to be done in these occasions'.[82]

6.78 Palliative Care Australia (PCA) highlighted that people who outlive the 12 or 16 week timeframe would return to their ongoing SAH Program classification, with the option to request an urgent classification reassessment from the 12-week point. PCA explained that this scenario may present some flexibility for participants and aged care providers to expend the ongoing quarterly budget more swiftly than usual, to maintain a daily budget approximately equivalent to that provided by the EOL Pathway. It however noted that this 'administratively complex solution relies on extremely swift and responsive aged care reassessment processes'. PCA explained:

> Even if these processes work as intended to provide close to 'real-time' consideration of applications from Pathway participants, it remains a burdensome approach for older people and their families because it:
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> - requires an aged care reassessment of the needs of very frail older people who are close to death – a potentially invasive requirement even when handled with sensitivity.
> - creates avoidable uncertainty for older people, families and providers about continuity of supports and the budget available.

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80 Australian Nursing and Midwifery Federation, *Submission 113*, p. 6. See also Tasmanian Department of Health, *Submission 42*, p. 2.

81 Inspector-General of Aged Care, *Submission 26*, p. 6. See also Advance Ageing Western Australia, *Submission 89*, p. 10; RSL Australia, *Submission 81*, pp. 3–4; Flexi Care Inc, *Submission 41*, [p. 4].

82 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 12.

- demands that providers and older people make decisions about how to manage their ongoing quarterly budget based on the likely timing of their impending death.[83]

6.79 PCA noted that the requirement for reassessment is inconsistent with the requirements for those who enter residential aged care to receive palliative care. PCA explained that while those people are required to have a short prognosis of three months or less to live, they are able to receive this care for the remainder of their lifetime in the event they outlive their prognosis.[84]

Cultural preferences

6.80 Submitters argued that the time limits of the EOL Pathway are 'misaligned with clinical uncertainty and cultural preferences'[85] associated with palliative care. NACCHO noted that the cap on funding for the EOL Pathway does not recognise that 'there are many Aboriginal and Torres Strait Islander cultural practices that happen in end of life that require travel to Country, family and community'. As such, the EOL Pathway does not currently consider these additional costs.[86]

6.81 AHCSA told the committee that the failure to include or specify cultural support for Aboriginal and Torres Strait Islander people is of concern when 'considering the holistic understanding of healthcare – as well as death and dying – Aboriginal people, with strong links to land, community, kinship and spirituality'. Some Aboriginal and Torres Strait Islander people may prefer to pass away on Country and:

> For people living in rural and remote communities, additional consideration is needed for providing supports within these geographically isolated areas, including the cost and logistics of services on Country. Specific preferences for cultural practices may also be expressed, such as traditional medicine, music and food; the End-of-Life Pathway should ensure individual support plans and budgets can support culturally appropriate, person-centred care for Elders.[87]

6.82 AHCSA told the committee that putting time limits on the EOL Pathway is 'not a culturally safe practice that considers the emotional and spiritual impact on

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83 Palliative Care Australia, *Submission 105*, pp. 5–6. See also Suncare Community Services, *Submission 92*, [pp. 5–6].

84 Palliative Care Australia, *Submission 105*, p. 6.

85 Maroochy Home Maintenance and Care Association Trading as Maroochy Home Assist, *Submission 8*, [p. 2]. See also City of Greater Geelong, *Submission 9*, p. 7; North and West Remote Health, *Submission 121*, [p. 5].

86 National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 12.

87 Aboriginal Health Council of South Australia, *Submission 94*, p. 6. See also National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Submission 27*, p. 14.

Aboriginal and Torres Strait Islander patients, families and the broader community'.[88] NATSIAACC explained:

> Specific concerns were raised about the current 12-to-16-week limit for the EoL Pathway, which was viewed as reflecting a clinical, Western lens that does not align with Aboriginal and Torres Strait Islander understandings of dying, grieving, and transition. Members identified several structural barriers embedded in the pathway, including clinical gatekeeping requirements such as an Australia-modified Karnofsky Performance Status (AKPS) score of 40 or less and the need for a medical certificate indicating "three months to live." These requirements were described as culturally insensitive and exclusionary, particularly for Elders and Older People who prefer community-based care, traditional healers, or who have limited engagement with hospital-led diagnostic systems.[89]

6.83 FECCA also provided comprehensive evidence regarding the impact of the limits of the pathway on CALD communities. It explained that older members of CALD communities consistently report that 'end-of-life care is inseparable from spiritual preparation, family presence and culturally specific rituals', and that providers have identified that 'rigid eligibility criteria and time limits often conflict with culturally grounded end-of-life practices'.[90]

6.84 FECCA submitted that the single episode access rule has been identified as a critical risk. That is, where individuals outlive an initial prognosis, there is no mechanism for re-entry to the EOL Pathway when needs later escalate. Providers 'warned that this creates distress and loss of continuity at the point where trust and culturally relational care are most important'.[91]

6.85 Family carers play a central role in end-of-life care in many CALD communities with approximately 25-30 per cent of Australian carers being from CALD backgrounds. The majority of these carers are women who often provide intensive care while balancing employment and other caring responsibilities. Providers have reported that pathway funding is primarily oriented to the dying person with insufficient recognition of the support needs of family carers during intensive home-based end-of life care. FECCA emphasised carers:

> … frequently require culturally appropriate respite, counselling and psychosocial support to sustain care without undermining family roles. In the absence of such support, the burden of care is intensified, increasing the risk of carer burnout and crisis admission.[92]

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88 Aboriginal Health Council of South Australia, *Submission 94*, p. 6.

89 National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Submission 27*, p. 14.

90 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 17.

91 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 17.

92 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, pp. 17–18.

6.86 Other issues which negatively impact CALD communities include interpreter access to facilitate advance care planning, and access to culturally competent palliative care. FECCA concluded that:

> … evidence indicates that while the End-of-Life Pathway represents a significant reform, its current design risks reproducing inequity for CALD communities. Time-limited access, inconsistent interpreter provision and uneven cultural competence constrain the ability of CALD older persons to die with dignity and continuity.[93]

Clarification of alignment between programs

6.87 The Inspector-General noted that there is some confusion regarding whether existing Commonwealth Home Support Program (CHSP) clients who wish to access the EOL Pathway will have to leave the CHSP and move on the SAH Program in order to access the pathway. The Inspector-General stated:

> There is a lack of clarity as to what impact the transition from CHSP to Support at Home will have on CHSP clients seeking to access the End-of-Life Pathway, including the risk that requiring the individual to move on to Support at Home in order to access the pathway will create administrative burdens and confusion at what is an incredibly emotionally weighted juncture.[94]

6.88 Further, there is 'additional confusion regarding whether transferring to Support at Home will also result in the introduction of a less flexible and more expensive 'fee-for-service' co-contribution model'. The Inspector-General concluded by calling on the Australian Government to 'make this information publicly available and unambiguously clear'.[95]

6.89 The Ethnic Communities Council NSW–SSD Coalition noted that CHSP providers have reported encountering confusion and misunderstanding regarding eligibility for the EOL Pathway, and consequently clients and families may be missing out on clinical support.[96] This was echoed by Queensland Health who noted that the EOL Pathway:

> … lacks prescribed timeframes for priority assessments or reviews. Some clients are not already linked with a provider when they enter the program, which can delay assessment. If assessments and the commencement of services for these clients are not prioritised, there is a significant risk that people may die before services begin, particularly given the requirement of an expected prognosis of three months or less.[97]

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93 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 18.

94 Inspector-General of Aged Care, *Submission 26*, p. 5.

95 Inspector-General of Aged Care, *Submission 26*, p. 5.

96 Ethnic Communities Council NSW – SSD Coalition , *Submission 53*, p. 15.

97 Queensland Health, *Submission 10*, p. 8.

6.90 The Australian Association of Gerontology recommended that 'the requirement for reassessment should be removed for those already receiving CHSP and seeking additional EOL support'.[98]

6.91 Juniper Aged Care expressed concern regarding the integration of the EOL Pathway with existing care arrangements. It noted that in states such as Western Australia end-of-life and palliative care is largely delivered through state-funded programs, with Silverchain the predominant provider. However, the SaH Program's single service model designates a main provider to manage a client's care funding and administration. Juniper Aged Care stated that:

> … these changes exacerbate long-standing issues with nursing under CHSP, where services are locked to one provider and providers cannot respond flexibly when clients develop acute or complex needs, despite clear demographic shifts toward higher acuity in the community.[99]

6.92 Juniper Aged Care argued that while 'the reforms emphasise consumer choice, in practice choice is being stripped away, with customers unable to retain their preferred clinicians (such as physiotherapists) and forced through third-party arrangements'. As such:

> This is inconsistent with the principles of the new Aged Care Act which places an emphasis on individual care and the right to choose. The Act states older people have the right to make decisions about their own life, including the care and services they receive.
>
> Without greater flexibility, genuine choice, and better integration with state-funded end-of-life care, the new pathway risks poorer outcomes for people at the end of life and increased reliance on hospital care.[100]

6.93 The Tasmanian Department of Health also called for close alignment between the EOL Pathway and services provided by state and territory governments. It submitted:

> As the Department also provides end of life support for people of all ages in Tasmania, it is essential that the aged care system and the Department's end of life services work together to support people at a particularly vulnerable time. Without this collaboration, individuals may face unintended consequences when transitioning between care systems, including disruptions to the delivery of care.[101]

Other concerns

6.94 Concern was also expressed in relation to whether providers are able to deliver the type of care required under current funding models. The AAG noted that 'EOL care requires rapid response visits, experienced staff, more hours per

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98 Australian Association of Gerontology, *Submission 122*, p. 5.

99 Juniper Aged Care, *Submission 54*, p. 12.

100 Juniper Aged Care, *Submission 54*, p. 12.

101 Tasmanian Department of Health, *Submission 42*, p. 3.

week, and often overnight or weekend availability' and suggested that 'many providers cannot deliver this under current funding models that do not support sufficient staffing levels'.[102]

6.95 The AAG also expressed concern that there 'remain evidence gaps in national reporting on community-based palliative care use and non-hospital costs, which limit evidence-based service planning and design'.[103]

6.96 Dementia Australia also highlighted a lack of data available on the adequacy of the funding cap and time limits on existing SAH Program participants and recommended that such data be made available prior to applying these parameters to transitioning CHSP clients.[104]

6.97 NACCHO told the committee that accessing the EOL Pathway is 'difficult, time-consuming and distressing to secure'. NACCHO detailed the experiences of a palliative client:

> … we have had to jump through so many hoops with him. We filled out the form with the GP, and he's had to sign another document, and have another assessment, then he needs an income assessment with Services Australia. By that point, by the time we've got all of this sorted he'll be so close to dying…. It's just awful.[105]

6.98 NACCHO recommended that the process for applying for the EOL Pathway be significantly simplified, and that funding and time limits should be increased.[106]

Recommendations

6.99 The committee received a number of recommendations to either remove the 12–16 week time limit or make provision for the EOL Pathway to be extended as required.

6.100 The Inspector-General highlighted that, in the Inspector-General's 2025 *Progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety*), she recommended the removal of the 16-week maximum for delivery of care to better align with recommendations of the Royal Commission into Aged Care Quality and Safety.[107]

6.101 The Local Government Association of South Australia similarly called for the Australian Government to 'replace the rigid 12-week palliative care limit with a

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[102] Australian Association of Gerontology, *Submission 122*, p. 11.

[103] Australian Association of Gerontology, *Submission 122*, p. 11.

[104] Dementia Australia, *Submission 115*, p. 9.

[105] National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 12.

[106] National Aboriginal Community Controlled Health Organisation, *Submission 118*, p. 12.

[107] Inspector-General of Aged Care, *Submission 26*, p. 6. See also Anglicare Australia, *Submission 64*, p. 8; Meals on Wheels Australia, *Submission 61*, [p. 7].

flexible, needs-based model that ensures continuous support throughout the end-of-life period and prevents distressing gaps in care for families and clients'.[108]

6.102 The Royal Australasian College of Physicians (RACP) and its Australasian Chapter of Palliative Medicine told the committee that it has 'key concerns regarding' the implementation of the EOL Pathway. These concerns include ensuring that personal care services are fully subsidised for those receiving palliative care; budget flexibility allowing those with life-limiting illness to carry over funds to manage fluctuating care needs; the need for fast-track assessments for people at the end of life to access the full entitlement without delay; and ensuring that the EOL Pathway has a flexible needs-based approach rather than rigid eligibility timeframes.[109]

6.103 The RACP noted it has had discussions with the Department of Health, Disability and Ageing (the Department), and received assurances that the department will be closely monitoring the EOL Pathway implementation. It however submitted, 'we continue to have concerns that, due to the limitations of the current policies for the EOL Pathway, the implementation of these policies will lead to poor outcomes for individuals'. It recommended that:

> … the Committee consider the removal or an extension of the time limit on the EOL Pathway funding, so people do not have services decreased or withdrawn completely at the very time they need it most.[110]

6.104 PCA called on the Department to commission an 'independent evaluation of the impact of prognosis-based eligibility criteria on access to palliative care pathways, in both home care and residential care – as recently recommended by the Inspector-General for Aged Care'. It also called on changes to be made to the Aged Care Rules to ensure that EOL Pathway participants can access continuity of aged care funding and supports for the duration of their lifetime including:

- an exemptions process to the 12 week limit and/or
- removing the maximum 16 weeks cap on participation in the pathway.[111]

6.105 Ageing Australia agreed with other submitters who called for the replacement of a time limited EOL Pathway with 'flexible, clinically guided periods' and also

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[108] Local Government Association of South Australia, *Submission 109*, p. 19. See also Benetas, *Submission 34*, p. 2; Mount Alexander Shire Council, *Submission 29*, p. 3.

[109] Royal Australasian College of Physicians, *Submission 5*, p. 1.

[110] Royal Australasian College of Physicians, *Submission 5*, p. 2. See also City of Greater Geelong, *Submission 9*, p. 7.

[111] Palliative Care Australia, *Submission 105*, p. 7. See also Ms Rebecca Sharkie MP, *Submission 96*, p. 5; Anglicare Australia, *Submission 64*, p. 9.

made additional suggestions including a rapid streamlined assessment process that would guarantee activation within 48-72 hours.[112]

6.106 Queensland Health suggested that those who require support beyond the time and budget constraints of the EOL Pathway be 'seamlessly transitioned to a higher level SAH Program plan without service interruptions, reassessment delays or cessation of essential care during this critical time in the person's end of life journey'. It noted that a reassessment could still occur over time but should not prevent those on the pathway from receiving immediate high-level care while their needs are being reviewed'.[113]

6.107 FECCA stated that for the EOL Pathway to 'meet its equity objectives, it must accommodate non-linear dying trajectories, guarantee language access, support family carers and treat cultural competence as core infrastructure'.[114] NATSIAACC similarly called on the EOL Pathway to include flexibility for Aboriginal and Torres Strait Islander Elders and Older People that is informed by cultural practice and community need.[115]

Government announcement

6.108 In the May 2026 budget, the Australian Government announced that it is changing the EOL Pathway to provide a second round of funding for participants who live beyond the initial 12-week funding period. This change will commence from early 2027.[116]

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112 Ageing Australia, *Submission 21*, pp. 10–11.

113 Queensland Health, *Submission 10*, p. 8.

114 Federation of Ethnic Communities' Councils of Australia, *Submission 102*, p. 18.

115 National Aboriginal and Torres Strait Islander Ageing and Aged Care Council, *Submission 27*, p. 15.

116 Department of Health, Disability and Ageing, End-of-Life Pathway | My Aged Care, (accessed 9 June 2026).

Chapter 7
Committee view and recommendations

7.1 The genesis of this inquiry lies in the findings of the committee's *Aged Care Service Delivery* report tabled in October 2025. That inquiry identified a number of topics which required additional examination by the committee including: whether the provisions for home modifications and the End-of-Life Pathway (EOL Pathway) under the Support at Home Program (SAH Program) are sufficient; and the preparedness of the Australian Government, service providers and older Australians for the transition of the Commonwealth Home Support Program (CHSP) to the SAH Program.

7.2 Though this inquiry has a particular focus on the above topics, the committee is acutely aware of the broader context of an aged care sector in crisis. The SAH Program has not delivered the reduction in waiting times for either assessment or receipt of care, and older Australians continue to die before receiving the help they deserve, and to which they are entitled to receive. Its co-contribution model is punishing those who have higher care needs, and some older Australians are being forced to make unfair choices between the services they require.

7.3 The issues facing the SAH Program will be more deeply examined by this committee in its concurrent inquiry due to table on 24 November 2026; however, it is clear the Australian Government's proposal to transition an estimated 800,000 older Australians to a program that already has extensive wait times is going to result in further suffering and unnecessary deaths.

7.4 The Australian Government continues to fail on delivering on the recommendations of the Royal Commission into Aged Care Quality and Safety, and the proposal to transition the CHSP to the SAH Program is yet another step in the wrong direction.

7.5 It was also clear from the *Aged Care Service Delivery* inquiry that the price caps on home modifications, and the time and funding limits of the EOL Pathway would have horrifying consequences for older Australians. But the Australian Government chose to ignore the resounding evidence received in relation to these matters and proceed with them anyway. This inquiry has confirmed the ongoing concern in relation to these measures by experts, advocates and older Australians, and it is time for the Australian Government to start listening.

Transition of the CHSP

7.6 In 2024–25, the Australian Government provided $3.1 billion in CHSP grants to 1,273 providers making the CHSP one of the Australian Government's largest grant programs.

7.7 It is the foundational program supporting ageing-in-place for older Australians. The CHSP's block-funding model has allowed older people to readily access services from an array of providers as required. It also operates as the de facto service provider for thousands of older Australians languishing on waiting lists for the SAH Program (and Home Care Packages prior to November 2025).

7.8 The recent findings of the Auditor-General provided concerning evidence that despite its critical function in the aged care system, the Australian Government fails to undertake appropriate monitoring, modelling and reporting in relation to the CHSP. The Auditor-General found that the Department of Health, Disability and Ageing (the Department) does not collect enough information and use it to check whether the program is delivering well. In addition, the Department does not collect enough information and use it check whether people who are eligible for the program are able to get the services they need when they need them.

7.9 Despite advising the Australian Government about supply and demand pressures, and checking that providers are fully using their grant funding, the Auditor-General found that the Department does not have a good way to measure current or future demand for these services, nor does it plan well for increasing demand in the future. The Auditor-General also noted that the Department does not have good systems and data to calculate how long it is taking people to receive services, and does not interact enough with service recipients and providers in relation to their experiences with the program.

7.10 The Auditor-General stated that the Department will need to obtain more robust assurance over eligibility, unmet demand, provider sustainability, service delivery quality, and the achievement of objectives to effectively support the CHSP's transition to the SAH Program.

7.11 The findings of the Auditor-General were reflected in the evidence provided to the committee by service providers and advocates. These witnesses described the CHSP as being both vitally important but also chronically underfunded and neglected by successive governments. As such, service providers are being forced to do more with less; provide unfunded services to particularly vulnerable clients; close their books to new clients; and in some cases, exit the market entirely.

7.12 While the Australian Government stated that it accepted all nine recommendations of the Auditor-General, the committee notes that it also stated that the implementation of these recommendations will reflect any decisions of the government regarding the future direction and management of the CHSP. The committee notes that detail on such decisions is almost entirely absent from the public domain and from evidence given to this committee.

7.13 Service providers expressed considerable anxiety regarding the proposed transition of the CHSP to the SAH Program; a transition which appears to be so

utterly lacking in detail or planning that neither the Department, nor service providers could articulate what the future of the CHSP may be after 1 July 2027. The Australian Government does not appear to have undertaken sufficient consultation, modelling or planning for the proposed transition of a program that provides service to almost a million older, vulnerable Australians.

7.14 The Department appears to be relying on noting that the transition won't occur before 1 July 2027 as reassurance to those expressing anxiety that this date is rapidly approaching. This is alarming, disappointing, and entirely insufficient. Service providers require considerably more consultation, engagement, and information regarding the changes they will be experiencing and implementing in the future. A transition of this size cannot be done in an ad hoc manner. Lessons must be learnt from the introduction of both the National Disability Insurance Scheme (NDIS) and the introduction of the SAH Program.

7.15 The evidence provided by submitters that a transition of this size should take at least three to four years and ideally be staged in such a way that adjustments can be made in response to challenges which arise, is compelling.

7.16 While this inquiry does not intend to replicate the work of its concurrent inquiry into the operation of the SAH Program, this inquiry must acknowledge the many concerns witnesses have raised with the operation of the SAH Program since its introduction. The operation of the SAH Program has been significantly impacted by extensive waitlists for both the assessment for, and receipt of services. Uptake of, and satisfaction with, the SAH Program also appears to have been impacted by the co-contribution model which has seen older Australians paying more for services than they have in the past. Service providers also noted the technological, administrative and workforce impost of transitioning to, and gaining familiarity with, the new requirements of the SAH Program.

7.17 It is in this context that the committee is concerned that adding an additional almost one million older Australians to a program already struggling will lead to catastrophic outcomes for older Australians, and the broader aged care system. It is clear that the SAH Program must be given time to settle into place with a reduction in waitlists, and adjustments made to policy settings as required, before the transition of the CHSP is contemplated.

7.18 It is only with adequate consultation with the broader sector, and after the implementation of the modelling, reporting and monitoring recommended by the Auditor-General that any transition should begin to be planned. The committee is of the view that 1 July 2027 should serve as the starting date for planning and consultation rather than the starting date for transition.

Recommendation 1

7.19 The committee recommends the Department of Health, Disability and Ageing immediately implements the recommendations of the Auditor-General in the

Effectiveness of the Commonwealth Home Support Program **report tabled 14 May 2026. The implementation of these recommendations should not be conditional on any future decisions regarding the transition of the Commonwealth Home Support Program.**

Recommendation 2

7.20 The committee recommends that the Department of Health, Disability and Ageing commissions an independent cost-benefit analysis that examines the value of the CHSP against the cost of delivering aged care through other programs, including the Support at Home Program and residential aged care. This should also include analysis of the level of funding required to ensure that it is able to meet current and future demand. The final report of this cost-benefit analysis should be made public.

Recommendation 3

7.21 The committee recommends that the Department of Health, Disability and Ageing begin a consultation and co-design process in collaboration with service providers, advocacy groups, older Australians, state and territory governments, and experts regarding the future of the Commonwealth Home Support Program.

Funding models

7.22 While the Royal Commission into Aged Care Quality and Safety envisaged a single, combined aged care program, it crucially recommended the retention of the benefits of each of its component programs, delivering a demand-driven system predicated on assessed need.

7.23 As noted during the *Aged Care Service Delivery* inquiry, this committee had, and retains, serious concerns regarding the fee-for-service co-contribution model introduced by the SAH Program. The committee is further concerned, in the absence of information or reassurances from the Australian Government, that this model will replace the current block funding model for the CHSP after its transition into the SAH Program.

7.24 It is clear from evidence received by the committee that removing block funding would have catastrophic consequences for a range of service providers and ultimately older Australians. Block funding ensures the viability of service providers with funding to cover fixed costs like infrastructure, vehicles, and a trained workforce, ensuring services can continue regardless of attendance levels. Without this funding, service providers have indicated that they will have to exit the market leaving older Australians without necessary services.

7.25 The viability of CHSP providers is particularly important in thin markets where they play an essential role in connecting older people with their communities. In these markets there may only be a sole provider, or a small number of

providers, able to provide essential services. The impacts of thin markets are felt most acutely by Aboriginal and Torres Strait Islander people and it is vitally important that CHSP providers are supported in continuing to provide culturally safe and appropriate care.

7.26 Additional funding for thin market providers should be readily available to ensure their viability. The committee notes that such funding has been extended to providers under a grant system for SAH Program providers, but is of the view that automatic thin market funding should be applied to reduce the administrative burden on providers, and be extended to CHSP providers as required.

7.27 The committee also cannot ignore that underinvestment in the CHSP by successive governments has effectively led to block-funding capping participation. This is despite the CHSP being a cost-effective primary prevention program that enables more people to age in place and delays entry into more expensive forms of aged care including the SAH Program and residential aged care.

7.28 However, as noted above, the Australian Government does not appear to have adequate modelling, monitoring or reporting in place in relation to the CHSP that would identify both the benefits and challenges of the program, including the needs of thin market providers. As discussed above, this should serve as the starting point for any consideration of reform.

7.29 The committee is of the view that the future of the CHSP must be assured. This will only be achieved through collaboration and co-design, careful consideration of funding models and ensuring that reform is not rushed. This includes consideration of the operation of the Single Assessment System and the SAH Program in order to determine if a transition is desirable or even possible in the current operating environment.

Recommendation 4

7.30 The committee recommends that the Australian Government extend funding to the Commonwealth Home Support Program for an additional three years after July 2027 to allow time for consultation and co-design to occur. This additional time will also allow for the operation of the Single Assessment System and the Support at Home Program to be assessed in order to inform any future consideration of the transition of the Commonwealth Home Support Program.

Recommendation 5

7.31 The committee recommends that the Commonwealth Home Support Program be retained as a separate block-funded program, and not transitioned into the Support at Home Program.

Recommendation 6

7.32 The committee recommends that automatic thin market funding be provided via direct subsidy payments for eligible providers (replacing grant processes).

Home modifications

7.33 Home modifications are critical for older Australians wishing to age at home. They are essential in reducing hospitalisations and delaying or preventing residential aged care entry. Accessible housing also promotes quality of life, productivity, and reduces care costs for people with disability and mobility impairments.

7.34 It is therefore of serious concern to the committee that the Australian Government has implemented a lifetime cap on home modifications of $15,000. Such a cap is counterproductive to the goal of ageing in place. Rather than supporting people to remain living in their homes and communities as their needs change, the cap risks cutting off access to essential supports when they are most needed. This is going to place additional pressures on hospitals and residential aged care facilities as older Australians are unable to be discharged into unsafe home environments.

7.35 This lifetime cap is likely to acutely affect a number of cohorts including: those who live in rural, remote and very remote communities; those with degenerative conditions; renters; Aboriginal and Torres Strait Islander Elders and older people; Culturally and Linguistically Diverse older people. The committee is deeply concerned that older people in these communities will be left to suffer in unsuitable housing, or forced into hospitalisation or residential aged care.

7.36 The committee notes that this lifetime cap is not aligned with funding for home modifications under the CHSP which provides up to $15,000 per year. The committee is therefore concerned that any future transition of the CHSP to the SAH Program will see older people lose access to these higher funding amounts.

7.37 Reducing funding for home modifications does not represent a cost-saving measure for the Australian Government when older Australians will be forced to move to higher cost care options. Further, it is fundamentally in opposition to the principle of person-centred care – that is, people having the right to be safe, treated with dignity and respect, and receive high quality care and services.

7.38 Home modifications should be available on a needs-basis informed by clinical assessment, and there should be recognition that some sectors of the community will require additional flexibility and funding.

Recommendation 7

7.39 The committee recommends the Australian Government abolish the $15,000 lifetime cap on home modifications, and establish a new funding framework

for home modifications that is more responsive to individual needs and circumstances.

End-of-Life Pathway

7.40 The funding and time limits set on the EOL Pathway were widely criticised in evidence to this inquiry, and the *Aged Care Service Delivery* inquiry, as inhumane, arbitrary and traumatising for both older Australians, their families and carers and care providers.

7.41 While the committee welcomes the Australian Government's announcement in early May 2026 that a second round of funding is going to be made available for patients who live beyond 12 weeks, it is concerned that this won't be available until early 2027 potentially leaving many older Australians without access in the intervening time. In addition, there are few publicly available details regarding how this funding will be administered, and how much funding will be available for each recipient.

7.42 The committee is shocked and concerned that access to the EOL Pathway is single-use. That is, if a person outlives or recovers from their initial prognosis then they cannot access the Pathway again when it is required.

7.43 The committee notes that many witnesses including the Inspector-General of Aged Care advocate for the abolition of the time and funding limits placed on the delivery of care, and its replacement with a flexible, needs-based model that ensures continuous support throughout the end-of-life period and prevents distressing gaps in care for families and clients.

Recommendation 8

7.44 The committee recommends the Australian Government abolish the funding and time restrictions placed on the End-of-Life Pathway. The committee recommends the development of a flexible, clinically guided, needs-based model that provides funding for end-of-life care for older Australians wishing to receive care in their home.

Senator Penny Allman-Payne
Chair
Greens Senator for Queensland

Additional Comments - Labor Senators

1.1 The Albanese Labor Government is delivering once-in-a-generation reforms to Australia's aged care system— reforms that provide high-quality, world-class aged care services to the older Australians who built our communities and deserve a system that we can all be proud of.

1.2 Labor senators would like to express their thanks to those who contributed to the Committee's inquiry into the transition of the Commonwealth Home Support Program (CHSP) to Support at Home (SaH). In particular, we acknowledge the 131 individuals and organisations who made submissions to inform the Committee's work, as well as those who accepted invitations to attend and give testimony at its two public hearings in Canberra and Brisbane.

1.3 As was demonstrated by the evidence supplied to the Committee, the Commonwealth Home Support Program is highly valued for its role in providing entry-level community and home care services to over eight hundred and thirty thousand older Australians.

1.4 As a program funded through grant agreements with individual providers, the Commonwealth Home Support Program also ranks as of the largest grant programs administered by the Commonwealth— in the 2024/25 financial year, over $3.1 billion was provided through grants to over one thousand two hundred providers throughout the country, with these providers encompassing government, non-government and not-for-profit organisations.[1]

1.5 Whilst the value of the Commonwealth Home Support Program is clear and its role as the starting point in an older Australians aged care journey is important, it is also clear that improvements to the way the program operates are needed to ensure it continues to deliver those services older Australians need most in a manner that is both effective and efficient.

1.6 In 2021 the Royal Commission into Aged Care Quality and Safety shocked Australians with its damning assessment of an aged care system that was failing after nearly a decade of neglect under the Coalition. In their final report, Royal Commissioners the Honourable Tony Pagone QC and Lynelle Briggs AO made one hundred and forty-eight recommendations to improve the provision of aged care in Australia. They called for transformative change, for the establishment of a new rights-based system, for a person-centred aged care system that ensured older Australians were treated with humanity, dignity and

[1] Australian National Audit Office, *Effectiveness of the Commonwealth Home Support Program*, 14 May 2026, p. 5.

respect.[2] Their recommendations also called for the implementation of an entirely new Act of Parliament, with the Albanese Labor Government delivering on this recommendation with the commencement of the *Aged Care Act 2024* (Aged Care Act) on 1 November 2025. Most relevant to this inquiry, recommendation twenty-five called for the establishment of an aged care program that combined the Commonwealth Home Support Program with other home care programs.

1.7 As was noted in the Department of Health, Disability and Ageing's submission to the inquiry, since 2022 the Government has committed over $35.5 billion to improve safety, dignity and quality in aged care, with annual government spending on aged care is expected to double from approximately $25 billion in 2021-22 to approximately $50 billion in 2028-29.

1.8 The Albanese Labor Government has also acted to:

- Introduce mandatory care minutes and nursing requirements;
- Fund wage increases in aged care to attracted and retain more workers to the sector;
- Provide greater training and supported entry pathways to increase the capacity of the aged care workforce;
- Strengthen the Aged Care Quality Standards;
- Expand the oversight and enforcement powers of the Aged Care Quality and Safety Commission;
- Expand incident reporting to include home and flexible care; and
- Simplify access and better tailor services for older Australians through the new Single Assessment System.

1.9 Whilst Labor senators value the evidence that has been provided to the Committee and the genuine desire among relevant stakeholders to work together with government to strengthen Australia's aged care system, we do not accept the characterisation of the Government's reform efforts that pervades throughout the narrative of the Chair's report. We also regret that, at times, it appears there are some in the Parliament who are more concerned with using the committees of the Senate— and aged care policy generally— as a means to advance their own political objectives rather than to deliver positive public policy outcomes for our communities.

1.10 Labor senators acknowledge that many of those who contributed to the Committee's inquiry expressed a desire for a greater degree of certainty about what the future of the Commonwealth Home Support Program and its relationship with Support at Home might be. In doing so, we also acknowledge the very clear and repeated commitments from the Government that the

[2] Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect, Vol. 3A: The new system*, p. 19.

Commonwealth Home Support Program will not become part of Support at Home before 1 July 2027. As was explained during the Committee's hearing on 6 February 2026 by the Department of Health, Disability and Ageing's Deputy Secretary, Ageing and Aged Care Group, Ms Sonja Stewart, this does not equate to the transition occurring on 1 July 2027:

> That announcement was quite specific in terms of it being no earlier than 1 July 2027. So, I do understand that there might be questions around that date as 'starting from' 1 July 2027. However, it was quite clear that it was 'no earlier than'.[3]

1.11 The Albanese Labor Government's reforms to aged care are generational, because they need to be—the system Labor inherited from the Coalition upon coming to office was quite simply, and quite disgracefully, broken. Labor senators know that generational reform of this type doesn't happen in a single moment, rather it is a long-term effort that requires decision-making that is careful and considered.

1.12 Labor senators agree that there is a need for Government to communicate what the future of the Commonwealth Home Support Program and its relationship with Support at Home will be, in a timely way. Throughout the reform process, the Government has been clear with older Australians, their families, providers and the workforce about the nature of its reforms, their implications, and what they will mean for the lives of older Australians— we are confident that this approach will continue.

1.13 We also acknowledge that while the Government is considering the future of the Commonwealth Home Support Program, it has put in place the funding and support that providers of aged care services through the program need to continue to deliver their important services to older Australians and to keep them connected to their communities. Commonwealth Home Support Program grant agreements are in effect from 1 July 2025 to 30 June 2027 with annual indexation, payments to providers in arrears and a National Unit Price Range for most service types continuing to apply during the two-year grant funding period.

1.14 It is the view of Labor senators that, whilst Government decision-making processes take their course, individuals or organisations would be well advised not to make assumptions about what any future arrangements might be. We also agree that it is important that the Government takes the time to get the settings right, so as to best deliver on the systemic changes the Royal Commission said we so desperately needed.

1.15 Labor senators point out that at each stage of its ambitious reforms the Albanese Labor Government has engaged closely with older Australians, listening to

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[3] Ms Sonja Stewart, Deputy Secretary, Department of Health, Disability and Ageing, *Proof Committee Hansard*, Canberra 6 February 2026, p. 32.

them and responding to their experiences. As the Chair's report notes, since the commencement of the Aged Care Act on 1 November 2025, the Government has responded to a number of concerns that have arisen by making system changes to ensure the system delivers on the needs of older Australians, for example by changing the way that personal care is treated under Support at Home and by extending End-of-Life Pathway arrangements. These and other actions, such as exempting payments made to survivors through the Stolen Generations Redress Scheme from resident aged care means testing assessments, are all signs of a government that is going about the task of reform in a manner that is careful, considered and methodical, and which also has the interests of the older Australians at its centre.

1.16 In acknowledging the Government's commitment to listening to older Australians and responding to their experiences as it rebuilds Australia's aged care system after nearly a decade of neglect under the Coalition, Labor senators hope this inquiry has been of value to the Government in considering what the future of the Commonwealth Home Support Program might be. We also support the broad intent of the recommendations, including the importance of a robust community-based support scheme and the need to ensure providers are afforded sufficient time to prepare for any future transition.

1.17 It is our view that, while there are aspects of the Commonwealth Home Support Program that need improvement, it is fundamentally an important and valuable program that provides older Australians with access to the entry-level care they need to continue living their lives with independence and dignity. As was noted by the Minister for Health and Ageing, the Honourable Mark Butler MP at a recent speech to the National Press Club:

> Dignity in older age— through a world class aged care system— is the least our parents and grandparents deserve.[4]

1.18 Nonetheless, it is important the Government consider in detail what changes are necessary to ensure the Commonwealth Home Support Program is sustainable and delivers the care needs of older Australians in an equitable way. In testimony given to the Committee by Chief Executive Officer of the Council on the Ageing, Ms Patricia Sparrow:

> There are definitely positives of the CHSP program, like the range of different services that you can get, like that it's got a localised base and there's great community involvement, but there are still negatives.[5]

1.19 Labor senators encourage the Government to consider the evidence this inquiry has received, the findings of the Australian National Audit Office on the effectiveness of the Commonwealth Home Support Program (which have been

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4 The Honourable Mark Butler MP, National Press Club, (accessed 20 June 2026).

5 Ms Patricia Sparrow, Chief Executive Officer, Council on the Ageing, *Proof Committee Hansard*, Canberra 6 February 2026, p. 9.

made public since the commencement of the inquiry) and the experiences of older Australians, as it takes the time determine the future design of this important program, whilst continuing to ensure providers have the confidence they need to deliver services without any changes to the model in the near term.

Senator Dorinda Cox
Deputy Chair
Labor Senator for Western Australia

Senator Michelle Ananda-Rajah
Labor Senator for Victoria

Senator Karen Grogan
Labor Senator for South Australia

Additional Comments - Coalition Senators

1.1 Coalition Senators thank all individuals, providers, peak bodies and stakeholders who contributed to this inquiry. The evidence received reinforced the critical role the Commonwealth Home Support Programme (CHSP) plays in supporting older Australians to remain living independently in their homes and communities.

1.2 Coalition Senators note that this inquiry was necessary because of the significant uncertainty created by the Albanese Labor Government regarding the future of CHSP or any block funding opportunities for aged care services. The Government has provided little detail about the future program or any replacement beyond 1 July 2027, creating concern for older Australians who rely on CHSP services and providers who require long-term funding certainty to plan services, retain staff and ensure continuity of care.

1.3 Evidence received by the Committee consistently demonstrated that CHSP remains a highly valued and effective program in the aged care system. Submissions highlighted the program's ability to provide timely access to entry-level supports, reduce social isolation, help older Australians maintain independence, and delay or prevent the need for more intensive and costly care.

1.4 The overwhelming evidence presented to the inquiry demonstrated that CHSP, and its block funding model in particular, serves a distinct purpose within the aged care system. Submissions repeatedly raised concerns that the strengths of CHSP, such as rapid access to services and flexibility for providers to meet changing client demands, could be lost if it were absorbed into the Support at Home program.

1.5 Coalition Senators also note the strong support from providers and stakeholders for retaining a block funding model. Evidence to the inquiry highlighted that block funding remains one of the most cost-effective ways to deliver entry-level aged care services with evidence provided that some services cost at least 40 to 50 per cent more to deliver under Support at Home than under CHSP. Differences were even more stark in regional, rural and remote communities.

1.6 The evidence received by this inquiry sends a clear message to the Albanese Labor Government: older Australians, providers and communities deserve certainty about the future of CHSP. The Government must act quickly to provide that certainty.

1.7 Coalition Senators note deep concerns about what would happen to the approximately 860,000 older Australians currently relying on CHSP services — including social support, transport, meals and domestic assistance — if that funding were cut after 1 July 2027. More than 200,000 people are already waiting for an aged care assessment or a Support at Home package and the Government

has provided no credible explanation of how older Australians who depend on these services today would continue to receive the support they need if CHSP funding disappears.

1.8 The evidence received by this inquiry reinforces concerns about the Government's implementation of other aged care programs, including the operation of the Integrated Assessment Tool and the lack of human override in aged care assessments.

1.9 Coalition Senators will continue to advocate for policies that improve access to aged care services, reduce waiting times, and ensure older Australians can access the support they need, when and where they need it.

Senator the Hon Anne Ruston
Liberal Senator for South Australia

Senator Wendy Askew
Liberal Senator for Tasmania

Senator Alex Antic
Liberal Senator for South Australia

Appendix 1
Submissions and additional information

Submissions

1 HammondCare
2 Northern Territory Government
3 Australian Community Transport Association
4 NovaCare Nursing
5 Royal Australasian College of Physicians
6 The Community Transport Company
7 Australian Primary Health Care Nurses Association
8 Maroochy Home Maintenance and Care Association Trading As Maroochy Home Assist
9 The City of Greater Geelong
10 Queensland Health
11 Dr Anna Howe
12 Murrundindi Shire Council
- Attachment 1
- Attachment 2

13 Kingsgrove Community Aid Centre
14 Your Side Australia
15 Professor Kathy Eagar
16 Sutherland Food Services
17 Australian National Audit Office
- Attachment 1

18 Hornsby Ku-ring-gai Community Aged/Disabled Transport Service Inc
19 Wyndham City Council
20 Silverchain
21 Ageing Australia
22 Aboriginal Health and Medical Research Council of NSW
23 Kirinari
24 Australian & New Zealand Society for Geriatric Medicine
25 UnitingCare Australia
26 Inspector-General of Aged Care
27 National Aboriginal and Torres Strait Islander Ageing and Aged Care Council
28 IRT
29 Mount Alexander Shire Council
30 Multicultural Communities Council of South Australia Inc
31 Armidale Uralla Meals on Wheels Inc
32 Community Options INC
33 Uniting Communities

34 Benetas
35 Prof Michael Fine
36 Whiddon
37 Randwick Waverley Community Transport Group Ltd.
38 Ms Adelina Tabila
39 Department of Health, Disability and Ageing
40 Professor Diane Gibson
41 Flexi Care Inc.
42 Tasmanian Department of Health
43 Occupational Therapy Australia
44 Australian College of Nurse Practitioners
45 Aged Care Workforce Remote Accord
46 Council of Elders
47 Sydney Multicultural Community Services
48 Tamworth Meals On Wheels Inc
49 MND Australia
50 La Trobe University
51 Indigo
52 Allied Health Professions Australia
53 The Ethnic Communities Council of Queensland
54 Juniper Aged Care
55 Ethnic Communities Council NSW- SSD Coalition
56 Social Futures Ltd
57 Ethnic Communities' Council of Victoria
58 Lite n' Easy
59 Community Industry Group
60 Amplify Alliance
61 Meals on Wheels Australia
62 Anglicare Sydney
63 St George Community Transport
64 Anglicare Australia
65 Western Sydney Community Forum
66 Centre for Cultural Diversity in Ageing on behalf of the PICAC Alliance
67 Newtown Neighbourhood Centre
68 City of Salisbury
69 Victorian Sector Support and Development Partnership
70 Access Sydney Community Transport
71 Inner Sydney Voice - CHSP Leaders Network
72 Sydney Community Collaborative
73 Australian Physiotherapy Association
74 South Australian network of Sector Support and Development Network
75 Australian Human Rights Commission
76 Department of Health, Disability and Ageing

77 Community Culture Ltd
78 Australian Rehabilitation and Assistive Technology Association (ARATA)
79 Byron Shire Respite Service
80 Mr Kieran McGregor
81 RSL Australia
82 Australian Podiatry Association
83 Australian Unity
84 Aged and Disability Advocacy Australia
85 BaptistCare
86 Vision 2020 Australia
87 National Seniors Australia
88 Uniting NSW.ACT
89 Advance Ageing Western Australia
90 Ms Margaret Walsh
91 BlueCare (UnitingCare Queensland)
92 Suncare Community Services Limited
93 Catholic Health Australia
94 Aboriginal Health Council of South Australia
95 Vision Australia
96 Ms Rebekha Sharkie MP
97 Older Women's Network NSW
98 Life Care
99 Carers NSW
100 Community Transport Organisation
101 Victorian Government
102 Federation of Ethnic Communities' Councils of Australia
103 Assistive Technology Suppliers Australia
- Attachment 1

104 Aged Rights Advocacy Service
105 Palliative Care Australia
106 National Aboriginal Community Controlled Health Organisation
107 Older Persons Advocacy Network
108 Municipal Association of Victoria
109 Local Government Association of South Australia
110 Mr Ian Yates
111 LGBTIQ+ Health Australia
112 Local Government NSW
113 Australian Nursing and Midwifery Federation
114 United Workers Union
115 Dementia Australia
116 Victorian Aboriginal Community Controlled Health Organisation
117 Housing for the Aged Action Group
118 National Aboriginal Community Controlled Health Organisation

119 Government of Western Australia
120 COTA Australia
121 North and West Remote Health
122 Australian Association of Gerontology
123 Dr Silvia Pfeiffer
124 CHSP Alliance
- 124.1 Supplementary to submission 124
- 124.2 Supplementary to submission 124
- 124.3 Supplementary to submission 124

125 Freewave Aged Care
- 125.1 Supplementary to submission 125

126 Name Withheld
127 Neta Care
128 Mr Marcus Wigan
129 Linked Community Services
130 Confidential
131 Confidential

Additional Information
1 Support at Home Rollout: Provider Feedback Report

Answer to Question on Notice
1 Answers to Questions taken on Notice – NATSIAACC – Canberra, 6 February 2026
2 Answers to Questions Taken on Notice – Meals on Wheels Australia – Canberra, 6 February 2026
3 Department of Health, Disability and Ageing - Answer to Senator Ruston's Question Taken on Notice - 06 February 2026
4 Department of Health, Disability and Ageing - Answer to Senator Ruston's Question Taken on Notice - 06 February 2026

Appendix 2
Public Hearings and Witnesses

Friday 6 February 2026
Committee Room 2S1
Parliament House

Canberra

Meals on Wheels Australia
- Ms Claudia Odello, Chief Executive Officer
- Mrs Leeanne Wright, Service Manager

Older Persons Advocacy Network
- Mr Craig Gear, Chief Executive Officer

COTA Australia
- Mr Corey Irlam, Deputy Chief Executive Officer
- Ms Patricia Sparrow, Chief Executive Officer

UnitingCare Australia
- Ms Georgina Watson, Head, Policy

HammondCare
- Ms Marcela Carrasco, Executive General Manager, Home Care

Bolton Clarke
- Mr Tim Hicks, Executive General Manager, Policy and External Relations

National Aboriginal and Torres Strait Islander Ageing and Aged Care Council
- Mrs Kim Whiteley, Chief Executive Officer

Inspector-General of Aged Care
- Mrs Natalie Siegel-Brown, Inspector-General of Aged Care

Department of Health, Disability and Ageing
- Ms Julia Atkinson, Assistant Secretary, Home Support Operations Branch, Access and Home Support Division
- Ms Rachel Blackwood, Assistant Secretary, Single Assessment System Branch, Access and Home Support Division
- Mr Robert Day, First Assistant Secretary, Quality and Assurance Division
- Mr Daen Dorazio, First Assistant Secretary, Residential Care Division
- Ms Emily Harper, First Assistant Secretary, Market and Workforce Division
- Ms Nicole Jarvis, Acting First Assistant Secretary, Service Delivery Division

- Mr Joshua Maldon, First Assistant Secretary, Reform Implementation Division
- Mr Greg Pugh, First Assistant Secretary, Access and Home Support Division
- Mrs Rowena Sierant, Director, Assistive Technology and Home Modifications Section, Support at Home Operations Branch, Access and Home Support Division
- Ms Sonja Stewart, Deputy Secretary, Ageing and Aged Care Group

Monday 16 February 2026
Queensland Parliament House
Cnr George and Alice Sts

Brisbane

Ageing Australia
- Mr Tom Symondson, Chief Executive Officer
- Mr Roald Versteeg, General Manager, Policy and Advocacy

National Seniors Australia
- Mr Chris Grice, Chief Executive Officer
- Ms Jacintha Victor John, Principal Aged Care and Health Adviser

Lived experience panel
- Robin

Lived experience panel
- Jen

Silverchain
- Ms Carolyn Bell, Executive Director, Aged Care
- Ms Bronwyn Perry, Executive Director, Strategic Communications

Flexi Care Queensland
- Mr Adrian Morgan, General Manager

Catholic Health Australia
- Mr Joel Reading, Acting Chief Executive Officer

Kirinari
- Ms Diane Lynch, Chief Executive Officer

North and West Remote Health
- Ms Bret Appel, General Manager, Community Services
- Mrs Sarah Bohan, General Manager, Allied Health
- Mr John Cain, Chief Executive Officer

- Mrs Rahni Cotterill, Executive Manager, Allied Health and Community Services

Australian Community Transport Association (with QLD representative)

- Mr Murray Coates, Chief Executive Officer

Maroochy Home Maintenance and Care Association Trading As Maroochy Home Assist

- Mrs Julie Stacey, General Manager

The Ethnic Communities Council of Queensland

- Dr Lisa Ward, Chief Executive Officer

Diversicare

Cura Aged Care

- Ms Jessica McAdam, Chief Operating Officer, Multicultural Communities Council Gold Coast

Federation of Ethnic Communities' Councils of Australia

- Ms Mary-Ann Geronimo, Chief Executive Officer

NACCHO

- Ms Monica Barolits-McCabe, Executive Director
- Ms Nadine Blair, Director, Policy
- Ms Juliette Spurrett, Director, Aged Care

Professor Kathy Eagar