Catholic Health Australia

Pre-Budget Submission 2026–27: Aged Care

January 2026

Catholic Health Australia

Executive Summary

Australia's aged care reforms are being challenged at the system edges - where funding meets delivery, where capital meets demand, and where health and aged care intersect. The aged care system is at a critical juncture. Significant reform is underway through the introduction of Support at Home, changes to residential aged care funding, and broader efforts to integrate aged care more effectively with the health system. However, current policy and funding settings risk undermining these reforms by failing to address key delivery constraints, capital shortfalls and system interface failures.

The result is not only reduced access and poorer outcomes for older Australians, but increasing fiscal and service delivery pressure across the broader care economy - particularly on hospitals, where aged care system failures frequently manifest as delayed discharges, avoidable admissions and inefficient use of acute capacity.

These failures are already creating fiscal leakage and hospital pressure. The recent Senate Inquiry's recommendation to end the rationing of Home Care Packages (HCP) underscores the urgent need for a coordinated transition from a rationed model to a demand-driven system. Targeted Commonwealth action in the 2026-27 Budget is essential to address these issues and ensure that reforms foster a responsive, equitable, and sustainable aged care continuum.

This submission argues that aged care reform will not succeed through program design alone. To deliver on the Government's objectives, Budget decisions must address the practical conditions that determine whether funded services can actually be delivered - including workforce capacity, assessment and care coordination, residential capital viability, and the interface between aged care and health systems.

Catholic Health Australia (CHA) proposes a focused set of Budget priorities across three areas:

- **Support at Home** - where demand continues to outstrip supply and where underinvestment in care management and assessment risks leaving funded places undeliverable, misallocated or failing to deliver appropriate outcomes for older Australians.
- **Residential aged care** - where sustained capital underinvestment is constraining bed supply, accelerating service closures in thin markets, contributing to hospital discharge pressures and disproportionately impacting poorer Australians.
- **The health–aged care interface**, where structural misalignment between programs and funding streams is driving inefficiency, cost shifting and avoidable harm.

The priorities outlined in this submission are deliberately targeted at these priorities. Fully meeting future demand for aged care will require substantial long-term investment and policy reform. However, well-designed interim measures and enabling investments can materially improve system performance now, protect existing Commonwealth expenditure, and reduce downstream fiscal risk.

Taken together, these proposals are intended to strengthen the foundations of aged care reform, support system sustainability, and ensure that public investment delivers intended outcomes for older Australians and the broader health system.

Budget Priorities at a Glance

Support at Home

- **Commence a staged transition toward demand-based Support at Home funding**, including funding for additional fully funded packages from 2026–27 to reduce waitlists and unmet need. Cost approximately $1.0–$2.4 billion per annum, depending on scale.
- **Increase the care management allocation under Support at Home from 10 per cent to 15 per cent**, enabling effective delivery for higher-acuity participants and protecting service quality. Cost: neutral.
- **Introduce supplementary assessment and reassessment grants** under the Single Assessment System to address demand surges, complexity and regional delivery challenges. Cost: $110–$330 million per annum.
- **Defer the introduction of Support at Home price caps by 12 months to reduce delivery and market stability risks** during early implementation, enable IHACPA to assess the effectiveness of prices in practice, and support the establishment of clear, enforceable consumer protections.
- **Strengthen the End-of-Life pathway within Support at Home**, including flexible extension and renewal mechanisms where clinically required. Cost: very small net cost.

Residential Aged Care

- **Implement a time-limited interim uplift to the Accommodation Supplement** for supported residents in high-risk services, pending full accommodation pricing reform. Cost: $600 million–$1 billion per annum.
- **Extend Base Care Tariff (BCT) reduction exemptions** to residential aged care homes with very high proportions of supported residents, consistent with existing thin-market exemptions. Cost: neutral.
- **Establish a national concessional finance mechanism** (such as low-interest loans or guarantees) to unlock stalled residential aged care capital projects, particularly in thin markets and high-supported services (fiscal impact dependent on design). Cost: dependent on scale.

Health and Aged Care Interface

- **Establish a National Prevention Investment Fund** to progressively increase investment in prevention and early intervention across the care economy.
- **Pilot integrated Support at Home and Hospital-in-the-Home models**, including in residential aged care settings, to improve transitions and reduce avoidable hospital use.
- **Introduce targeted housing-related tax concessions** to support aged care workforce attraction and retention in high-need areas. Cost: $100–$250 million per annum, depending on uptake.
- **Leverage migration settings** by reintroducing targeted student work-hour exemptions for aged care qualifications, with potential net positive fiscal impacts.
- **Commission an independent evaluation of prognosis-based eligibility criteria** for palliative and end-of-life care funding. Cost: $1–2 million.

Chapter 1. Support at Home

Background

The Commonwealth Government should prioritise funding for Support at Home packages that reflect actual demand. This includes increasing the number of full packages available and basing funding decisions on robust demand modelling that considers demographic trends, population ageing, and older Australians' strong preference to age at home.

There is a key fiscal and delivery risk at play. If the Government funds Support at Home places but does not adequately fund the core enablers – care management and timely assessment – then a material share of that investment will be undeliverable or misallocated, pushing older Australians into higher-cost hospital and residential care and increasing pressure on state health systems. The Commonwealth has committed to a demand-driven Support at Home system, but current Budget settings primarily fund places rather than the delivery infrastructure required to make that system work.

Without targeted investment to address these structural constraints, waitlists will persist, providers will struggle to deliver approved care, and the Commonwealth's substantial investment in Support at Home will not achieve its maximum potential outcomes. This chapter presents a coherent package of measures to ensure Support at Home is funded and delivered as a genuinely demand-driven, clinically effective and fiscally responsible program:

- funding Support at Home to meet demand
- enabling delivery through adequate care management
- ensuring timely access through a well-resourced Single Assessment System.

Policy Priorities

Priority 1: Government fund Support at Home to the extent that demand for in-home care is met

Decision sought

That the Commonwealth commit to a staged transition toward a demand-driven Support at Home system, beginning in 2026–27 with funding for a material increase in the number of fully funded Support at Home packages.

Rationale

Demand for in-home care already exceeds funded supply, with projections indicating that more than 170,000 older Australians will be waiting for care by mid-2026 under current settings.[1] Current projections indicate that the Support at Home waitlist could reach approximately 200,000 people by June 2027, assuming annual growth of around 30,000 individuals.[2] Even with the allocation of 83,000 additional packages,[3] an estimated 117,000 older Australians would remain without access. While interim funding provides partial support, it is insufficient to deliver safe and effective care for people with

[1] McIlroy, T. (2025, October 14). *Up to 300,000 Australians will be on aged care waitlist by 2030 under new changes, modelling shows*. Retrieved 12/12/2025 from: https://www.theguardian.com/australia-news/2025/oct/14/australia-aged-care-waitlist-changes

[2] McIlroy, T. (2025, October 14). *Up to 300,000 Australians will be on aged care waitlist by 2030 under new changes, modelling shows*. Retrieved 12/12/2025 from: https://www.theguardian.com/australia-news/2025/oct/14/australia-aged-care-waitlist-changes

[3] Australian Government Department of Health and Aged Care. (2025, October 30). *20,000 fast-tracked home care packages delivered*. Retrieved 12/12/2025 from: https://www.health.gov.au/ministers/the-hon-sam-rae-mp/media/20000-fast-tracked-home-care-packages-delivered?language=en

moderate to high needs, resulting in clients declining services and providers being unable to meet assessed requirements.

The Government has committed to Support at Home,[4] but current Budget settings fund only a limited number of places rather than the full cost of care required to meet assessed need. This creates the appearance of capacity while leaving a large structural funding gap in place, with ongoing cost-shifting into hospital and residential aged care.

A credible fiscal benchmark for Support at Home is the Commonwealth's subsidy levels under the Home Care Package system, which ranged from approximately $11,000 per year for basic support to over $63,000 for high-needs care. With unmet demand concentrated in higher-need cohorts, a conservative planning assumption is that the average cost of a fully funded Support at Home package is around $40,000 per person per year.

On this basis, fully funding the current cohort of approximately 117,000 people waiting for in-home care would require investment in the order of $4-5 billion per year. While it is not feasible to close this gap in a single Budget – given workforce and system constraints – it highlights the scale of the structural funding shortfall under current settings.

System impact

A staged expansion of funded Support at Home packages would materially reduce waitlists, improve access to care for higher-need older Australians, and reduce avoidable hospitalisations and premature entry into residential aged care. Over time, this would ease pressure on state health systems and improve the sustainability of Commonwealth aged care expenditure.

Financial impact

A realistic and deliverable first step would be to fund an additional 25,000 to 60,000 fully funded Support at Home packages from 2026–27.

Using a conservative benchmark of $40,000 per package per year, this implies an incremental Commonwealth investment of approximately:

- $1.0 billion per year (25,000 packages), to
- $2.4 billion per year (60,000 packages).

This would allow Government to make a meaningful down-payment on closing the waitlist while aligning growth in funded places with workforce and system capacity.

Priority 2: Enable delivery through effective care management by allocating up to 15 per cent of Support at Home packages to this enabling service

Decision sought

That the care management cap under Support at Home be increased from 10 per cent to at least 15 per cent from 1 July 2026.

Rationale

Support at Home participants are presenting with increasingly complex clinical, cognitive, and social needs. Effective care management is essential to coordinate services, manage risk, and ensure that funded care is actually delivered. Under the previous Home Care Package system, care management

[4] Australian Government Department of Health and Aged Care. (2025, October 30). *20,000 fast-tracked home care packages delivered*. Retrieved 12/12/2025 from: https://www.health.gov.au/ministers/the-hon-sam-rae-mp/media/20000-fast-tracked-home-care-packages-delivered?language=en

accounted for around 17 per cent of package funding. The current 10 per cent cap under Support at Home represents a material reduction in funding for this critical function.

Under-funded care management creates strong system distortions. Providers face incentives to avoid higher-acuity clients, experienced care managers are leaving the workforce, and care becomes fragmented. This directly undermines the Commonwealth's investment in Support at Home by increasing the likelihood of hospitalisation,[5] service breakdown and premature entry into residential aged care.

In a system that is progressively moving toward demand-based funding, inadequate care management is not just a quality issue – it is a fiscal risk that reduces the value and effectiveness of the Government's expenditure on in-home care. The care management supplement, available to specific populations, acknowledges the benefits of additional care management hours. This cap, which better reflects actual need, should be available to all older Australians.

System impact

Increasing the care management cap to 15 per cent would stabilise the care management workforce, allow providers to safely support people with higher and more complex needs, and improve continuity of care. The evidence demonstrates that effective care management reduces crisis-driven residential entry and high-acuity hospital episodes that drive Commonwealth-funded aged care and hospital activity.

Financial impact

The net Commonwealth fiscal impact is expected to be limited when assessed against avoided downstream costs in the aged care and hospital systems.

AIHW data indicates that approximately 84,000 people exit home care each year, with around 40 per cent transitioning into residential aged care – approximately 33,000 people annually.[6]

Residential aged care is a high-cost setting for the Commonwealth, with average annual subsidy levels exceeding $100,000 per resident.[7,8]

As an illustrative scenario, if improved care management delayed entry into residential care by just six months for 2 per cent of those who would otherwise transition each year – around 670 people – the Commonwealth would avoid approximately $33 million in residential aged care expenditure, based on average residential care costs. This does not assume system-wide behavioural change; it reflects a very modest improvement in care continuity and stability for a small subset of higher-risk clients.

Additional fiscal benefits would arise from reduced emergency presentations and hospital admissions associated with service breakdown and crisis-driven residential entry. While the distribution of these savings spans both Commonwealth and state budgets, they directly protect the Commonwealth's investment in Support at Home by preventing escalation into higher-cost care pathways.

Final Commonwealth costs will depend on the level of co-contribution revenue forgone and the extent to which improved care management reduces transitions into high-cost residential and hospital care.

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[5] Lyhne, C. N., Bjerrum, M., Riis, A. H., & Jørgensen, M. J. (2022). Interventions to prevent potentially avoidable hospitalizations: A mixed methods systematic review. *Frontiers in Public Health, 10,* 898359. https://doi.org/10.3389/fpubh.2022.898359

[6] Australian Institute of Health and Welfare. (2025, June 27). *People leaving aged care.* Retrieved 24/12/2025 from: https://www.gen-agedcaredata.gov.au/topics/people-leaving-aged-care#:~:text=Last%20updated:%2027%20June%202025,for%20exits%20from%20home%20care

[7] Australian Institute of Health and Welfare. (2025, June 27). *Spending on aged care.* Retrieved 22/12/2025 from: https://www.gen-agedcaredata.gov.au/topics/spending-on-aged-care

[8] Department of Health, Disability and Ageing. (2025, October 8). *Aged care data snapshot – 2025.* Retrieved 22/12/2025 from: https://www.gen-agedcaredata.gov.au/resources/access-data/2025/october/aged-care-data-snapshot-2025

Priority 3. Introduce supplementary grants for assessment organisations to support demand surges and complex assessments under Support at Home

Decision sought

That the Commonwealth establish a supplementary assessment grants program from 1 July 2026 to enable Single Assessment System organisations to respond to:

- demand surges (including transition-related reassessment increases)
- complex assessments (e.g., interpreter supports, supported decision-making)
- regional, rural, and remote delivery cost drivers (e.g., extended travel and transport).

Rationale

Timely, accurate assessment and reassessment are fundamental to ensuring older Australians receive the right level of care under Support at Home and that Commonwealth funding translates into delivered services.

The introduction of the Single Assessment System was intended to streamline access by consolidating multiple assessment pathways. While recent Budget funding supports implementation of the Single Assessment System,[9] funding does not automatically adjust to demand growth or assessment complexity. However, persistent delays in assessment and reassessment remain a major operational constraint, with performance frequently falling below targets in 2024–25.[10] These delays are especially acute in regional, rural, and remote areas where assessors face greater travel requirements and workforce shortages.

Where assessment capacity does not keep pace with demand, approved care cannot commence or be adjusted when needs change. This creates a direct delivery risk: Commonwealth investment in Support at Home places may not convert into delivered care, exacerbating unmet need, increasing reliance on interim arrangements, and creating avoidable care deterioration for older Australians.

Assessment delays also contribute to broader system pressures, including hospital discharge delays and bed block for older patients. Recent reporting shows that thousands of medically fit older patients have remained in hospital beds due to aged care placement shortages, underscoring the link between aged care access barriers and hospital capacity pressures.[11]

Supplementary grants for assessment organisations would help ensure workforce capacity, complexity loadings, and regional cost pressures are recognised, enabling the system to respond flexibly to growth in demand without compromising equity, quality, or timeliness.

System impact

Supplementary grant funding would enable assessment organisations to:

- expand workforce capacity during demand surges and transition periods, reducing wait times for assessment and reassessment

[9] Department of Health, Disability and Ageing. (2025). *Budget 2025–26: Health and Aged Care Portfolio Budget Statements (Budget related paper no. 1.9)*. Commonwealth of Australia. https://www.health.gov.au/sites/default/files/2025-03/budget-2025-26-health-and-aged-care-portfolio-budget-statements.pdf

[10] Department of Health, Disability and Ageing. (2025). *Annual report 2024-25*. Commonwealth of Australia. https://www.health.gov.au/sites/default/files/2025-11/department-of-health-disability-and-ageing-2024-25-annual-report.pdf

[11] ABC News. (2025, 12 December). *More than 3,000 aged care patients stuck in hospital beds as discharge backlogs grow*. Australian Broadcasting Corporation. Retrieved 24/122025 from: https://www.abc.net.au/news/2025-12-12/aged-care-patients-stuck-in-hospital-beds/106123998

- support complex assessments through appropriate loadings (e.g., interpreter services, supported decision-making, culturally tailored resources)
- offset regional, rural, and remote delivery costs by funding extended travel time and transport needs.

Improved assessment timeliness and capacity will support faster access to funded Support at Home packages and adjustments when client needs change. By reducing delays in the assessment pipeline, this initiative helps ensure that Commonwealth Support at Home funding is delivered effectively and that older people receive care when and where they need it.

Timely and accurate assessment can also reduce system strain by alleviating discharge delays and hospital congestion associated with aged care access shortfalls.[12]

Financial impact

Using current sector estimates and accounting for an expected surge in reassessments during the transition to Support at Home, supplementary grants could apply to approximately 500,000 to 600,000 assessments and reassessments per year.[13]

Based on historic Commonwealth spending on aged care assessment activity, and accounting for increased costs associated with demand surges, assessment complexity, and regional delivery factors, an indicative grant range of $200 to $600 per assessment suggests an annual cost of approximately $110 million to $330 million.[14]

This represents a modest enabling investment relative to total Support at Home expenditure and is targeted at ensuring that funded packages can be delivered and adjusted in a timely, equitable, and effective manner. Final Commonwealth costs will depend on program design parameters, including eligibility criteria, complexity loadings and regional weighting.

Delays in assessment and reassessment also contribute to hospital discharge delays and avoidable acute care utilisation. Independent analysis estimates that hospital discharge delays attributable to aged care access issues cost an average of approximately $6,661 per patient.[15] By improving assessment timeliness and capacity, supplementary grant funding would reduce these avoidable costs and protect the Commonwealth's broader Support at Home investment by preventing escalation into higher-cost acute and residential care pathways.

By funding supplementary assessment capacity, the Commonwealth protects its broader Support at Home investment from underspend and misallocation, and reduces fiscal and service delivery risks associated with assessment bottlenecks.

[12] ABC News. (2025, 12 September). *States warn aged care bed shortages are leaving thousands of older people stuck in hospital.* Australian Broadcasting Corporation. Retrieved 24/122025 from: https://www.abc.net.au/news/2025-09-12/federal-government-aged-care-hospital-beds-waitlist/105763730

[13] Australian Institute of Health and Welfare. (2025, October 15). *Aged care.* Retrieved 17/12/2025 from: https://www.aihw.gov.au/reports/australias-welfare/aged-care

[14] Productivity Commission. (2025). *Report on Government Services 2025: Community services (part F).* https://assets.pc.gov.au/ongoing/report-on-government-services/2025/community-services/rogs-2025-partf-overview-and-sections.pdf

[15] Neeland, J. (2025, 19 November). *When one system saves, another pays: the real cost of delayed aged care reform.* Helloleaders.com.au. Retrieved 24/122025 from: https://helloleaders.com.au/article/when-one-system-saves-another-pays-the-real-cost-of-delayed-aged-care-reform

Priority 4. Defer the introduction of Support at Home price caps by 12 months

Decision sought

That the introduction of price caps under Support at Home be deferred by a further 12 months to mitigate delivery and viability risks during early implementation. This deferral would provide time for prices to be set transparently, tested in operation, and supported by clear and enforceable consumer protections.

Rationale

Price caps are a significant structural change to the funding and delivery of in-home aged care services. If set incorrectly or introduced prematurely, they risk undermining provider viability, constraining service availability, and reducing choice for older people - particularly in thin markets and for higher-complexity services.

CHA initially developed the proposal to defer price caps, and Government agreed that the risks of premature introduction of capped pricing substantially outweighed any benefits. These risks have not yet been substantially mitigated or addressed, particularly given the delay of the commencement of the Aged Care Act 2024 to 1 November 2025.

At present, there are less than five months until the scheduled removal of current price caps, yet the anticipated prices have not been made publicly available. This creates material uncertainty for providers and limits their ability to plan service delivery, workforce deployment and contractual arrangements.

In addition, the Independent Health and Aged Care Pricing Authority (IHACPA) will have extremely limited operational experience with existing Support at Home prices before price caps need to be finalised and announced – noting that the ideal timing for such an announcement is already behind us. In practice, this provides a very limited evidence base to assess whether prices are reasonable, effective, and reflective of real-world delivery costs across different service types and locations.

Introducing price caps without sufficient testing and transparency risks repeating well-documented problems seen in other capped pricing environments, where prices fail to reflect complexity, geographic variation and workforce costs, leading to service withdrawal or cross-subsidisation.[16,17] It is also likely to lead to:

- hindering of specialised providers focused on high-quality services from entering the market
- providers adjusting their case-mix based on profitability, further impacting less profitable or purpose-driven providers and reducing consumer choice
- older Australians making service choices influenced by their experience with the co-contribution regime - including personal care - to minimise out-of-pocket costs.

Consumer protections

CHA recognises and supports the Government's objective of protecting older people from unreasonable pricing. Consumer protections should be more clearly articulated alongside this deferral of price caps, so that consumers can be assured that prices they are charged are reasonable. These explicit consumer protections might include:

- clear authority for the Aged Care Quality and Safety Commission to require reimbursement or remediation where a client is overcharged

[16] Investopedia. (2024). *Price cap regulation.* Retrieved 10/01/2026 from: https://www.investopedia.com/terms/p/price-cap-regulation.asp

[17] Centre for International Economics (CIE). (2015). *Analysis of retail price controls and their impacts on investment and service delivery.* Prepared for the Australian Government.

- a transparent set of actions the Department will take where pricing is deemed unreasonable or not based in actual costs
- further publicity around the publicly available pricing providers are required to submit to the Department to encourage consumer choice.

Strengthening these protections would provide meaningful safeguards for older people while avoiding the unintended consequences of prematurely imposed price caps.

System impact

Deferring price caps by 12 months would:

- reduce the risk of service withdrawal or reduced availability during early Support at Home implementation
- allow IHACPA to assess the effectiveness and adequacy of prices based on real delivery experience
- improve market stability and provider confidence
- create space to implement clearer, enforceable consumer protections.

This approach supports a smoother transition to Support at Home, protects older people's access to care, and reduces the risk of early system failure that would ultimately increase pressure on hospitals and residential aged care at a time when neither system can afford it.

Financial impact

Deferring the introduction of price caps is expected to have no direct fiscal impact, as it does not increase subsidy rates or package values. Any short-term Budget exposure should be assessed against the risk of service disruption, reduced access and higher downstream costs associated with premature price suppression in a still-maturing system.

Priority 5: Strengthen the End-of-Life pathway in Support at Home

Decision sought

That the Commonwealth strengthen the End-of-Life (EoL) pathway in Support at Home by establishing a rapid escalation mechanism to approve extension to EoL funding; and in the long-term, amend Support at Home policy settings to allow renewal of the EoL funding period as clinically necessary.

Rationale

Support at Home includes an EoL pathway intended to enable older Australians to receive dignified, clinically appropriate care in their home at the end of life. This pathway has the potential to reduce unnecessary hospitalisation, respect individual preferences, and improve system efficiency.

However, current design settings – particularly the fixed three-month funding limit – create material risks for provider viability and may discourage uptake. End-of-life trajectories are often uncertain, especially for older people with non-cancer diagnoses, dementia, or multi-morbid chronic conditions. Where individuals outlive the funded period, providers face significant unfunded costs or must transition clients back into mainstream Support at Home arrangements that are not clinically appropriate, press them towards residential aged care, or admit them to hospital.

Home-based EoL care is inherently resource-intensive. It often requires rapid escalation of services, higher staff skill levels, after-hours availability, coordination with general practice and specialist palliative care, and increased support for families and carers. These costs are front-loaded and unpredictable, reflecting the variable nature of end-of-life trajectories. Despite this, evidence shows that home-based

palliative care reduces overall health system expenditure compared to hospital-based care by reducing hospital visits and lengths of stay.[18,19,20]

A rigid three-month funding limit does not align with clinical reality and transfers financial risk from the system to individual providers. Where funding ceases but care needs persist, providers face a choice between absorbing unfunded costs, withdrawing services, or avoiding the pathway entirely – outcomes that undermine quality of care and system objectives. Funding flexibility is therefore essential for both care integrity and provider participation.

Strengthening the EoL pathway within Support at Home aligns with the Royal Commission's emphasis on person-centred, rights-based care, while also supporting health system sustainability by reducing avoidable hospital admissions at the end of life.

CHA recommends targeted reforms to ensure the Support at Home EoL pathway is clinically appropriate and viable for providers:

- Short-term: Establish a rapid escalation mechanism allowing the Department to approve extensions to EoL funding within days where a person outlives the initial three-month period and ongoing end-of-life care is clinically required, with funding continuity while decisions are finalised.
- Long-term: Amend Support at Home settings to allow the EoL funding period to be renewed as many times as clinically necessary, ensuring funding aligns with care needs rather than fixed time limits.

System impact

Strengthening the EoL pathway in this way would deliver clear benefits across the system:

- Improved access and consistency: Providers would be more willing to utilise the pathway where funding risk is appropriately managed.
- Higher quality end-of-life care: Older Australians would receive sustained, appropriate care without arbitrary disruption.
- Reduced hospital demand: Avoidable emergency presentations and inpatient admissions near end of life would be reduced.
- Provider sustainability: Funding settings would better reflect the true cost and risk profile of delivering end-of-life care in the home.

Critically, these changes would ensure that provider behaviour aligns with policy intent, rather than working against it.

Financial impact

Extending and renewing EoL funding would increase expenditure relative to a fixed three-month cap, but the fiscal impact is expected to be modest and offset by avoided hospital and residential care costs, which are substantially higher on a per-day basis. Uptake is limited to a small end-of-life cohort, and many individuals will die within the initial three-month period, meaning extensions would apply to relatively few cases and for short durations, while preventing disproportionately higher downstream costs.

[18] Palliative Care Australia. (2017). *Economic Research Sheet: The Economic Value of Palliative Care*.

[19] Spencer, L. et al., *Comparative costs of palliative care settings: A rapid review*, Palliative Medicine (2024).

[20] Palliative Care Australia, *National Palliative Care Strategy – Consumer Evidence Base*.

Chapter 2. Residential Aged Care

Background

Australia is building far fewer residential aged care beds than required to meet population ageing and increasing acuity. In 2023-24, fewer than 1,000 new beds were completed nationally, against an estimated requirement of more than 10,000 beds per year over coming decades. This shortfall is already contributing to hospital patient flow and discharge challenges (sometimes referred to as exit block or bed block), with older people remaining in acute care settings because appropriate residential care is unavailable.

Constrained capital investment reflects funding and financing settings that do not adequately support long-term viability or stewardship. This is particularly challenging for not-for-profit, mission-driven providers, including those services operated by Catholic organisations.

Policy Priorities

Priority 1: Interim adjustment to the Accommodation Supplement for supported residents

Decision sought

That the Commonwealth implement a time-limited interim adjustment to the Accommodation Supplement targeted to services most exposed to structural under-funding, pending the full implementation of residential accommodation pricing reform. This measure is intended to stabilise high-risk facilities while the Government considers and implements the longer-term recommendations of the Residential Aged Care Accommodation Pricing Review.

Rationale

CHA's submission to the Residential Aged Care Accommodation Pricing Review identified a persistent gap between current Accommodation Supplement rates and the minimum funding required to maintain safe, compliant, and dignified residential aged care infrastructure, particularly in services with high proportions of supported residents.[21]

For these services, current supplement settings operate as a hard cap on accommodation revenue and do not reflect underlying capital, financing, and maintenance costs.[22] Independent sector financial data confirms that accommodation revenue is insufficient to fund depreciation, refurbishment, and capital renewal, resulting in ongoing accommodation losses and erosion of long-term viability.[23]

Consistent with the position advanced in CHA's Review submission, an interim adjustment equivalent to approximately 50 per cent of the current funding gap would represent a pragmatic stabilisation measure. This approach materially reduces under-funding while recognising fiscal constraints and preserving incentives for efficient delivery and prudent capital management. Importantly, it does not pre-empt or substitute for final pricing reform.

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[21] Catholic Health Australia. (2025). *Submission to the Residential Aged Care Accommodation Pricing Review*. Retrieved 17/12/2025 from: *(CHA internal submission)*

[22] Department of Health and Aged Care. (2025). *Accommodation supplement for aged care service providers*. Retrieved 17/12/2025 from: https://www.health.gov.au/topics/aged-care/providing-aged-care-services/funding-for-aged-care-service-providers/accommodation-supplement-for-aged-care

[23] StewartBrown. (2024). *Quarterly Financial Snapshot Q4 2024–25*. Retrieved 17/12/2025 from: *(as cited in CHA Submission on Residential Aged Care Accommodation Pricing Review)*

System impact

A targeted interim uplift would stabilise services at greatest risk of service contraction or closure, protect access for low-income older Australians, and mitigate further deterioration in residential bed supply, particularly in thin markets and high-supported facilities.

By preventing the loss of residential capacity, this measure would also reduce pressure on hospitals arising from delayed discharges into residential aged care, protecting the Commonwealth from higher downstream costs associated with extended hospital stays and unplanned transitions.[24]

Financial impact

Based on current sector data, CHA estimates that an interim uplift of approximately $45 per supported resident per day, targeted to not-for-profit providers with more than 50 per cent supported residents, would apply to approximately 35,000 to 60,000 residential places nationally.[25,26]

On this basis, the indicative cost of the interim adjustment is estimated to be in the order of $600 million to $1 billion per annum, with a central estimate of approximately $750 million per year. Final costs would depend on eligibility thresholds, duration and implementation parameters.

This targeted, time-limited investment should be assessed against avoided costs associated with declining residential capacity, including increased hospital bed occupancy and pressure on Commonwealth-funded aged care and health systems.

Indicative costing is based on publicly available Australian Institute of Health and Welfare (AIHW) data on residential places and provider mix, sector financial performance analysis, and CHA's prior submission to the Residential Aged Care Accommodation Pricing Review.

Priority 2: Extend Base Care Tariff reduction exemptions

Decision sought

That the Commonwealth extend existing exemptions from Base Care Tariff (BCT) reductions to residential aged care homes with very high proportions of supported residents (for example, supported-resident ratios above 70 per cent). This targeted measure would protect mission-based services from unintended financial penalties while preserving accountability for quality and safety.

Rationale

Under current policy settings, providers that do not meet mandated care-minute targets are subject to reductions in their BCT payments. While this accountability mechanism is appropriate in most circumstances, it creates disproportionate risk for homes with very high concentrations of supported residents.

These services often operate in thin markets with constrained workforce availability and limited capacity to fund additional care hours beyond what BCT revenue supports. In these contexts, care-minute shortfalls reflect structural workforce and funding constraints rather than provider performance or intent.

The policy framework already recognises comparable structural disadvantage by exempting certain providers from BCT reductions, including homelessness-specialist services and facilities located outside

[24] Australian Institute of Health and Welfare. (2024). *Hospital resources and emergency department care*. Retrieved 17/12/2025 from: https://www.aihw.gov.au/reports-data/myhospitals

[25] *Australian Institute of Health and Welfare.* (2024). *People using aged care*. Retrieved 17/12/2025 from: https://www.aihw.gov.au/reports/aged-care/people-using-aged-care

[26] *Royal Commission into Aged Care Quality and Safety.* (2021). *Final report: Care, dignity and respect (Volumes 1–2)*. Retrieved 17/12/2025 from: https://agedcare.royalcommission.gov.au/publications/final-report

Modified Monash Model (MMM) 1 areas. Homes with very high supported-resident ratios face analogous cost and workforce pressures and should be treated consistently within the existing exemption framework.

Extending the exemption would not weaken regulatory oversight or quality expectations. Affected services would remain subject to the same quality, safety, and compliance requirements as the rest of the sector and continue to be monitored by the Aged Care Quality and Safety Commission.

System impact

Extending BCT reduction exemptions to high-supported homes would prevent perverse outcomes in which facilities serving the poorest and most vulnerable older Australians are financially penalised for structural constraints beyond their control. It would support service continuity, protect access for supported residents, and reduce the risk of accelerated closures or service contraction in thin markets.

By stabilising these homes, the measure would also support whole-of-system efficiency. Closure or contraction of high-supported services frequently results in displaced residents occupying public hospital beds or transitional care places, increasing pressure on acute health infrastructure and driving higher Commonwealth-funded hospital and aged care costs.

Financial impact

CHA considers this measure to be largely budget neutral. Current Budget assumptions are based on providers receiving their full BCT entitlement, and extending exemptions would primarily prevent the withdrawal of funding already assumed in forward estimates.

Any minor fiscal impact would be offset by avoided costs associated with service closures or reduced residential capacity, including increased reliance on Commonwealth-funded hospital activity, transitional care, and higher-acuity aged care pathways.

Priority 3: Establish a national concessional finance mechanism to unlock residential aged care investment

Decision sought

CHA recommends the Commonwealth establish a targeted concessional finance mechanism to support the construction, expansion, and refurbishment of residential aged care infrastructure, particularly in thin markets and high-supported services where access to commercial capital is most constrained. Appropriate models would include a low-interest loan facility or guarantee scheme, such as that recently implemented in Western Australia after an election commitment was made by the current WA Government.

Rationale

Australia is building materially fewer residential aged care beds than required to meet population ageing and increasing acuity.[27] Addressing this gap over the long term will require substantial capital investment and broader policy reform, including accommodation pricing reform, workforce growth, and planning settings that better align supply with demand.

However, there are near-ready projects that are currently marginal or stalled, not because demand is absent, but because financing costs and risk profiles render them unviable under current settings.

[27] Sector analysis indicates that in FY2025 only around 578 to 800 new residential aged care beds were added nationally — a small fraction of the estimated 9,000–10,000 new beds needed each year to meet demand driven by population ageing and increasing care needs. https://www.colliers.com.au/en-au/research/residential-aged-care-places-fy18-fy25-trends

Concessional finance represents a low-hanging-fruit intervention that can unlock these projects quickly, without pre-empting longer-term reform or requiring large upfront grants.

Recent state policy developments demonstrate the role concessional finance can play in addressing residential aged care supply constraints. In the lead-up to the 2025 Western Australian State Election, the WA Cook Government committed to establishing a $100 million low-interest loan scheme to support the construction, expansion, and refurbishment of residential aged care facilities, explicitly recognising the impact of aged care capacity shortfalls on hospital discharge and system pressures.[28]

The scheme was subsequently implemented following the election, offering loans of up to $20 million with terms of up to 15 years. This reflects a deliberate policy choice to use concessional finance as a targeted, fiscally disciplined mechanism to unlock stalled or marginal residential aged care projects without relying on large upfront capital grants.

A Commonwealth concessional finance mechanism would align responsibility for aged care system sustainability with the level of government that funds, regulates, and bears much of the downstream cost of residential aged care shortfalls.

Financial impact

The financial impact of this program would depend on:

- its scale in and design
- any contributions from state and territory governments such as that already made by Western Australia.

What is clear is that this would be a highly cost-effective way to stimulate supply of residential aged care beds, given that disbursements are loans (albeit at low interest rates).

[28] Western Australian Government. (2026). *Cook Government delivers low-interest loans to boost aged care capacity.* Government of Western Australia.

Chapter 3. The Health and Aged Care Interface

Background

The interface between health and aged care is a critical juncture in Australia's care system, where the ability to deliver the right care, in the right place, at the right time can determine outcomes for older people and broader system and service sustainability. As demand for both acute and long-term care grows, this interface should function as a seamless continuum of support. Instead, it is often marked by fragmentation and inefficiencies that compromise timely, appropriate care.

Three systemic issues underpin these challenges:

- Fragmented funding models: Separate funding streams for health and aged care create gaps in service continuity and accountability. This fragmentation frequently leads to cost-shifting between systems, delays in care transitions, and unnecessary hospital admissions – contrary to the principle of providing care where it is most appropriate.
- Limited political visibility and advocacy for prevention: Acute care dominates policy attention, while preventative measures that could keep people well and independent receive insufficient focus. This imbalance results in reactive spending on high-cost interventions rather than proactive investment in strategies that enable older people to remain in their homes and communities longer.
- Lack of accountability for integrated outcomes: Current performance frameworks measure outputs within individual sectors, not shared outcomes across the interface of health and aged care systems. Without clear accountability for timely, coordinated care, incentives for collaboration remain diffuse, leaving vulnerable and marginalised cohorts of people exposed to system failures.

These structural barriers mean that older Australians often experience care that is delayed, delivered in the wrong setting, or fails to prevent avoidable deterioration. A national approach that prioritises prevention and integration between care sectors is essential to ensure people receive the right care, in the right place, at the right time – while reducing unnecessary demand on hospitals and residential aged care.

Ongoing Workforce Shortages

Workforce shortages across Australia's health, aged care, and disability sectors are placing increasing pressure on the delivery of essential services. Despite growing demand driven by an ageing population and rising care needs, the supply of workers is not keeping pace. This misalignment undermines the sustainability and effectiveness of the care economy.

Without coordinated national action, these shortages – projected to reach approximately 285,000 workers by 2049–50, particularly among aged and disability carers, nursing support, and personal care workers – will continue to escalate. A cohesive, system-wide approach to strategically invest in our care workforce is urgently needed. Such reforms must address structural barriers to workforce attraction and retention – including housing affordability, cost of living, pay and conditions, and competition from adjacent sectors and international markets.

Aged care, as well as the broader care and support economy are undergoing significant reform, but without integration across health, aged care, and disability sectors, these efforts risk being piecemeal. A connected approach focused on systems and processes is essential to building a sustainable, skilled, and satisfied workforce capable of addressing the issues facing our fragmented care landscape.

Policy Priorities

Priority 1: Investment, measurement, and valuation of prevention outcomes across the care economy

Decision sought

That the Commonwealth commit to progressively increasing the proportion of government investment dedicated to prevention through the establishment and implementation of a National Preventive Investment Fund, underpinned by a national framework for measuring, valuing, and guiding investment in prevention initiatives.

Rationale

Investment in prevention delivers substantial benefits for individuals, governments, and communities, far outweighing both direct and indirect costs. Evidence consistently shows that health gains are most pronounced in disadvantaged communities, where targeted interventions can significantly improve outcomes and reduce inequities. By improving population outcomes, prevention strategies can help slow the long-term growth of care-related expenditure.

The most pressing challenge, however, lies in measuring and valuing preventative outcomes.[29] While strong evidence supports the cost-effectiveness of programs targeting chronic disease, avoidable hospitalisations, falls prevention, and early childhood development, benefits are often diffuse and difficult to quantify in financial terms. This measurement gap perpetuates underinvestment, particularly in sectors historically marginal to productivity and economic reform agendas – such as aged care, disability, and mental health – despite their growing role in employment and social wellbeing.[30]

Given the integrated responsibilities of the Department of Health, Disability and Ageing, a national framework to support government investment in prevention offers a timely opportunity to align investment with the changing acuity and complexity of care needs. By embedding flexibility and responsiveness, the framework can support tailored approaches that reflect the unique needs of different cohorts and care settings, ensuring prevention is prioritised not only for its long-term value but also for its relevance across the continuum of care. Crucially, it must recognise that prevention is not one-size-fits-all, with programs targeting young people differing significantly in design, delivery, and political traction compared to those for older adults or people with disability.

Further, the establishment of a National Prevention Investment Fund, leveraging existing and previous funding arrangements, would support the implementation of a national framework.[31] Unlike a modified budget process, a dedicated fund would provide a clear scope, greater transparency, and a sustained medium- to long-term commitment to prevention activities. It would reduce reliance on shifting government priorities across electoral cycles, ensuring continuity and strategic investment in prevention initiatives. The Fund should operate as a managed portfolio with explicit guardrails (e.g. minimum shares for long-horizon benefits and for non-health sectors) and publish annual statements showing expected benefit–cost ratios, distributional impacts, and the evidence maturity of funded programs.

[29] Australian Government The Treasury (2023). *Measuring what matters*. Retrieved from: https://treasury.gov.au/policy-topics/measuring-what-matters

[30] Catholic Health Australia (CHA). (2025, August 13). *Catholic Health Australia Submission: Economic Reform Roundtable 2025*. Catholic Health Australia. https://cha.org.au/catholic-health-australia-submission-economic-reform-roundtable-2025/

[31] Catholic Health Australia (CHA). (2025, September 14). *Catholic Health Australia Submission: Response to Productivity Commission's Interim Report on Pillar 4 – Delivering Quality Care Efficiently*. Catholic Health Australia. https://cha.org.au/catholic-health-australia-submission-response-to-productivity-commissions-interim-report-on-pillar-4-delivering-quality-care-efficiently/

System impact

Implementing a national framework to support investment in prevention would deliver significant and wide-ranging benefits:

- Better outcomes for individuals through earlier risk reduction and detection, improved quality of care, enhanced wellbeing, and longer life expectancy with fewer chronic conditions.
    - Stronger community and economic benefits through lower future demand for services, freeing resources for other priorities; increased workforce participation as people stay healthier and carers face less burden; improved social cohesion through greater independence for older Australians.
- Greater system efficiency through a reduced reliance on costly acute interventions, shifting from reactive crisis management to proactive prevention and early intervention, ensuring more efficient use of health and aged care resources.
    - By embedding prevention into policy and funding decisions, this framework would help ensure care is delivered in the right place, at the right time – improving outcomes while reducing long-term costs.

Financial impact

The National Preventive Health Strategy recommends allocating 5 per cent of all healthcare expenditure to prevention by 2030, which would equate to about $8.9 billion in prevention funding for health care alone, in 2022-23.[32]

A realistic first step would be to implement a staged increase in prevention investment. For example, the Victorian Government has committed an average of $833 million per year for prevention between 2023-24 and 2025-26 under the Early Intervention Investment Framework.[33]

National targets should also align with the direction of the National Preventive Health Strategy and be publicly tracked (e.g. via the AIHW dashboard) to reinforce accountability across electoral cycles.

The proposed National Prevention Investment Fund could use these figures as a baseline or apply similar modelling to determine the appropriate funding level required to establish the national framework and support preventative initiatives across the care economy. Importantly, prevention should extend beyond health and aged care, with the Fund's administration guided by principles that promote nationally coordinated action across all policy domains, particularly those addressing the social determinants of health.

Finally, an economic evaluation of the Fund should adopt a societal perspective, recognising that prevention outcomes are often diffuse and accrue across multiple sectors. This approach would strengthen the evidence base for valuing prevention and ensure investment decisions reflect both fiscal and social returns.

[32] Australian Government Department of Health, Disability and Ageing. (2021). *National Preventive Health Strategy 2021–2030*. Retrieved from: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en

[33] Victoria State Government. (2024, November 18). *Early Intervention Investment Framework*. Retrieved from: https://www.dtf.vic.gov.au/early-intervention-investment-framework

Priority 2: Investment in Support at Home, in parallel with Hospital-in-the-Home, to ensure older people can access the right care, in the right place.

Decision sought

That the Commonwealth fund pilot programs to integrate Support at Home with Hospital-in-the-Home (HITH), beginning with HITH delivery in residential aged care homes using a model similar to Residential In Reach (RIR), with a view to expand this approach to all Support at Home recipients over time.

Rationale

The overarching goal of aged care reform should be to match resources to the evolving care needs of older Australians, with flexibility to adapt as those needs change. Delivering truly demand-driven care requires appropriate funding, effective regulation, and a well-supported workforce. CHA urges the Government to implement current reforms to Support at Home with a clear focus on advancing this strategic policy objective, as referred to in previous section of this submission.

Demand for home-based care continues to grow, and most older Australians prefer to receive support at home.[34] Research shows that 71% of respondents aged 55–69 wish to remain in their own home should they require care.[35] However, as Australians live longer, their health and dependency profiles will shift. Rising rates of obesity, depression, dementia, and other complex conditions will increase the need for integrated, high-acuity services. Already, the proportion of HCP recipients with high and complex needs is increasing.[36] In residential aged care, acuity has also risen: approximately 37% of residents have a high care rating under Aged Care Funding Instrument (ACFI) assessments,[37] and over half (54%) of the 242,000 people in permanent care have dementia.

HITH offers a proven model to address these challenges. By enabling acute-level care in a home setting, HITH can reduce exit block, support older Australians' preference to remain at home, and ease pressure on hospitals. Exploring HITH as part of aged care reform represents a strategic opportunity to deliver better outcomes for individuals while improving system efficiency.

Integrating aged care with HITH presents a transformative opportunity to improve outcomes and reduce system pressures. With appropriate clinical oversight, home-based supports – such as those delivered through Support at Home programs – can enable recovery, maintain independence, and prevent avoidable hospital readmissions.

A comparable model, RIR has demonstrated success by providing hospital-level clinical support to residential aged care facilities (RACFs).[38] This approach significantly reduces inappropriate hospital transfers and improves continuity of care.

Integration of HITH with Support at Home aligns with the National Health Reform Agreement priorities and leverages HITH's proven benefits: improved quality of life, reduced hospital-acquired risks, and

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[34] Skatssoon, J. (2020, July 16). *Most want home-based aged care*. Australian Ageing Agenda. https://www.australianageingagenda.com.au/royal-commission/most-want-home-based-aged-care/; and demand has almost doubled - Zara Zadro. (2024, September 11). *"I've got nobody else": Home aged care lags behind high demand*. @9News; 9News. https://www.9news.com.au/national/aged-care-home-pension-support-disability-nursing/cd6a257f-b1ef-46c9-b376-4d6cdc8790fb

[35] Royal Commission into Aged Care Quality and Safety. (2020). *Research Paper 4 – What Australians think of Ageing and Aged Care* (p. 48). https://data.gov.au/data/dataset/2eae3889-8a5e-413a-9496-5fd80f7ae370/resource/feb81cc0-0f8f-4a42-bd2f-3e54540f6cad/download/for-release-research_paper_4_-_what_australians_think_of_ageing_and_aged_care.pdf

[36] Australian Institute of Health and Welfare (AIHW). (2025, April 30). *Admissions into aged care*. Retrieved from: https://www.gen-agedcaredata.gov.au/Topics/Admissions-into-aged-care

[37] Australian Institute of Health and Welfare (AIHW). (2023, June 28). *Older Australians: Aged care*. Retrieved from: https://www.aihw.gov.au/reports/older-people/older-australians/contents/aged-care#Assessment

[38] Rayner, J.-A., Fetherstonhaugh, D., Bauer, M., & McDonald, E. (2017). Evaluation of Residential in Reach: From the perspective of residential aged care. *Figshare*. https://doi.org/10.26181/6064185f653b4

cost-effectiveness. To achieve this, investment is needed in workforce capability and capacity to deliver these supports at scale. Pilot funding should be provided for HITH delivery in residential aged care homes and a model similar to RIR adopted, with a view to expand this model to Support at Home recipients in the long-term.

System impact

In the long term, investing in Support at Home alongside HITH will deliver measurable system-wide benefits by improving patient flow and ensuring older Australians receive care in the most appropriate setting. Investment in this pilot would:

- establish a precedent for linkage funding between health and aged care systems
- test integration across different funding models (residential care, home care, and hospital care)
- inform scalable implementation strategies for HITH in home care settings.

Financial impact

Pilot funding should account for the following cost components:

- **Clinical integration and workforce grants** to enable residential aged care providers to train staff, develop and deliver protocols, and liaise with HITH teams in local hospitals. Costing could be modelled based on similar large-scale initiatives such as Victoria's Better-at-Home initiative,[39] in which funding for the initiative considered the need for training and ongoing liaison between residential care providers and local hospitals.
- **Technical equipment**, such as telehealth kit or carts, at an estimated $9,000 per residential care home.[40] Alternatively, remote monitoring kits may be included in this equipment list.
- Funding to undertake **independent monitoring and evaluation** of the pilot implementation, including navigation of multiple jurisdictions, assessment of clinical government maturity etc. This cost could be modelled after similar pilots of the virtual hospital model, such as in Victoria.[41,42]
- Separate **digital integration and data enablement funding** to design interfaces, maintain reporting structures, align privacy and security measures, and undertake technical onboarding consistent with National Health Reform Agreement (NHRA) aims.

The net Commonwealth cost is expected to be modest when assessed against avoided downstream costs in aged care and hospital systems, which may include but are not limited to:

- Direct episode cost reduction compared to inpatient bed days, based on Activity-Based Funding (ABF) pricing using NEP/NWAU benchmarks.
- Avoided emergency department presentations through admission-avoidance pathways.
- Reduced hospital-acquired complications (HACs) such as pressure injuries, infections, and delirium, lowering length of stay for older patients.
- Lower readmission rates enabled by continuity of care and early escalation through HITH.

Savings will vary by economies of scale (i.e., when the number of episodes of care delivered in the home increases relative to the inputs), site selection, case mix, and digital maturity. Even modest

[39] Victorian Department of Health. (2025, April 14). *Better at Home initiative*. Retrieved from: https://www.health.vic.gov.au/patient-care/better-at-home-initiative

[40] South Western Sydney PHN. (2025). *Telehealth equipment offered to residential aged care homes*. Retrieved from: https://swsphn.com.au/news/telehealth-equipment-offered-to-residential-aged-care-homes/

[41] Talevski, J., Semciw, A. I., Boyd, J. H., Jessup, R. L., Miller, S. M., Hutton, J., Lawrence, J., & Sher, L. (2024). From concept to reality: A comprehensive exploration into the development and evolution of a virtual emergency department. *Journal of the American College of Emergency Physicians Open*, *5*(4), e13231. https://doi.org/10.1002/emp2.13231

[42] Victorian Department of Health. (2025). *Victoria's virtual hospital pilot*. Retrieved from: https://www.health.vic.gov.au/news/victorias-virtual-hospital-pilot

improvements in care continuity could deliver significant fiscal benefits while improving outcomes for older Australians.

Priority 3: Integrating housing, infrastructure, and health care policy to support workforce participation

Decision sought

That the Commonwealth Government urgently explore and implement rental support measures for essential health and aged care workers, including:

- exemptions from salary packaging caps; and
- rental deductions up to a defined limit for properties located within a specified proximity to workplaces.

Rationale

Genuine health and wellbeing for all people begins with access to secure, affordable housing that meets the care needs of its residents. In line with CHA's ethos, Catholic organisations, civil society, and governments share a moral imperative to address the housing crisis and rising homelessness, with a particular focus on supporting the most vulnerable in our communities. CHA's position on housing and homelessness policy is available here.

To build a resilient aged care workforce, government must better integrate housing and workforce policy – particularly as rental unaffordability for care workers continues to rise. Anglicare Australia's 2025 Rental Affordability Snapshot shows that rental affordability for low-income and minimum-wage households is near zero across Australia, even as listings increased to 51,238 and the national vacancy rate hovered around 1.3%. In short, more supply has not translated into meaningful affordability for renters at the lower end of the market. This reality underscores the urgent need for targeted measures that help essential workers live closer to their workplaces.

Proposal 1: $5,000 Ring-Fenced Rent Sub-Cap

Currently, many aged care workers employed by not-for-profit providers can access salary packaging benefits up to $15,900 for general living expenses. Introducing an additional $5,000 rent-specific sub-cap would allow workers to package an extra $5,000 of rent tax-free specifically to address housing concerns. This targeted concession helps workers afford accommodation near their workplace, improving retention in high-cost regions. Importantly, this measure is a tax concession – not a direct cash payment – meaning that the cost to government is foregone tax revenue rather than new expenditure.

Proposal 2: Rental Deduction Cap

A complementary measure would allow eligible aged care workers to claim a tax deduction for part of their rent, up to a defined annual limit (e.g., $10,000). This reduces taxable income, lowering income tax and putting more money back in workers' pockets without increasing wages. The deduction would be capped and tied to proximity rules, ensuring support is targeted to those most affected by rental stress and workforce shortages.

System impact

Together, these measures provide practical, fiscally responsible tools to address rental stress, improve workforce attraction and retention, and reduce reliance on costly agency staff – all while supporting the sustainability of aged care services.

As an illustrative scenario, this investment would:

- Deliver a material pay advantage for a workforce currently lagging behind market rates for comparable graduate roles, improving attraction and retention and supporting long-term workforce stability.
- Provide up to $15,000 in tax-effective benefits per eligible worker through combined salary packaging and rent deductions. Assuming 50% uptake across the sector, this equates to $2.09 billion in gross benefits, significantly improving disposable income and competitiveness of aged care roles.
- Reduce provider costs by lowering turnover. With replacement costs of $5,000–$7,000 per worker, a 10% reduction in turnover across 279,000 residential care workers would save providers approximately $139.5 million annually.
- Lower reliance on agency staff, where average rates of $50–$70 per hour could otherwise cost providers more than $50 million annually.
- Support not-for-profit providers to overcome recruitment barriers in high-cost regions, enabling economies of scale and continuity of care.

Financial impact

Model 1 – $5000 Ring-Fenced Sub-Cap

Based on current sector data,[43] the indicative cost of introducing a $5,000 ring-fenced salary packaging sub-cap for eligible aged care employees is estimated to range between approximately $39 million and $194 million per annum, depending on uptake and provider eligibility scenarios. On this basis, the central estimate – assuming 50% uptake and 45% provider eligibility[44] – is approximately $100 million per year. Final costs would vary according to actual workforce participation, eligibility thresholds, and implementation settings, and should be considered alongside potential benefits such as improved workforce retention and reduced recruitment pressures.

Model 2 – Rent Deduction Cap ($10,000)

Based on current workforce and rental information,[45] the indicative cost of introducing a rent deduction cap for aged care workers is estimated to range between approximately $52 million and $311 million per annum, depending on uptake and cap sensitivity. On this basis, the central estimate – assuming a $10,000 cap and 50% uptake – is approximately $138 million per year. Final costs would vary according to actual renter share, uptake rates, and cap settings, and should be considered alongside potential benefits such as improved housing affordability and workforce stability.

This estimate draws on publicly available data on the residential aged care workforce, Anglicare's Rental Affordability Snapshot,[46] and marginal tax rate assumptions.

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[43] Where there are approximately 279,000 employees in the residential care workforce based on: Jobs and Skills Australia. (2025, October). *Health care and social assistance*. Retrieved from: https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/industries/health-care-and-social-assistance#sectors-1

[44] FBT salary-packaging exemptions (such as the $15,900 living-expenses cap) apply only to employees of organisations that are FBT-exempt or concessional under the Fringe Benefits Tax Assessment Act. Based on the Aged care service list: 30 June 2025 this means that only organisations that are "Charitable", "Religious" and at times, "Community based" would qualify for these exemptions. While up to 58% of all residential aged care services could be classified as a PBI and enable their employees to access $15,900 cash-equivalent salary packaging cap, the actual proportion that do qualify as PBIs would be lower in practice.

[45] Jobs and Skills Australia. (2025, October). *Health care and social assistance*. Retrieved from: https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/industries/health-care-and-social-assistance#sectors-1

[46] Anglicare's results imply many aged care workers face severe rental stress, particularly in metro hotspots, which could push the aged care workforce renter share above the national 31% baseline in those locations. Conversely, in lower cost regional areas, renter share might be closer to (or below) the national average. CHA's indicative estimate is that an estimated number of renters (within the aged care workforce) = 279,000 x 0.31 = 86,490.

Priority 4: Leverage migration policy to strengthen workforce sustainability

Decision sought

That the Commonwealth reintroduce an exemption to the fortnightly working hour cap for international students on visas studying qualifications in the care economy.

Rationale

Australia's aged care sector faces a structural workforce gap that threatens the stability of care delivery. Current workforce policy settings are misaligned with the scale and urgency of demands, creating acute shortages that cannot be addressed through domestic training strategies alone.

Migration policy presents a critical opportunity to address these challenges as part of a coordinated, long-term workforce strategy. While investment in local training pipelines remains essential, these measures alone cannot meet the immediate and projected demand for qualified aged care workers. Strategic migration settings can complement domestic efforts by ensuring timely access to skilled professionals, particularly in high-need roles and underserved regions.

Regional prioritisation is key. Workforce maldistribution is most severe in rural and remote communities, where shortages compromise access and quality of care. Similar principles already embedded in health workforce policy settings apply to international medical graduates (IMGs), who are required to work in designated distribution priority areas before accessing broader practice rights. A similar approach for aged care migration pathways could help address these inequities.

Immediate Action

International students on visas studying qualifications in the care economy – particularly aged care – should be exempt from the current fortnightly working hour cap. This measure would serve as an interim solution to address the acute shortfall of direct aged care workers and meet growing demand driven by Australia's ageing population.[47] This exemption aligns with previous temporary measures introduced during the COVID-19 pandemic to alleviate critical workforce shortages.

Long-Term Strategy

Migration must be treated as a strategic lever, not a short-term fix. Australia faces intense global competition for a limited pool of skilled health and care professionals.

To remain competitive, migration settings must:

- be streamlined and prioritised for high-need roles
- coordinate with domestic training pipelines to ensure system resilience
- include reforms to visa pathways, faster recognition of international qualifications, and improved onboarding and retention supports for internationally qualified workers.

System impact

Genuine collaboration across governments, providers, and communities is essential to make migration policy an effective lever for addressing aged care workforce challenges. These challenges are not limited to workforce numbers – they include systemic barriers such as housing affordability, maldistribution of skills, limited access to childcare, transport constraints, high non-attendance rates, and shortages of specialist supervision and teaching capacity.

[47] Egan, C. (2024, September 4). International student number cuts may hit aged care workforce. *The Weekly Source.* https://www.theweeklysource.com.au/cuts-to-international-student-numbers-a-blow-to-aged-care-workforce/

By embedding regional insights into a coordinated national approach – consistent with the *Jobs and Skills Roadmap for Regional Australia*[48] – migration policy can help overcome these barriers and support sustainable workforce development in rural and remote communities. This means prioritising distribution to areas of greatest need, aligning with existing health workforce policy settings for international medical graduates, and ensuring that migration complements domestic training pipelines rather than replacing them.

This proposal delivers three critical impacts:

- Supports aged care reform compliance: Provides additional labour capacity to meet mandatory care minutes targets and 24/7 registered nurse requirements without altering Australian National Aged Care Classification (AN-ACC) funding rules.
- Improves regional equity: Enables targeted placement in distribution priority areas,[49] reducing maldistribution and strengthening service continuity in rural and remote regions.
- Leverages international education strategically: Unlocks the potential of international students already enrolled in care-economy qualifications,[50] stabilising the aged care workforce while reforms increase demand for skilled and flexible staff.

This proposal could equate to increased tax revenue (positive budget impact) for the Commonwealth based on specific scenarios and settings as set out below.

Financial impact

The net Commonwealth fiscal impact is expected to be modest when assessed against potential benefits such as alleviating workforce shortages and reducing reliance on agency staffing.

Based on current visa and workforce data, the estimated impact of the (re)introduction of a targeted exemption for international students enrolled in aged care qualifications ranges from a $1 million net cost (assuming a low uptake scenario) to a $33 million net gain in Year 1 (assuming a high uptake scenario).

Under a central assumption of 20,000 eligible students and 50 per cent uptake, the estimated impact is a net gain of approximately $6 million.

These estimates are informed by plausible eligibility ranges (12,000–35,000 students),[51] three uptake scenarios (30%, 50%, 70%), and assumptions on additional hours worked, wage rates,[52] and marginal tax rates aligned with ATO guidance.[53] Administrative costs for compliance and sector communication have also been considered in this indicative modelled cost.

Final impacts would depend on actual enrolment numbers, hours worked beyond the current cap, and implementation parameters, and should be assessed against potential benefits such as alleviating workforce shortages and reducing reliance on agency staffing.

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[48] Jobs and Skills Australia. (2025, August 14). *Jobs and Skills Roadmap for Regional Australia - Phase 1*. Retrieved from: https://www.jobsandskills.gov.au/publications/jobs-and-skills-roadmap-regional-australia-phase-1

[49] Department of Health, Disability and Ageing. (2024, November 3). *Distribution Priority Area*. Retrieved from: https://www.health.gov.au/topics/rural-health-workforce/classifications/dpa?language=en

[50] Study Australia. (2023, June 6). *Work hours limit for student visa holders to be re-introduced*. Retrieved from: https://www.studyaustralia.gov.au/en/tools-and-resources/news/work-hours-limit-for-student-visa-holders-to-be-re-introduced

[51] Australian Government Department of Education. (2024). *International student monthly summary and data tables*. Retrieved from: https://www.education.gov.au/international-education-data-and-research/international-student-monthly-summary-and-data-tables

[52] Based on the Aged Care Award Pay Guide, accessed at: *Fair Work Commission*. (2024). Fairwork.gov.au. https://calculate.fairwork.gov.au/payguides/fairwork/ma000018/pdf

[53] Noting that majority of international students working in Australia would be considered an Australian resident for tax purposes. Australian Taxation Office. (2025, June 18). *Tax rates – Australian resident*. Retrieved from: https://www.ato.gov.au/tax-rates-and-codes/tax-rates-australian-residents

Priority 5: Independent evaluation of prognosis-based eligibility criteria for palliative care funding

Decision sought

That the Commonwealth commissions an independent evaluation of the prognosis-based eligibility criteria for palliative care funding across residential and home-based aged care.

Rationale

Palliative care funding in aged care is currently determined by prognosis-based eligibility criteria rather than the clinical needs of the individual, for both residential and home-based settings.[54] This approach presents significant challenges, particularly for older Australians nearing end of life, including:

- Restricting access to essential care, which contradicts the Royal Commission's vision of rights-based, timely access to palliative care.
- Delays in assessment and care provision, creating inefficiencies and shifting accountability across multiple providers within the broader care economy.

The Royal Commission into Aged Care Quality and Safety highlighted the importance of timely, rights-based access to palliative care and cautioned against eligibility frameworks that unintentionally exclude older people with complex or uncertain trajectories. Similarly, the Aged Care Inspector-General and Palliative Care Australia have raised concerns that prognosis-based models are inconsistent with best practice and create inequitable access across care settings.

Given concurrent legislative and policy developments, such as reforms to Support at Home, and increasing emphasis on person-centred care, there is a compelling case to independently evaluate whether current eligibility criteria remain fit for purpose. Without such evaluation, there is a risk that aged care policy settings will continue to fragment end-of-life care and shift responsibility across providers and systems.

An independent, time-limited evaluation of prognosis-based eligibility criteria for palliative care funding across residential and home-based aged care, with a focus on clinical appropriateness, equity, system impacts, and alignment with rights-based care principles is needed.

System impact

An independent evaluation would provide an evidence base to inform future reform and deliver several system-level benefits:

- Improved access and equity: Ensuring eligibility criteria better reflect clinical need would enable earlier, more consistent access to palliative care for older Australians, regardless of diagnosis or prognosis uncertainty.
- Better quality of care and outcomes: Earlier palliative care is associated with improved symptom control, reduced distress, and better support for families and carers.
- Reduced pressure on acute services: Timely palliative care can prevent avoidable hospitalisations and emergency presentations near end of life.
- Stronger policy coherence: Evaluation findings would support alignment across aged care, health, disability, and end-of-life policy settings, reducing fragmentation and duplication.

Importantly, an independent evaluation allows Government to test reform options without pre-empting outcomes, supporting careful, evidence-based policy development.

[54] Inspector General of Aged Care (IGAC). (2025, August 7). *2025 progress report from the Inspector-General of Aged Care*. Retrieved from: https://www.igac.gov.au/collections/2025-progress-report-inspector-general-aged-care

Financial impact

An independent evaluation is expected to be modest in cost and time limited. Based on comparable national policy reviews, CHA estimates costs in the order of $1–2 million over 12–18 months, covering:

- independent expert panel and secretariat support
- data analysis across aged care and health systems
- targeted stakeholder consultation
- public reporting and recommendations.

These costs should be assessed against potential downstream savings from reduced hospital utilisation and improved end-of-life care coordination.