Catholic Health Australia –

Submission to the Inquiry into the Support at Home Program

July 2026

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of community care provision. Catholic organisations are major providers of Support at Home programs.

Our members operate 80 hospitals in each Australian state and the Australian Capital Territory, providing around 30 per cent of private hospital care and 5 per cent of public hospital care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged advocating for an equitable, compassionate, best practice and secure health system that is person-centred and community focused in its delivery of care.

Contents

Item	Page number
Overall comments	3
List of recommendations	4
Access to care	8
System viability and sustainable funding	12
End-of-life care	25
Lessons and safeguards for implementation	27

Overall comments

Catholic providers continue to be strong supporters of the Aged Care Act 2024 - including the Support at Home Program. The emphasis on expanding and strengthening the system that supports older Australians to remain in their homes for longer is strongly aligned with the expressed preferences of older people and their families. It also reflects the evidence that home-based care - when well-designed and adequately resourced - can deliver better outcomes for individuals while reducing avoidable demand on residential aged care and the hospital system. Catholic providers are supportive of this policy direction and committed to its successful implementation for the older Australians they serve. A rights-based system that enables older Australians to age at home with dignity reflects values the Catholic aged care sector has long upheld.

Catholic providers deliver approximately 20 per cent of aged care services in the community in Australia, collectively serving more than 50,000 home care and support consumers across metropolitan, regional, and remote communities. This includes an above-average commitment to providing services in regional areas and to older Australians with low means. This gives Catholic providers valuable insight into the challenges of building an effective and equitable system of home care across the nation.

As implementation progresses, challenges are emerging that warrant careful attention. These include implementation issues that can be resolved with a more collaborative approach between consumers, providers and Government. However, there are also broader structural issues that require policy changes. These challenges span access, system viability, end-of-life care, and the way reforms are communicated and implemented. At a policy level, significant challenges are emerging in:

- ensuring the system is progressing towards being genuinely demand-driven and that access is equitable and timely;
- sustaining the viability of the system that delivers care so that services remain available to those who need them; and
- ensuring older Australians nearing the end of life can access the right care, at the right time, and for as long as they need it.

There have been several positive policy changes since the program commenced such as the Government focusing on effective consumer protections and delaying price caps in Support at Home until such time as there is sufficient data to support their implementation. The move to extend access to the End-of-Life Pathway was also a prudent step while the broader needs of older Australians receiving palliative care are considered.

Catholic providers – as not-for-profit, mission-driven organisations – bring a long tradition of service to those most in need, and it is that tradition which drives their commitment to ensuring Support at Home becomes a system that serves all older Australians.

The recommendations set out in this submission reflect a commitment to the success of Support at Home, identifying practical opportunities to refine the program and ensure that implementation matches intent. Realising its potential will require Government and the sector to work in close and sustained partnership, addressing transition challenges with urgency, refining financial and program design settings, and together building a system that facilitates access to safe, high-quality care that meets the needs and upholds the dignity of every older Australian.

List of Recommendations

CHA recommends that the Committee recommend:

Access to care

01

Commit to a staged transition to a demand-based Support at Home system

Including releasing up to 60,000 additional fully funded packages each year to clear the waitlist within four to six years.

02

Issue guidance on managing clients receiving interim funding

Specify which services must be maintained and which may be deferred, within a defined interim period and commit to transitioning clients on interim funding to full packages by December 2026.

03

Establish a standardised reporting framework for Support at Home waitlists

Including separate reporting for clients receiving interim funding.

04

Reform the assessment system

Ensure professional judgement is available across all assessments, make the escalation process timely and inclusive of independent advocates, refine the IAT to reliably capture frailty and clinical complexity, and ensure the tool's decision-making is transparent and explainable.

05

Engage in co-design with Aboriginal and Torres Strait Islander communities and community-controlled organisations

Develop and deliver culturally appropriate and culturally safe communication methods for the Support at Home program.

System viability and sustainable funding

06

Increase the care management cap to 15 per cent

Allow for the stabilisation of the care management workforce, enable providers to safely support people with higher and more complex needs, reduce unnecessary hospitalisations and improve continuity of care.

07

Review and simplify the structure and claiming process of care management

Reconsider the quarterly pooled structure and streamline the administrative steps required for providers to claim care management funding.

08	**Amend the funding model to allocate care management funding pro-rata from a participant's start notification date** Ensure providers are appropriately funded for mandatory care management activities from the point of first engagement.
09	**Urgently examine the deterioration in provider margins under Support at Home, in partnership with the sector** Including the adequacy of service pricing, the underestimation of transition and administrative costs, and the sustainability of current settings - and act to stabilise provider viability before it results in reduced access to care.
10	**Reduce the administrative burden of Support at Home** Resolve operational and claiming issues that generate unrecoverable cost - including claims rejected without explanation, the absence of a recovery mechanism for claims missed due to system limitations, and unfunded care coordination for Assistive Technology and Home Modification packages. Further, establish a realistic funding mechanism for compliance-related IT costs and a streamlined central management system for verification of associated providers.
11	**Establish a dedicated escalation pathway for systemic platform issues within the My Aged Care and Services Australia systems** Including formal acknowledgment of reported issues, trackable reference numbers, and committed resolution timeframes. This mechanism should be supported by transparent reporting on outstanding system issues.
12	**Develop and mandate a standardised guideline governing the release of restorative care referral codes** Ensure codes are issued within a clearly defined and reasonable timeframe following a client's eligibility assessment.
13	**Strengthen restorative care eligibility criteria** Require clear clinical evidence that a person's support needs are attributable to a specific, recoverable episode, implemented concurrently with assessment and classification reforms.
14	**Establish a minimum viable service payment for AT-HM-only participants** Paid directly to registered providers upon execution of a service agreement, to offset the fixed costs where no ongoing classification budget exists.

15	**Review the low-tier Assistive Technology and Home Modifications (AT-HM) funding allocation** Ensure it is sufficient to meet the mandatory clinical requirements of the scheme.
16	**Increase the period over which funds can be rolled over** So that delays in monthly statement production do not strand funded care or penalise providers for system delays outside their control.
17	**Develop a robust definition of reasonable pricing through co-design** Co-design with consumers and providers, reflective of real-world market conditions including geographic cost variation.
18	**Commit to a longer-term redesign of co-contributions** Addressing shifting consumer behaviour, misalignment between Support at Home and CHSP, and low consumer awareness and buy-in.
19	**Make thin market grants a permanent, ongoing feature of Support at Home** To provide certainty for regional and remote service delivery and sustain access to care.
20	**Undertake an economic evaluation** To assess the costs and outcomes of the first 12 months of Support at Home implementation to generate evidence needed to inform the forward agenda for Support at Home.

End-of-life care

21	**Ensure End-of-Life Pathway funding is responsive to clinical reality** Establish a rapid mechanism to approve funding extensions within days where a person requires ongoing end-of-life care beyond the initial funded period, and amend program settings so that funding can be renewed as many times as clinically necessary.
22	**Improve timely access to services and equipment for End-of-Life Pathway participants** Including by enabling access to the high tier of assistive technology funding under the AT-HM scheme and ensuring assessment anticipates the predictable trajectory of end-of-life decline rather than point-in-time need alone.
23	**Establish a formal mechanism for Commonwealth and State coordination on end-of-life care** Including clear delineation of funding and service delivery responsibilities across the aged care and health systems.

Lessons and safeguards

24	**Commit to providing at least six months' advance notice of major program changes under Support at Home** Including any major changes to the Commonwealth Home Support Programme, to give providers, clients and government systems sufficient time to prepare.
25	**Apply the lessons of the "no worse off" principle to the design and communication of future reforms** Pressure-test major changes against predictable lay understanding and communicate them accordingly.

1 Access to care

Recommendations 1–5

> *"A fully funded Support at Home system minimises higher expenditure on emergency health services and residential aged care and is a foundational commitment to the dignity and wellbeing of older Australians."*

The most fundamental test of Support at Home is whether older Australians who need care at home can access it. The consequences of failing this test extend beyond the individual: older Australians waiting for home care occupy hospital beds they no longer need, contributing to delayed discharge and placing additional pressure on the acute care system. Demand for services already outstrips supply by a significant margin, and the gap continues to widen. This chapter addresses the barriers to access: the volume of unmet demand, the adequacy of interim arrangements, and the operation of the assessment system that determines what care people receive.

1.1 Implement a staged transition to a demand-based system

Demand for Support at Home packages continues to significantly exceed available supply, creating a critical gap that places pressure on older Australians, their families, and the broader care system. The Government's accelerated release of 10,000 Support at Home packages as part of the Budget 2026-27 is a welcome step, reflecting recognition of the scale of unmet need. However, the waitlist for an ongoing Support at Home package has reached 100,191 as of March 2026, with more than 98,600 people waiting to be assessed for aged care needs.[1,2] Failure to fully fund in-home care carries significant consequences including accelerated functional decline, preventable hospitalisation, premature entry to residential aged care, and delayed discharge in the acute hospital system. A fully funded Support at Home system minimises higher expenditure on emergency health services and residential aged care and is a foundational commitment to the dignity and wellbeing of older Australians.

> *Support at Home must scale up substantially to absorb and meet the growing demand today and into the future. If Support at Home is not successful, it is not just a systems failure - it will be a societal failure for the largest older generation in Australia's history. It's encouraging that the Government is listening to feedback, to the stories of participants and announcing positive changes, but there is more work to do - best achieved through working together."* — LARGE-SIZED AGED CARE PROVIDER

[1] Australian Institute of Health and Welfare. (2026). *Support at Home program data report 1 January – 31 March 2026.* https://www.gen-agedcaredata.gov.au/resources/publications/2026/may/support-at-home-program-data-report-1-january-31-march-2026

[2] Australian Institute of Health and Welfare. (2026). *Single Assessment System (SAS) quarterly needs assessment data report: 1 January – 31 March 2026.* https://www.gen-agedcaredata.gov.au/resources/publications/2026/may/single-assessment-system-(sas)-quarterly-needs-assessment-data-report-1-january-31-march-2026

It should be recognised that the Government has provided substantial support to dramatically expand capacity in the home care system over the past five years. At 31 December 2020, 173,495 older Australians had access to a Home Care Package.[3] By 31 March 2026, this figure had risen to 364,723 people with access to a Support at Home package. This represents an increase of over 191,000 people, more than double the 2020 total, reflecting both the scale of underlying demand for in-home care as Australia's population ages, and the expansion in Government-funded packages delivered through successive Budgets and the Support at Home reforms.

The Government's aim to provide 40,000 new Support at Home packages over the 2026-27 financial year, with 10,000 packages brought forward exceeds the estimated annual demand growth of approximately 30,000 packages.[4] The concern, however, is the pace at which the existing backlog will be reduced. Under current settings, the backlog would take more than a decade to clear. This presents a challenge that must be addressed considering an average wait time of 364 days from application to commencement of a Support at Home ongoing package.[5] We therefore recommend that the Government commit to a clear timeframe for clearing the existing waitlist and fund package releases accordingly. Consistent with our pre-Budget submission, an additional 25,000 to 60,000 fully-funded packages per year, would clear the existing backlog within a more reasonable period and move the system closer to meeting the needs of those waiting for care.

> **Recommendation 1:** That the Government commit to a staged transition to a demand-based Support at Home system. This should include the release of up to 60,000 additional fully funded Support at Home packages each year with a clear trajectory to clear the Support at Home waitlist within four to six years.

In the interim, a high number of new Support at Home recipients are receiving packages that fund 60 per cent of their care needs. This places providers in an acutely challenging position where they are bound by obligations to deliver quality care without the resources to fully meet each client's assessed needs. Clear, practical guidance from Government is needed on how providers should prioritise service delivery and communicate transparently with clients during this period of interim funding. Equally important is the need for rigorous reporting on interim package allocations. Where individuals receiving interim funding are counted alongside those on full packages, there is a risk of overstating the number of older Australians whose needs are being fully met. A clear

> *"We have clients who have been assessed as requiring significantly more care than their interim package funds. Our case managers are placed in the difficult position of deciding which essential services can be delivered, and which must be delayed, despite knowing the client's assessed needs."*
>
> — MEDIUM-SIZED AGED CARE PROVIDER

[3] Australian Institute of Health and Welfare. (2021). *Home care packages program data report: 2nd quarter 2020–21* (1 October – 31 December 2020). GEN Aged Care Data. https://www.gen-agedcaredata.gov.au/getmedia/e09a2ac6-0d5c-4cb4-ab82-2d0648c12308/Home-Care-Data-Report-2nd-Qtr-2020-21.pdf

[4] 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

[5] Department of Health, Disability and Ageing. (2026). *Aged Care Act 2024 – Wait times report.* Australian Government. https://www.health.gov.au/resources/publications/aged-care-act-2024-wait-times-report?language=en

understanding of the true extent of the funding gap is needed to drive further investment towards a demand-based system.

Administrative processes add a further burden on providers during this period. Transitioning a client from an interim package to their full allocation requires providers to re-engage with the client and, in many cases, repeat elements of the administrative process already completed once. Similarly, with no defined timeframe for how long a client remains on a minimum service offer, providers must manually check the status of each client to determine whether they remain on this offer. A clear, published timeframe for the minimum service offer, alongside a streamlined and time-bound transition process from interim to full funding, would meaningfully reduce this administrative load and allow providers to plan and report with greater certainty.

For some clients, the shortfall in interim funding is significant enough to deter them from the program altogether. Recognising that an interim package would not provide enough to cover their full care needs, some clients choose to remain on the Commonwealth Home Support Program (CHSP) rather than move into Support at Home. This reinforces the urgency of transitioning clients off interim arrangements and onto fully funded packages, rather than allowing interim funding to become a long-term arrangement.

> **Recommendation 2:** That the Department issue guidance on managing clients receiving interim funding, specifying which services must be maintained and which may be deferred, within a defined interim period and commit to transitioning clients on interim funding to full packages by December 2026.

> **Recommendation 3:** That the Government establish a standardised reporting framework for Support at Home waitlists, including separate reporting for clients receiving interim funding, to accurately guide policy decisions and monitor program capacity across the aged care sector.

1.2 Address current gaps in the assessment system

The Integrated Assessment Tool (IAT) determines both eligibility and the classification level that drives a participant's funding, making it foundational to Support at Home. Therefore, an inaccurate assessment can have a negative cascading effect through the entire care journey. Given the volume of assessments and the need for consistency across geographies and assessors, CHA recognises the case for an algorithmic tool. The objective should be to get the balance right between that consistency and the clinical judgement needed to capture individual complexity.

Since commencement, concerns have centred on the tool's inability to reflect frailty, clinical complexity and fluctuating conditions, and on the limited ability of assessors to depart from an algorithmic result they consider incorrect - reflected in a marked rise in requests for outcome reviews. CHA welcomes the Government's recent introduction of an escalation pathway allowing assessment organisations to refer cases to the System Governor where the tool does not adequately capture a person's needs, and its priority pathway for rapidly progressing conditions. These are constructive steps.

To ensure these refinements deliver in practice, CHA considers the following principles should guide the assessment system:

- professional judgement should be available across all assessments, not only exceptional or outlier cases (a point also made by the Older Persons Advocacy Network);
- the escalation process should be timely and agile, and involve independent aged care advocates, consistent with positions advanced by OPAN and COTA Australia;
- the tool itself should be refined so that frailty, complexity and high-risk domains are reliably captured across both clinical and non-clinical assessor pathways; and
- reform of the tool should proceed together with the assessment and classification reform referenced in the restorative care section, since under-classification drives inappropriate use of short-term pathways.

The assessment system should also consider financial hardship at this early stage of entry into aged care, reducing paperwork-related barriers for applicants and the financial risk to providers if a person is unable to meet co-contributions.

> **Recommendation 4:** That the Government build on its recent assessment reforms by ensuring professional judgement is available across all assessments rather than outlier cases alone, making the escalation process timely and inclusive of independent advocates, and refining the IAT so that frailty, clinical complexity and high-risk domains are reliably captured across all assessor pathways, implemented together with the assessment and classification reform referenced in the restorative care section, and including consideration of financial hardship at the point of assessment.
>
> Above all, the tool's decision-making should be transparent and explainable, so that older people and their families can understand and meaningfully engage with the classification and funding decisions being made about them.

1.3 Culturally safe communication with Aboriginal and Torres Strait Islander communities

Communication should place cultural safety at the forefront. Developing resources in partnership with Aboriginal and Torres Strait Islander communities and community-controlled organisations is essential to ensuring that Support at Home reaches First Nations older people in ways that are culturally appropriate and culturally safe.

> **Recommendation 5:** That the Department engage in co-design with Aboriginal and Torres Strait Islander communities and community-controlled organisations to develop and deliver culturally appropriate and culturally safe communication methods for the Support at Home program.

2 System viability and sustainable funding

Recommendations 6–20

"Where providers cannot sustainably deliver Support at Home, the consequence is not merely a financial one for the organisation but a reduction in the services available to older people, felt first and most sharply in regional and remote communities and among those with complex needs."

Meeting the demand for care described above depends on a delivery system that is viable and sustainable. This chapter addresses the financial and operational pressures that, if unresolved, will constrain the system's capacity to deliver the care older Australians need. The viability of providers is not an end in itself; it is the precondition for access.

2.1 Enable delivery through effective care management

The new Support at Home program is designed to care for older Australians with higher acuity needs, enabling them to age in place at home for longer. Effective care management is essential to coordinate services, manage risk, and ensure that funded care is delivered, particularly as participants present with increasingly complex health challenges. However, the Government's reduction of the care management cap from 20 per cent to 10 per cent does not reflect the actual costs of delivering care management to an older person. This creates a fundamental tension, namely that the aged care system is being asked to expand access to in-home support and care for people with greater needs, while the key funding mechanism that enables these outcomes has been halved.

Care management is a central component of most models of in-home aged care. It is delivered by a person or team who develops a relationship with the older person and ensures the supports they receive are tailored to their individual needs. In practice, this includes developing and reviewing the care plan, coordinating clinical and social services, facilitating transitions into and out of hospital, and - critically - identifying early changes in functional capacity that may be addressed through adjusted supports before they escalate. Care management is therefore essential to maintaining the wellbeing, independence, and safety of older Australians receiving care at home.

The quarterly pooled structure of the care management cap compounds this issue, as it does not adequately account for the operational realities of delivering in-home care. Provider caseloads are not static: client numbers grow, participants transition in and out of services requiring careful handover, new admissions demand intensive onboarding (i.e., the specificity of care plans and service agreements), and existing clients experience acuity spikes that require a rapid escalation in care management input. The current pooled quarterly cap assumes a steady-state caseload that does not exist in practice, and risks leaving providers under-resourced precisely at the moments when care management is most critical to keeping older Australians safely at home.

Even where the cap structure permits providers to draw down the full 10 per cent, providers report difficulty doing so in practice due to the administrative workload involved in claiming. Care partners must complete multiple discrete steps, such as recording a progress note and creating an associated appointment, before time can be charged against care management. Care partners have reported that this multi-step process adds meaningful extra administrative time to each claim, compounding the structural issues with the cap described above.

> *"Our case managers now spend substantially more time completing administrative steps required to claim care management funding. Every additional minute spent navigating systems is time that cannot be spent supporting older Australians."*
>
> — LARGE AGED CARE OPERATOR

Other challenges with care management claiming have been reported by providers. A specific example concerns existing care management accounts for which new participants receive no care management funding for their initial quarter. Funding is calculated and credited from the following quarter onward, yet providers are required to deliver care management to all participants from the point of engagement. This means the first quarter of mandatory service delivery for every new participant must be absorbed entirely from the provider's existing pooled funds, with no mechanism to backdate or reconcile the shortfall. This is a significant challenge for providers who must deliver extensive care management during a new participant's first quarter. As outlined in the Support at Home program manual, care management activities for new participants include:

- onboarding the participant to the program;
- understanding the participant's goals, communication preferences, and cultural supports;
- determining what services will be received and how they will be delivered;
- establishing a service agreement;
- developing a care plan and budget; and
- identifying risks to health and safety.

Delivering this level of care management without adequate funding places significant strain on providers, and risks compromising the quality of support participants receive.

Catholic providers are working diligently to maintain high standards of care and sustain clear, ongoing communication with clients as they navigate the complex transition to Support at Home. Many of our members have already made significant investments into IT systems to support care management, scheduling, reporting, and claiming under the new program, and some have undertaken broader transformation projects specifically designed to absorb the reduction in care management funding. Catholic providers have also developed and facilitated seminars for care managers to increase understanding of their role in facilitating the transition to Support at Home for older people, as well as the development of training programs to educate staff around the new claiming and reporting procedures under Support at Home. These efforts demonstrate the sector's commitment to delivering on the intent of the reforms, but they also underscore the scale of the operational and financial burden being carried by providers – a burden that the current 10 per cent care management cap does not adequately recognise.

An appropriate care management cap is also essential to retaining the existing care management workforce. With each care manager (or "care partner") typically responsible for

45–60 clients, the scale and complexity of their workload is already considerable. Developing a single service agreement, for example, requires clarity, compliance, and active client consent, alongside a deep working knowledge of the Support at Home framework – a process that demands a consistent and methodical approach supported by robust systems and preparation. The reduction in the care management cap has placed much of this skilled workforce at risk of redundancy, as provider funding models can no longer sustain existing staffing levels. Care managers who leave the aged care sector are unlikely to return, and each departure represents a permanent loss of expertise at precisely the moment the sector is being asked to support older Australians with higher acuity needs.

> **Recommendation 6:** That the care management cap is increased to 15 per cent to allow for the stabilisation of the care management workforce, enable providers to safely support people with higher and more complex needs, reduce unnecessary hospitalisations and improve continuity of care.

> **Recommendation 7:** That the Government review and simplify the structure and claiming process of care management, including reconsidering the quarterly pooled structure to better reflect fluctuating caseloads, and streamlining the administrative steps required for providers to claim care management funding.

> **Recommendation 8:** That the Department amend the funding model to allocate care management funding pro-rata from a participant's start notification date, consistent with the approach already applied to newly established care management accounts, to ensure providers are appropriately funded for mandatory care management activities from the point of first engagement.

2.2 Provider viability and the pressures on service delivery

The long-term viability of providers is the precondition for older Australians being able to access care at all. Where providers cannot sustainably deliver Support at Home, the consequence is not merely a financial one for the organisation but a reduction in the services available to older people, felt first and most sharply in regional and remote communities and among those with complex needs. It is in that context - the sustainability of the system that delivers care - that the following financial pressures should be viewed. The most pressing challenge facing providers under Support at Home is a sharp deterioration in the margins on home care operations. Catholic providers are reporting that operating positions which sat broadly in line with industry averages before 1 November 2025 have, in a number of cases, moved into deficit under the new program. Contribution margins on home care businesses have in some instances more than halved in the months following commencement, with several providers reporting net margins that are now negative. Because a contribution margin sits before the allocation of overheads, the underlying operating position is generally worse again. These are not marginal fluctuations; they describe a set of circumstances that cannot be sustained without corrective action.

This deterioration is being experienced broadly across the sector rather than in isolated cases, and it puts at risk the very investment in Support at Home that the reform depends

upon. The picture reflects a combination of factors - the design of funding mechanisms, transition costs, claiming and system difficulties, and conservative service utilisation by participants uncertain about co-contributions - whose relative impacts are still being diagnosed. What is clear is that the revenue shortfall is real, that it is widely felt, and that it requires urgent and collaborative attention before it translates into service reductions or market exits, particularly in regional areas and for higher-complexity care.

A central contributing factor is that service charge-out rates appear to have been set too low from the outset. Independent benchmarking, including analysis by Steward Brown, suggests sector-wide service rates were set approximately 20 per cent below sustainable levels, with the administrative burden of transition significantly underestimated in the modelling. This finding is important because it inverts a common assumption in public commentary. Rather than providers charging excessive prices under Support at Home, the evidence suggests many are charging *too little* to remain viable.

A further and distinct driver of margin pressure is the significant additional administrative burden that has accompanied the transition. Providers are carrying a large volume of claiming, reporting, reconciliation and compliance work that is substantially greater than under the Home Care Package Program, much of which is not directly billable to a participant's budget and is therefore absorbed into overheads. The associated providers framework, which allows participants to access services from secondary providers, currently operates without a centralised registration or verification system, requiring providers to manually confirm each arrangement - a process that is time-consuming, error-prone, and unscalable. The administrative burden takes many other forms:

- claims rejected without a stated reason, forcing repeated manual follow-up;
- claims missed after cut-off because software limitations required manual processing, with no recovery mechanism;
- care coordination costs for Assistive Technology and Home Modification packages that arrive without a corresponding Support at Home package; and
- retrospective claiming for hardship approvals with no bulk submission mechanism.

Individually minor, these tasks accumulate across a provider's caseload into a material and unfunded operational cost. Reducing this burden is both a viability measure and a care-quality measure, since every hour spent reconciling or investigating a rejected claim is an hour not spent supporting older people.

As an example of the administrative burden providers are carrying, one provider estimated that over a period of four weeks, signing new service agreements for Support at Home participants required over 900 hours of effort from home care staff. The breakdown of estimated staff time is shown below, along with the total time estimated to undertake the work required.

Scenario	Estimated staff time
Agreement completed via DocuSign	~35 minutes total (20 min CM + 5 min RM + 10 min admin)
Agreement completed in person	Between 1 hour 20 min and 4 hours 20 min (1-hour visit + up to 3 hours travel + 20 min admin)
Agreement sent by mail	~40 minutes total (20 min to prepare and send + 20 min admin when returned)

Clients with budget challenges	~3 hours total (1 hour preparation + up to 1.5-hour visit + 30 min admin)
Clients who struggle with DocuSign or are hesitant to sign	An additional 1-hour home visit on top of the original work
Clients who have not signed or who have complained	Approximately 2–4 hours per client, including a home visit and follow-up

Figure 1 - Estimated staff time to complete new service agreements

Scenario	Duration (hrs)	Clients	Total time (hrs)
DocuSign	0.58	250	145
Mail	0.66	100	66
Visit	2	350	700
Total	**–**	**700**	**911**

Figure 2 - Total time estimation to complete new service agreements

Compounding these operating pressures is the capital cost of ongoing regulatory change. Successive amendments to the program's rules have required providers to reinvest in and upgrade their IT systems, generating costs that fall outside normal operating expenditure. Providers were initially allocated $10,000 to meet these technology requirements, an amount that has been substantially exceeded given the volume and pace of change since. With further reform on the horizon, a realistic funding mechanism for compliance-related IT costs is important to provider viability.

> **Recommendation 9:** That the Government, in partnership with the sector, urgently examine the deterioration in provider margins under Support at Home - including the adequacy of service pricing, the underestimation of transition and administrative costs, and the sustainability of current settings - and act to stabilise provider viability before it results in reduced access to care.

> **Recommendation 10:** That the Government reduce the administrative burden of Support at Home by resolving operational and claiming issues that generate unrecoverable cost - including claims rejected without explanation, the absence of a recovery mechanism for claims missed due to system limitations, the absence of a streamlined central management system for verification of associated providers, and unfunded care coordination for Assistive Technology and Home Modification packages - and establish a realistic funding mechanism for compliance-related IT costs.

CASE STUDY Waitlisting and place take-up deadlines

Under Support at Home, placing a participant on a provider waitlist does not pause the take-up deadline associated with their allocated place. If that deadline expires while the participant remains waitlisted, the place will automatically lapse and be withdrawn, without any intervening notification to the provider. This represents a departure from previous business-as-usual practice.

Many providers routinely waitlisted participants until funding was confirmed, then commenced services upon approval. Under Support at Home, this workflow is no longer viable: where a participant is approved while on a waitlist, no notification is triggered to alert the provider to commence services. The risk of placement lapse therefore falls silently on the provider and, ultimately, on the participant.

Providers are advised to avoid waitlisting participants once funding has been allocated. This is particularly critical for Restorative Care Places, where allocation is immediate. However, implementing this shift has proven difficult, given how embedded the prior workflow was across the sector.

Two further system-level improvements would reduce avoidable confusion and cost. First, the terminology used within the My Aged Care platform should be clarified and standardised, so that providers and consumers can navigate the system with consistent understanding of its terms. Second, providers and consumers should have access to the same information from a systems perspective - where one party sees data the other does not, it creates the conditions for the problems illustrated in the case study above.

> **Recommendation 11:** That the Government establish a dedicated escalation pathway for systemic platform issues within the My Aged Care and Services Australia systems, including formal acknowledgment of reported issues, trackable reference numbers, and committed resolution timeframes. This mechanism should be supported by transparent reporting on outstanding system issues to ensure accountability and maintain provider and consumer confidence in the Support at Home program.

2.3 Standardise the release of restorative care codes

A significant barrier within the Support at Home restorative care pathway is the lack of consistency in how referral codes are allocated to eligible clients. Current practice varies considerably depending on the individual assessor conducting the eligibility assessment, rather than being governed by a standardised, transparent process.

In some cases, assessors withhold the restorative care referral code until the client has identified and confirmed which provider they intend to engage. In other cases, where the client's preferred provider is already known at the time of assessment, the assessor releases the code immediately. This discretion-based variation means that two clients with equivalent needs and equal entitlement to restorative care can experience markedly different pathways and timeframes, depending solely on which assessor they happen to be allocated.

The practical consequence of this inconsistency is significant delay. Clients who are assessed as eligible for restorative care, and who should be able to access it promptly, have been left waiting as long as five months before receiving the referral code needed to commence services. For a program intended to deliver short-term, time-limited intervention

to restore or maintain a person's independence, a five-month wait substantially undermines its purpose. The functional decline restorative care is designed to prevent or reverse may already have occurred by the time the client can access support. This points to a need for clearer, nationally consistent guidance on when and how restorative care referral codes are released, ensuring that eligible clients can access the pathway without unnecessary and avoidable delay.

> **Recommendation 12:** That the Department develop and mandate a standardised guideline governing the release of restorative care referral codes, ensuring codes are issued within a clearly defined and reasonable timeframe following a client's eligibility assessment.

Separately, evidence from the sector suggests the restorative care pathway is increasingly absorbing people whose needs warrant a higher ongoing classification rather than a short-term intervention - a consequence of the assessment challenges discussed above. Where this occurs, the pathway's limited funding is exhausted without resolving the underlying need, contributing to the viability pressures described in the preceding section. Strengthening restorative care eligibility criteria, implemented concurrently with the assessment reforms recommended earlier in this submission, would help ensure the pathway serves its intended purpose.

> **Recommendation 13:** That the Department of Health, Disability and Ageing strengthen restorative care eligibility criteria to require clear clinical evidence that a person's support needs are attributable to a specific, recoverable episode, implemented concurrently with the assessment and classification reforms outlined elsewhere in this submission.

2.4 Reform the Assistive Technology and Home Modifications scheme

Like the issues above, the design of the Assistive Technology and Home Modifications (AT-HM) scheme bears directly on system viability as well as whether older Australians can access the equipment and modifications they have been assessed as needing. Because providers cannot recover the cost of servicing AT-HM-only participants, referrals are being declined, so the viability challenge here presents first and foremost as an access problem for older people.

The Support at Home program contains a significant structural gap affecting participants who are approved for AT-HM funding without a concurrent ongoing Support at Home classification. AT-HM funding is allocated through a separate priority system that can run well ahead of ongoing classification decisions. In some cases participants remain in this position for more than twelve months. Throughout that period, the program provides no mechanism to fund the care management, administration, compliance, staffing, and system costs a provider must incur to service participants receiving AT-HM only. Providers are consequently being asked to onboard, assess, coordinate, and remain accountable for a participant's care with no corresponding revenue stream, and the result is that AT-HM-only referrals are being declined due to financial necessity rather than by choice. This problem is most acute at the lowest funding tier, where the total AT-HM allocation is up to $500 per year. Where an occupational therapist assessment and prescription is required before equipment or

modifications can be arranged, the cost of that clinical pathway alone can absorb most of the available funding, leaving little or nothing for the equipment or modifications needed.

> *"Despite our commitment to meeting client needs wherever possible, we have had to consider declining referrals for clients requiring only Assistive Technology because there is simply no funding available to cover the mandatory care management and compliance obligations. Due to funding constraints, we were only able to offer simple solutions to the client despite being assessed as needing more complex assistance."*
>
> — MEDIUM-SIZED AGED CARE PROVIDER

The operational consequences for providers who do accept these clients are significant. Accepting an AT-HM-only client triggers the full suite of obligations under the Aged Care Act 2024 and the Aged Care Quality Standards, including service agreements, assessments, reporting, compliance, and insurance, none of which diminish due to limited funding. Care management under Support at Home is funded as a ten per cent component embedded within ongoing classification budgets. Where no classification exists, there is no care management funding to draw on. Without funded care management, aged care workers cannot take a holistic view of the client, assess changing needs, identify emerging risks, or coordinate broader supports, restricting the quality and safety of care while the provider absorbs unrecovered cost. At the lowest funding tier, these two challenges compound one another – a limited funding allocation cannot sustain the clinical requirements of the scheme, and a regulatory environment demands full provider accountability regardless.

Recommendation 14: That the Government establish a minimum viable service payment for AT-HM-only participants, paid directly to registered providers upon execution of a service agreement, to offset the fixed costs of onboarding, compliance, and care coordination where no ongoing classification budget exists.

Recommendation 15: That the Government review the low-tier AT-HM funding allocation of up to $500 per 12 months to ensure it is sufficient to meet the mandatory clinical requirements of the scheme, including occupational therapist assessment and prescription for products, equipment, or modifications.

2.5 Enable meaningful rollover of unspent funds

Support at Home allows a proportion of unspent funds to be carried between quarters, in recognition that care needs and service delivery do not fall neatly within quarterly boundaries. In practice, however, the mechanism is being undermined by delays in the production of monthly statements, without which unspent funds cannot be reconciled and spent.

Providers have been working with Services Australia and with software vendors to expedite the delivery of monthly statements and turnaround times are improving. However, even once the system is functioning as intended, statement production may take weeks on average.

The consequence is that the window in which a provider can actually direct rolled-over funds toward a client's care is compressed to a fraction of the intended period. Funds that were allocated to meet an older person's assessed needs are effectively stranded by an administrative delay, and the client does not receive the care those funds represent.

Further contributing to the confusion of participants, they are often unable to view their true balance at the start of the month, with rolled-over funds only becoming visible during the second month. This compounds the reduction in package utilisation and system efficiency. But just as importantly, it has led to hesitancy from older Australians to use the care services they need, for fear of over-subscribing to their package.

A moderate increase in the period that funds can be rolled over would provide a buffer against these delays, ensuring that system and statement-production timing does not deprive older Australians of funded care or penalise providers for delays outside their control. This is a pragmatic, low-cost adjustment that directly protects service delivery during the transition period.

> **Recommendation 16:** That the Government increase the period over which funds can be rolled over, so that delays in monthly statement production do not strand funded care or penalise providers for system delays outside their control.

2.6 Consumer protections and the deferral of price caps

Catholic providers welcome the Government's decision, announced in May 2026, to defer the introduction of price caps under Support at Home, together with the accompanying package to strengthen consumer protections. CHA had called for this deferral, and its adoption is a constructive and evidence-based outcome. Setting caps at this stage - against a pricing baseline that is neither stable nor fully understood - would have risked entrenching unsustainable rates, reducing consumer choice, and lengthening already strained waitlists, particularly in regional areas and for higher-complexity services.

CHA strongly supports the consumer protection measures announced alongside the deferral, including empowering the Aged Care Quality and Safety Commission to order refunds in cases of overcharging, publishing a quarterly summary of Support at Home prices, monitoring the prices of personal care services as they transition into the Clinical Care category, encouraging providers to limit price increases to twice per year, and engaging consumer and sector peak bodies alongside the Commission to establish a robust definition of reasonable pricing. These measures address the legitimate concern about pricing without the adverse consequences that premature caps would have introduced.

This deferral should be used to build the evidence base that any future pricing decision requires. As set out in section 2.2, independent benchmarking suggests current prices may sit below sustainable levels rather than above them. The priority now is to allow pricing data to mature across the first full year of operation. Should the Government contemplate caps in future, they should not be introduced before there is clear evidence of pricing function within Support at Home, and providers should be afforded no less than six months to adapt.

Any interpretation of cost data must also account for geographic variation. The unit prices reflected in the Independent Health and Aged Care Pricing Authority (IHACPA) 2026–27 Support at Home pricing advice are based on national average costs and do not capture the significant variation that exists across different geographic contexts. IHACPA's own findings

indicate that for some service categories, such as personal care, costs can be up to 43 per cent higher when delivered in remote or very remote communities compared with metropolitan and regional centres.[6] Any assessment of pricing, and any future definition of reasonable pricing, must reflect this variation to ensure market sustainability and equitable access across rural and remote Australia.

> **Recommendation 17:** That a robust definition of reasonable pricing be developed through co-design with consumers and providers, reflective of real-world market conditions including geographic cost variation.

2.7 Rethink the design of co-contributions

Moving personal care services into the Clinical Care category - where they attract no co-contribution - was the right decision in the circumstances, and CHA supported it. It provided immediate relief against outcomes that were deterring older people from accessing essential personal care. However, that decision addresses a symptom rather than the underlying design question. If co-contributions are to achieve their policy purpose of meaningfully and sustainably reducing the burden on Government of funding aged care, a longer-term rethink of how they are designed and implemented will be required. As part of this design, a key goal of setting co-contributions appropriately must be to protect access for older Australians of low means.

Three factors make this rethink necessary. First, changes in consumer behaviour are already being observed, with co-contributions deterring uptake. Sometimes this has occurred because they are unaffordable - particularly for full pensioners who are renting - and sometimes because older people decline services on principle. Second, contribution requirements are not aligned between Support at Home and the Commonwealth Home Support Programme, creating an incentive for consumers to remain on CHSP when their needs have exceeded that program's capacity. Third, consumer awareness of, and buy-in to, the role of co-contributions in the system is low, which erodes trust - an effect compounded where Support at Home entitlements are lower than what a participant previously received.

CASE STUDY When staying at home costs less but the system makes it harder

One Catholic provider reported the experience of a 90-year-old participant on a Classification 7 package whose daily care needs - including morning assistance, transport, meals, and clinical oversight - exceed his funded allocation by approximately $20,000 per year. Despite his expressed wish to remain at home, his family is considering residential care to alleviate the financial burden.

Residential care would cost the system considerably more than the combined Support at Home and private funding currently supporting him at home - an outcome that is neither person-centred nor cost-effective.

Experiences like this illustrate that the current co-contribution settings are not yet optimised to support the program's objectives or aligned with the broader aged care system. Taken together, these factors mean the current co-contribution settings are unlikely to deliver the

[6] Independent Health and Aged Care Pricing Authority (IHACPA). (2026). *Support at Home cost collection 2025 final report.* https://www.ihacpa.gov.au/resources/support-home-cost-collection-2025-final-report

sustainable funding contribution intended, while simultaneously suppressing appropriate service uptake. A considered redesign with aligned settings across programs, attention to affordability, and a clear public rationale that builds consumer understanding and acceptance would better serve both the fiscal objective and older Australians' access to care.

> **Recommendation 18:** That the Government commit to a longer-term redesign of co-contributions, recognising the personal-care-into-clinical-care decision as an appropriate short-term measure, and addressing shifting consumer behaviour, misalignment between Support at Home and CHSP, and low consumer awareness and buy-in.

2.8 Make thin market grants permanent

Support at Home relies on targeted grant funding to sustain service delivery in thin markets. These are typically the regional, rural and remote communities where population sparsity, distance and higher delivery costs mean the standard funding model alone cannot support a viable service. For the older Australians living in these communities, these grants are frequently the difference between having access to in-home aged care and having none at all.

At present this funding is delivered through grant rounds that are opened iteratively rather than as a standing, permanent feature of the program. Each round requires providers to apply, wait for outcomes, and operate without certainty about whether funding will continue beyond the current period. This stop-start approach is poorly suited to the nature of the need it addresses.

The iterative approach carries real consequences. Providers cannot commit to long-term investment in staff, infrastructure or local partnerships in a community when the underlying funding may not be renewed. Skilled workers are difficult to attract and retain without the security of ongoing employment, and each interruption to service risks a community losing its only local provider - a loss that is often permanent and disproportionately affects older Australians with the fewest alternatives. It is also financially inefficient to deliver this care – which is plainly necessary over the long term – in grant-based increments. It limits opportunities for secure and potentially cheaper longer term contract arrangements providers might otherwise enter into.

These cost pressures are particularly acute in the delivery of aged care to Aboriginal and Torres Strait Islander peoples in rural and remote communities. In these settings, providers face materially higher costs including accommodation and cost-of-living expenses to recruit and retain staff, significant travel distances that reduce service capacity, and limited access to GPs and medical specialists - which can delay diagnosis and complicate clinical care planning. In some communities, providers are required to source or subsidise local accommodation for staff as a precondition for maintaining access to care. Permanent thin market funding is essential to sustaining culturally safe, clinically appropriate care for First Nations older people in these communities.

Making thin market grants a permanent, ongoing component of Support at Home would provide the stability needed to sustain services in the communities that depend on them most. Permanency would enable providers to plan and invest with confidence, support workforce stability in hard-to-staff areas, and give older Australians in regional and remote

communities the same reasonable expectation of continuity of care that their metropolitan counterparts enjoy.

There are a range of potential mechanisms to achieve this. Options include:

- a program stream analogous to the ongoing and short-term pathways already embedded in Support at Home;
- a geographic loading on service pricing consistent with the cost variation identified by the Independent Health and Aged Care Pricing Authority; or
- a dedicated supplement similar to the viability supplement that exists in residential aged care.

What matters is that the funding is structural and ongoing rather than contingent on periodic grant rounds.

> **Recommendation 19:** That the Government make thin market grants a permanent, ongoing feature of Support at Home rather than delivering them through iterative grant rounds, to provide certainty for regional and remote service delivery and sustain access to care in communities that depend on them.

2.9 Economic evaluation of Support at Home

The Support at Home program introduces a range of new funding mechanisms when compared to the previous Home Care Packages (HCP) program. These mechanisms - including the quarterly pooled care management cap, proposed service price caps, and client co-contributions - have not yet been comprehensively modelled, nor is there a robust evidence base to support meaningful analysis or refinement of their design. This gap is significant: the sector and IHACPA alike are being asked to operate, and to make consequential pricing and policy decisions, without the underlying data needed to do so with confidence as the system remains in transition.

The need for evidence-informed decision-making becomes more acute when considered against the forward agenda for the program. Ongoing revision of the structure and role of CHSP will be critical to get right. Given the scale of the CHSP and the structural differences between the two programs - Support at Home being a tiered, package-based funding model and CHSP a grant-based model – any decisions must be grounded in concrete evidence about how the funding mechanisms of each can be reconciled.

Applied to Support at Home, an economic evaluation could examine the cost-effectiveness and cost-utility of key funding levers - including the care management cap and co-contribution settings - by linking the resources invested in each mechanism to the outcomes they produce for older Australians. This would move the conversation beyond whether current settings are affordable in isolation, to whether they represent value for the system, for providers, and most importantly for the older people the program is designed to support.

This inquiry should recommend an economic evaluation be undertaken of the first 12 months of Support at Home implementation (1 November 2025 to 1 November 2026). Such an evaluation would generate the evidence needed to:

- inform the relationship between CHSP and Support at Home;

- refine the existing funding levers within Support at Home so that they better reflect sector realities and enable providers to care effectively for older Australians with increasing complexity and a preference to age in place; and
- assess the extent to which Support at Home has achieved the intent set out in the objectives of the new *Aged Care Act 2024*.

> **Recommendation 20:** That the Government undertake an economic evaluation to assess the costs and outcomes of the first 12 months of Support at Home implementation to generate evidence needed to inform the forward agenda for Support at Home.

3 End-of-life care

Recommendations 21–23

"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."

3.1 Strengthen the End-of-Life Pathway

Catholic providers commend the Government for strengthening of the End-of-Life Pathway within Support at Home as part of the Federal Budget for 2026-27, resulting in the option for older people to access an additional round of funding in cases where they continue to need services beyond three months. The recognition that Australians approaching the end of life deserve timely, well-resourced and dignified care in their home is a significant and welcome step. The pathway has the potential to reduce unnecessary hospitalisation, respect individual preferences, and improve system efficiency. The decision from Government acknowledges that this final stage of life carries particular care needs and timelines that warrant a strengthened funding approach and we thank the Government for prioritising this reform.

However, current design settings do not yet fully reflect clinical reality. 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.

While the extension of the End-of-Life Pathway is a welcome step, funding arrangements must ultimately align with clinical reality rather than fixed time limits to avoid transferring 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.

CHA recommends targeted reforms to ensure the Support at Home End-of-Life Pathway is clinically appropriate and viable for providers.

> **Recommendation 21:** That the Government ensure End-of-Life Pathway funding is responsive to clinical reality by establishing a rapid mechanism to approve funding extensions within days where a person requires ongoing end-of-life care beyond the initial funded period, with funding continuity maintained while approvals are processed, and by amending program settings so that funding can be renewed as many times as clinically necessary, determined by assessed need rather than fixed time limits.

Access to services and equipment under the pathway also warrants attention. Assessment for both services and assistive technology focuses on a person's current, point-in-time needs, an approach poorly suited to end-of-life care where rapid deterioration is predictable and equipment is frequently needed urgently. Assistive technology applications for pathway participants are reported to be handled more slowly than other pathway services, and participants are limited to the low ($500) or medium ($2,000) assistive technology tiers under the AT-HM scheme. Because those budgets must also cover assessment, prescription, delivery and administration, prescription costs alone can consume the greater part of a low-tier budget, leaving little for the equipment itself. Many people approaching the end of life require equipment beyond the medium tier, yet the high tier is not available to them. Palliative Care Australia has identified these barriers, and CHA supports reform in this area. Enabling pathway participants to access the high assistive technology tier, anticipating the predictable trajectory of decline rather than assessing only present need, and improving assessor education in palliative and end-of-life care would together ensure older Australians receive the equipment they need while they are still able to benefit from it.

> **Recommendation 22:** That the Government improve timely access to services and equipment for End-of-Life Pathway participants, including by enabling access to the high tier of assistive technology funding under the AT-HM scheme and ensuring assessment anticipates the predictable trajectory of end-of-life decline rather than point-in-time need alone.

> **Recommendation 23:** That the Government establish a formal mechanism for Commonwealth and State coordination on end-of-life care for older Australians, with clear delineation of funding and service delivery responsibilities across the aged care and health systems.

4 Lessons and safeguards for implementation

Recommendations 24–25

"A person can lose access to care they were assessed as needing because of a communication failure. These settings must be clearly communicated to older people to minimise the risk of service inaccessibility and reduce the burden on providers to navigate and explain changes that should be communicated by Government."

The challenges identified throughout this submission are not only matters of program design; they also reflect how reforms are communicated, implemented, and sequenced. This chapter draws on the experience of the first months of Support at Home to identify principles that should guide the implementation of future changes - including any future changes to the Commonwealth Home Support Programme.

4.1 Lessons from the "no worse off" principle

The "no worse off" principle was a commitment that participants transitioning from the Home Care Package (HCP) program not be financially disadvantaged under Support at Home. This policy was well intentioned and supported by the sector. However, the experience of implementation provides lessons as the Government considers further reform to both Support at Home and CHSP. The way the principle operated in technical terms did not always match the way participants and their families could reasonably be expected to understand it.

> *"The 'no worse off' principle was well-intentioned, but in reality, it has created headaches for providers and confusion for clients. Our staff have spent countless hours explaining the difference between what Government meant by 'no worse off' and what clients believed it meant."*
>
> — MEDIUM SIZED SERVICE PROVIDER

One of the most common examples of this divergence is in instances where the total available care for an older Australian under their package was reduced, which was more common with higher tier packages. The Government's intent was that an older Australian would not pay more for care. In practice, the no worse off commitment would be interpreted more broadly.

An everyday reading of "no worse off" diverged from its precise policy meaning and the gap created confusion, undermined trust, and placed providers in the position of reconciling the difference at the front line. This compounded the messaging and implementation challenges discussed above.

The consequences of these communication gaps are not merely administrative. For example, older people who have been approved for the Restorative Care Pathway but miss their take-up date - a deadline they may not have been told about - must be reassessed, and re-entry to the pathway may not be possible. A person can lose access to care they were assessed as needing because of a communication failure. These settings must be clearly communicated to older people to minimise the risk of service inaccessibility and reduce the burden on providers to navigate and explain changes that should be communicated by Government.

When the Government announced that personal care services would move into the Clinical Care category, it appropriately provided the sector with substantial lead time. This approach should be the standard for all major program changes. Critical changes to CHSP, Support at Home and the way in which they relate to each other should be announced at least six months in advance of implementation, to support effective change management and give providers, clients, and government systems sufficient time to prepare for reforms of this scale.

> **Recommendation 24:** That the Government commit to providing at least six months' advance notice of major program changes under Support at Home, including any major changes to the Commonwealth Home Support Programme, to give providers, clients and government systems sufficient time to prepare.

Further reforms should be pressure-tested not only for technical accuracy but against the predictable lay understanding of the language used to describe them. Where a reasonable participant would read and interpret a commitment differently from its technical operation, that divergence is an implementation risk that should be identified and addressed before rollout. This is particularly relevant where the misunderstandings resulting from Government messaging undermine the relationship of trust between providers and consumers that is integral to high quality care delivery. Building this discipline into the design of future changes, would reduce avoidable disputes and support smoother implementation.

> **Recommendation 25:** That the Government apply the lessons of the "no worse off" principle to the design and communication of future reforms, pressure-testing major changes against predictable lay understanding - not only technical accuracy - and communicating them accordingly.