

# Inspector-General of Aged Care

## **Inquiry into the transition of the Commonwealth Home Support Program to the Support at Home Program** Submission from the Inspector-General of Aged Care

January 2026



## Introduction

The Inspector-General of Aged Care (Inspector-General) welcomes the opportunity to make this submission to the Senate Community Affairs Legislation Committee's inquiry into the transition of the Commonwealth Home Support Program to the Support at Home Program.

## The Inspector-General of Aged Care

The Inspector-General, and the Office of the Inspector-General of Aged Care were established under the *Inspector-General of Aged Care Act 2023* (IGAC Act) to provide independent oversight of the aged care system. The Inspector-General exercises her statutory powers to monitor, investigate and report on the Commonwealth's administration, regulation and funding of the aged care system.

As embodied in the Office's [Strategic Framework](#), the purpose of the Inspector-General is ensuring integrity, transparency and accountability in the aged care system. The Inspector-General drives meaningful change across the aged care system by reviewing and reporting on systemic issues and identifying opportunities for positive change, in accordance with the IGAC Act. The Inspector-General's objective in delivering these functions is to ensure the government can truly administer and regulate an aged care system where every person receives kind, compassionate and high-quality care that promotes their rights, identity and independence.

## Summary of the Inspector-General's position and recommendations

The Commonwealth Home Support Program (CHSP) represents one of the greatest and most immediate opportunities the Australian Government has to fulfill its grand ambition for people to age in place while connected to their community, to create genuine savings, and potentially alleviate demand for aged care beds. The following submission is premised on this contention.

The CHSP is currently the Australian Government's primary vehicle for preventing acute ageing, supporting older people's preferences to age in place and keeping people out of higher cost and more intensive tertiary aged care and hospitals. In 2024–25, the CHSP supported approximately 838,964 older people in Australia to remain living independently and safely at home by providing entry-level home support with everyday living needs. However, despite supporting more than 55 per cent of the aged care client cohort, CHSP only comprises approximately 8 per cent of total Commonwealth aged care expenditure, making it highly cost-effective as a primary prevention program.

The Inspector-General is concerned that the proposed transition of the CHSP to Support at Home, if not done right, poses a huge risk to the program's ongoing ability to deliver on its original preventative purpose. Depending on the transition approach taken, it risks the introduction of a less flexible and more expensive 'fee-for-service' co-contribution model for entry-level support services aimed at preventing or delaying acute ageing. This is likely to further impact those who are most vulnerable or who live in regional or more remote regions and would undermine the intent of the Royal Commission, which envisaged a single, combined aged care program that **retained the benefits** of each of its component programs and delivered a demand-driven system predicated on assessed need.

The government also has a distinct opportunity here: the Inspector-General argues that this transition could be used to reinforce the program's preventative focus. Strengthening CHSP delivery



might help stretch the aged care budget by slowing demand for more intensive tertiary aged care. By doing so, more people could access aged care within the same overall funding envelope.

**This submission raises critical questions and considerations to which the government *must* have answers before it transitions its primary prevention vehicle for the aged care system, into a funding program that targets more tertiary intervention.**

Getting this right will support the government to deliver on the objectives of the *Aged Care Act 2024* with respect to upholding the rights of older people to independence, autonomy, freedom of choice and social connection, in a way that other programs are not currently structured to do. It could also defensibly generate significant savings to the aged care budget. Facilitating CHSP to better meet its original intent would deliver economic benefits through the prevention of acute decline, and honour older people's preferences to remain living independently at home and in their communities for as long as possible.

The Inspector-General considers it vital that the following core principles of the CHSP model be retained or embedded, whether by way of CHSP or under an alternative model for an entry-level aged care program. These are that:

- preference to age in place is honoured
- social connection is encouraged and enabled
- services and supports are equitably accessible and readily available
- funding models ensure the viability of a diverse variety of providers.

Under any transition, concerted attention must be paid to ensure these principles are not compromised.

## Recommendations

The Inspector-General makes the following recommendations for action by the Australian Government, for the committee's consideration.

1. **Provide greater clarity and transparency on the evidence base and modelling assumptions underpinning the proposed CHSP transition and facilitate meaningful engagement with the sector and broader community at the earliest possible opportunity.**
2. **Provide greater transparency of unmet need for CHSP services and supports by service type and region to support sector planning and transition preparedness.**
3. **Fund an independent analysis of the implications of the \$15,000 lifetime cap for home modifications and whether greater investment or raising the cap under the CHSP would offset the much greater cost of premature entry into residential aged care. The final report of this analysis should be made public.**
4. **Remove the 16-week maximum for delivery of care under the Support at Home End-of-Life Pathway and provide greater clarity on the intersection with CHSP services post-transition.**
5. **Retain a suitable funding model for CHSP providers operating in thin markets to provide certainty and ensure the ongoing viability of providers, including in the lead up to, and throughout, the transition of CHSP to Support at Home.**
6. **Fund an independent cost-benefit analysis of the CHSP, weighing the potential benefits of expanding CHSP against the cost of delivering higher level care at the tertiary end of the system if the delivery of entry-level home care supports is further constrained. The final report of this analysis should be made public.**



## Inspector-General's response to the Terms of Reference

Uncertainty is driven by a distinct lack of clear information on the timeline and transition approach

Following the November 2023 announcement that the Support at Home program would be delivered in two stages, there has been a distinct lack of clear information regarding the detail and timeline around the transition of CHSP. Many providers are concerned that information about the detail of the transition will be left to the last minute. The language of 'no earlier than' with respect to the tentative transition date of 1 July 2027 has created additional distress and confusion, while also leaving open-ended the suggestion that this date may again be changed, preventing existing CHSP providers from forward planning and providing certainty to their workforce.<sup>1</sup> Numerous CHSP providers, consumers, workers and aged care advocates have relayed this sentiment to the Inspector-General over a sustained period.

Additionally, there is limited publicly available information relating to the evidence base underpinning decision making around the transition of CHSP. Nor is there clarity around what, if any, modelling has been undertaken to support the notion that the tentative transition timeline is practical, or possible, for the majority of CHSP providers and clients. This lack of information makes it impossible to accurately assess the adequacy of the transition timeline or the readiness of impacted aged care providers.

**The Inspector-General recommends that the Australian Government provide greater clarity and transparency on the evidence base and modelling assumptions underpinning the proposed CHSP transition and facilitate meaningful engagement with the sector and broader community at the earliest possible opportunity.**

Older people waiting to access to assessment and CHSP services are likely to be further impacted

It is currently unclear to the Inspector-General what data the Department of Health, Disability and Ageing (the department) holds in relation to unmet need and wait times for CHSP services and supports. However, the Inspector-General has continued to hear overwhelming anecdotal evidence that demand for CHSP services exceeds available funding, and providers are routinely having to turn away prospective clients who have been assessed as needing CHSP supports. Although waiting times for CHSP services and supports can vary widely depending on location, the level of care required, and the availability of specific services, extended delays increase the risk of rapid deterioration and premature entry into higher-level care.

Furthermore, information provided to the Senate Estimates Community Affairs Committee in December 2025 has indicated that, as at 31 October 2025, there were approximately 116,150 older people waiting for an aged care assessment, with around 60 per cent of these specifically waiting for a home support assessment. Whilst it is understood that these numbers have slightly declined, it remains to be seen how quickly wait times for assessment will be reduced, particularly given the expected, exponentially growing demand for these services as Australia's population ages.

---

<sup>1</sup> The Hon Anika Wells MP, Minister for Aged Care (2023) [Support at Home to be rolled out in two stages](#) [accessed 14 January 2026].



Given the lack of clarity regarding the transition approach for the approximately 840,000 existing CHSP clients, coupled with the tens of thousands awaiting an assessment and an unknown number of prospective CHSP clients currently waiting in limbo for services, the Inspector-General is seriously concerned that the proposed transition will negatively impact waiting periods for assessment and receipt of care. This will likely be particularly problematic if the evidence base for the transition is not well understood, with existing waiting periods expected to carry over and potentially be further delayed as providers and the broader sector adjust to new processes. Additional delays would also be introduced if reassessment of existing clients is required, with further complications arising if older people receiving multiple CHSP services also need to be realigned to new Support at Home levels. Delays inevitably impact an older person's rate of cognitive and physical decline. This prejudices their rights first and foremost, but from an economic perspective, increases the rate at which they require more intensive levels of care. Therefore, the government has both a human rights and a fiscal interest in reducing these delays to the maximum extent possible.

If there is data available, it should be made public to support sector planning and transition preparedness. If there is no data available, the department should make clear what other information is forming the evidence base for the transition of CHSP to Support at Home.

**The Inspector-General recommends the Australian Government provides greater transparency of unmet need for CHSP services and supports by service type and region to support sector planning and transition preparedness.**

Home modifications are life-enhancing, cost-effective interventions enabling people to age in place safely and significantly reducing the cost of ongoing care

Home modifications are a significant enabler of older people's preferences to remain living independently at home and in their communities for as long as possible. They range from simple interventions such as the installation of handrails and grab bars, through to more complex renovations, such as wholesale bathroom redesigns and making an entire home wheelchair accessible, to ensure older people and their carers can access and use areas and features of their home safely and comfortably. When done properly, home modifications can significantly reduce or delay the need for entering higher cost and more intensive models of care.<sup>2</sup>

Under the current CHSP arrangements, clients are eligible to claim up to \$15,000 towards the cost of their home adjustments per financial year. Under Support at Home, funding for high tier home modifications will be capped at \$15,000 per lifetime. It is currently unclear to the Inspector-General whether the transition of CHSP to Support at Home will result in the introduction of the same \$15,000 lifetime cap. It is also unclear as to what information has been used to form the evidence base for introducing the lifetime cap of \$15,000 under Support at Home or what modelling has been done, if any, to determine why this is considered to be cost-effective. This is particularly concerning if it drives people, whom otherwise would be able to remain living at home, into higher cost and more intensive models of care, including residential care, which in 2024–25 required an approximate average subsidy of \$83,000 per individual.<sup>3</sup>

<sup>2</sup> See, for example, Hutchinson, et al (2025) [Home Modification Outcomes for Adults Aged 50 Years and Over and Their Relatives: A Scoping Review](#), *Occupational Therapy Journal of Research*, Cha (2025) [A Systematic Review of Home Modifications for Aging in Place in Older Adults](#), *Healthcare*.

<sup>3</sup> Department of Health, Disability and Ageing (2025) [Aged care data snapshot—2025](#).



Taxpayers' money should always be used in the most cost-efficient way possible, which means investing in measures that deliver both immediate and long-term savings. Home modifications are a clear example: evidence consistently shows they help older people remain safe and independent at home, avoiding far more expensive care interventions. Funding settings should therefore align with demonstrated need and proven benefit, rather than being constrained by potentially arbitrary caps that lack a clear policy rationale. It is vital to maximising the aged care budget, that the government examine whether increasing investment in home modifications would reduce public expenditure by preventing premature entry into residential aged care.

**The Inspector-General recommends that the Australian Government fund an independent analysis of the implications of the \$15,000 lifetime cap for home modifications and whether greater investment or raising the cap under the CHSP would offset the much greater cost of premature entry into residential aged care. The final report of this analysis should be made public.**

**The small, but expected number of people receiving end-of-life care who outlive standard predictions should not be penalised in their last days of life**

Many older people express a strong preference to die at home, rather than in a hospital or residential aged care setting and the decision to commence end-of-life care is deeply personal for individuals, their families and kin. The Statement of Rights included in the new *Aged Care Act 2024* establishes the right to equitable access to palliative care and end-of-life care.

Although CHSP does not directly fund or provide end-of-life care, clients can also access palliative care services from their local state-based health system in conjunction with their CHSP services. End-of-Life Pathway under Support at Home is also intended to complement state and territory-delivered palliative care services. However, CHSP clients approved for the End-of-Life Pathway are required to access services through Support at Home, which provides a payment of up to \$25,000 to be expended over a 16-week maximum period for funding the delivery of care.<sup>4</sup>

There is a lack of clarity as to what impact the transition from CHSP to Support at Home will have on CHSP clients seeking to access the End-of-Life Pathway, including the risk that requiring the individual to move on to Support at Home in order to access the pathway will create administrative burdens and confusion at what is an incredibly emotionally weighted juncture. In addition, under the current arrangements, access to additional care services and supports can generally be provided more expediently and flexibly via the CHSP, enabled by the block funding arrangements which are more easily scaled up and down to respond to individual circumstances. These features of the existing program are vital to delivering immediate support at a critical time.

There is additional confusion regarding whether transferring to Support at Home will also result in the introduction of a less flexible and more expensive 'fee-for-service' co-contribution model. The department will need to make this information publicly available and unambiguously clear.

End-of-life care in Australia is closely supervised by medical practitioners, with all people who commence the End-of-Life Pathway care estimated to die within the designated 12-week period, and score 40 or lower on the Australian-modified Karnofsky Performance Status (AKPS), meaning they are

---

<sup>4</sup> Department of Health, Disability and Ageing (2025) [Commonwealth Home Support Program: Program Manual 2025-2027](#), p. 51.



spending more than 50 per cent of their time in bed.<sup>5</sup> However, diagnosing dying is complex, prognoses are not always accurate and patient response is not always well understood or explicable.<sup>6</sup>

The small, but expected number of people receiving end-of-life care who outlive the 12–16 week prognosis should not be penalised in their last days of life. This is a process that requires medical supervision, not policy-imposed eligibility criteria. The Inspector-General’s *2025 Progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety* (2025 Progress Report) recommended the removal of the 16-week maximum for delivery of care under the Support at Home End-of-Life Pathway, to better align with recommendations 2, 35 and 118 of the Royal Commission.<sup>7</sup>

**The Inspector-General reiterates this recommendation for the Australian Government to remove the 16-week maximum for delivery of care under the Support at Home End-of-Life Pathway and provide greater clarity on the intersection with CHSP services post-transition.**

The viability of CHSP providers is particularly important in thin markets to ensure equity of access to aged care services and support for all older people in Australia

Thin markets for aged care services exist in many regional, rural and remote communities, as well as services tailored towards communities with diverse backgrounds and life experiences and culturally specific needs. The viability of CHSP providers is particularly important in these markets, in which they can play an essential role in connecting older people with their communities, and are often the sole provider, or one of only a few services delivering home supports. Providers operating in these markets can also face additional challenges resulting from increased travel costs and exacerbated workforce shortages, contributing to further inequity.

Funding through the ‘Support at Home Thin Markets grant program’ is available to support the viability of providers in rural and remote Australia, and for eligible Home Care Package (HCP) and Short-Term Restorative Care (STRC) providers servicing communities with diverse backgrounds and life experiences. However, it is unclear what supports exist to ensure the viability of CHSP providers operating in these thin markets, including whether they are eligible for the Support at Home Thin Markets grant program in the lead up to, and throughout, the transition. The Inspector-General has heard that uncertainty regarding future funding arrangements is already impacting the ongoing viability of some CHSP providers, leading to reduced service availability and increased wait times for an increasing number of older people. This is particularly problematic in regions already impacted by thin markets.

As highlighted by the Interim First Nations Aged Care Commissioner Andrea Kelly’s report *Transforming Aged Care for Aboriginal and Torres Strait Islander people*, the impacts of thin markets are felt more acutely by Aboriginal and Torres Strait Islander people who account for 18.2 per cent of people in remote locations and 47.2 per cent of people living in very remote locations.<sup>8</sup>

<sup>5</sup> Department of Health, Disability and Ageing (2025) [End-of-Life Pathway](#).

<sup>6</sup> Ding et al (2022) [Provision of end-of-life care in primary care: a survey of issues and outcomes in the Australian context](#), BMJ Open.

<sup>7</sup> Office of the Inspector-General of Aged Care (2025) [2025 Progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety](#).

<sup>8</sup> Interim First Nations Aged Care Commissioner (2024) [Transforming Aged Care for Aboriginal and Torres Strait Islander people](#).





Further to this, the Inspector-General has heard repeated concerns from some Aboriginal community-controlled organisations delivering CHSP services in thin markets that they are at risk of vacating the sector because collecting co-contributions from those with little means is counter-cultural. The realisation of this risk would see a significant loss of the local networks of care and community-held knowledge that are critical to delivering services in and among harder to reach regions and communities.

The Interim First Nations Aged Care Commissioner has previously warned of the adverse impacts of co-contributions on older Aboriginal and Torres Strait Islander people and recommended the government implement tailored aged care pathways for Aboriginal and Torres Strait Islander people, in line with the Royal Commission's recommendations. This recommendation, along with all those contained in the Interim Commissioner's November 2024 report, are yet to be responded to or actioned.<sup>9</sup>

**The Inspector-General recommends that the Australian Government retain a suitable funding model for CHSP providers operating in thin markets to provide certainty and ensure the ongoing viability of providers, including in the lead up to, and throughout, the transition of CHSP to Support at Home.**

## Material issues and other related matters that must be considered when transitioning CHSP

Alignment of the CHSP to the new Support at Home Program would disincentivise participation. This risks an unnecessary and avoidable strain on the budget

Noting that transition details have not yet been formally confirmed, the Inspector-General considers the proposed transition of CHSP to Support at Home risks the introduction of a less flexible and more expensive 'fee-for-service' co-contribution model for basic entry-level support services aimed at preventing or delaying acute ageing. The Inspector-General reiterates her position that the way in which the government has structured the new Support at Home program co-contribution model is inconsistent with the Royal Commission's vision and may undermine existing policy to promote people ageing in place, connected to their community and kin.

The Inspector-General's 2025 *Progress Report* raised concern that:

*The introduction of co-payments for all aged care recipients, including full pensioners who do not meet (or navigate) hardship provisions, is neither widely understood by the public nor aligned to the Royal Commission's vision of a system based on rights and entitlement. The service list is heavily weighted towards peoples' clinical and medical needs, which are 100% funded, while all non-clinical supports require co-payment. It is hard to comprehend why some supports, such as showering, are classified as 'non-clinical'. They have a clear clinical dimension if not in their delivery, then certainly in their absence.*

---

<sup>9</sup> Interim First Nations Aged Care Commissioner (2024) [Transforming Aged Care for Aboriginal and Torres Strait Islander people](#).





*Stakeholders have repeatedly warned the Office that Support at Home, and the introduction of co-payments, will see older Australians forgo important services that have been subsidised to date.<sup>10</sup>*

There is a serious risk that if similar changes are made to the existing co-contribution model for CHSP services, this will significantly increase service costs, resulting in older people, particularly those who face the greatest vulnerability, foregoing necessary care when they need it in order to afford other basic essentials. This in turn would entirely undermine the preventative intent of the CHSP by further accelerating cognitive and physical deterioration, driving older people into higher cost and more intensive models of care and hindering independence.

Currently, there are too many unanswered questions regarding the detail of the proposed transition of CHSP to Support at Home to be confident that the transition would represent a positive step in the aged care reform journey. Moreover, the Inspector-General holds a range of concerns with the broader rollout of Support at Home, as raised in the *2025 Progress Report*.<sup>11</sup> The Inspector-General considers it critically important that these issues are addressed and the evidence base underpinning decision making around Support at Home is better understood by the sector and the public alike before any further programs or functions are rolled into Support at Home.

**It is therefore imperative that the government fully considers the impact of any proposed changes to the funding and co-contribution mechanism for entry-level support services prior to CHSP transition, and makes the rationale for consequent decisions, public.**

Transitioning CHSP to Support at Home would further undermine the intent of the Royal Commission if the key benefits of the current program are not retained

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) identified a broad range of systemic issues within the aged care system and made 148 recommendations for change, most of which are still at varying stages of implementation.<sup>12</sup> Recommendation 25 called for a paradigm shift, proposing a new aged care program combining the existing CHSP, the Home Care Packages Program, residential aged care, residential respite, and short-term restorative care, retaining the benefits of each of the component programs, while delivering comprehensive care for older people.<sup>13</sup>

Whilst the Australian Government accepted this recommendation in-principle, it is primarily responding through the introduction of the new Support at Home program – the final policy design for which was announced on 12 September 2024.<sup>14</sup>

---

<sup>10</sup> Office of the Inspector-General of Aged Care (2025) [2025 Progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety](#), p. 93.

<sup>11</sup> Office of the Inspector-General of Aged Care (2025) [Support at Home](#).

<sup>12</sup> See Office of the Inspector-General of Aged Care (2025) [2025 Progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety](#) for further detail.

<sup>13</sup> Royal Commission into Aged Care Quality and Safety (2021) [Final Report: Care, Dignity and Respect — Volume 3A: The New System](#).

<sup>14</sup> The Hon Anthony Albanese MP, Prime Minister of Australia, The Hon Dr Jim Chalmers MP, Treasurer, The Hon Anika Wells MP, Minister for Aged Care (2024) [Press conference - Parliament House, Canberra](#) [accessed 14 January 2026].



The Inspector-General's 2025 *Progress report* assessed the government's reported measures or actions against recommendation 25 as 'rejected in favour of an alternative approach' and further observed:

*The Aged Care Act 2024 does not deliver recommendation 25 and there is no basis to conclude that there is any intention to combine residential aged care and residential respite and Support at Home to create a single program with the same funding and regulatory requirements...*

*The decision by the government not to implement the single consolidated aged care program underwritten by certainty of funding based on assessed need, as required by recommendations 25 and 41, prevents the establishment of the new model of integrated, entitlement-based care envisaged by the Royal Commission. The government's approach to these 2 fundamental, systems-changing recommendations would have been an opportunity to deliver the transformational change to aged care, so strongly advocated by the Royal Commission. Creating a 'new system' without these 2 central components, risks the sum total of the government's reforms as likely to only deliver incremental change.<sup>15</sup>*

**The Inspector-General reiterates this position and remains concerned that transitioning CHSP to Support at Home risks losing the original preventative intent of the program if not done right.**

## **An opportunity to enhance CHSP's role as the primary prevention vehicle for the aged care system**

The Inspector-General considers instead that there is an opportunity not to be missed here: the proposed transition to the Support at Home program could be viewed as providing a potential opportunity for the government to refocus on the original, preventative intent of the CHSP by ensuring that the relevant program parameters directly support this remit and that all consequences that may undermine its strengthening are contemplated and mitigated.

**Recommendation 25 was clear in its intent that the key benefits of each of the component programs should be retained in any new aged care program, specifically including the objective to 'prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to live independently as well as possible, for as long as possible.'<sup>16</sup>**

As CHSP is the primary prevention vehicle for the aged care system, the Inspector-General considers it vital that core principles of its model be retained or embedded, whether by way of CHSP or under an alternative model for an entry-level aged care program where:

- preference to age in place is honoured
- social connection is encouraged and enabled
- services and supports are equitably accessible and readily available
- funding models ensure the viability of a diverse variety of providers.

<sup>15</sup> Office of the Inspector-General of Aged Care (2025) [2025 Progress report on the implementation of the recommendations of the Royal Commission into Aged Care Quality and Safety](#), p. 79.

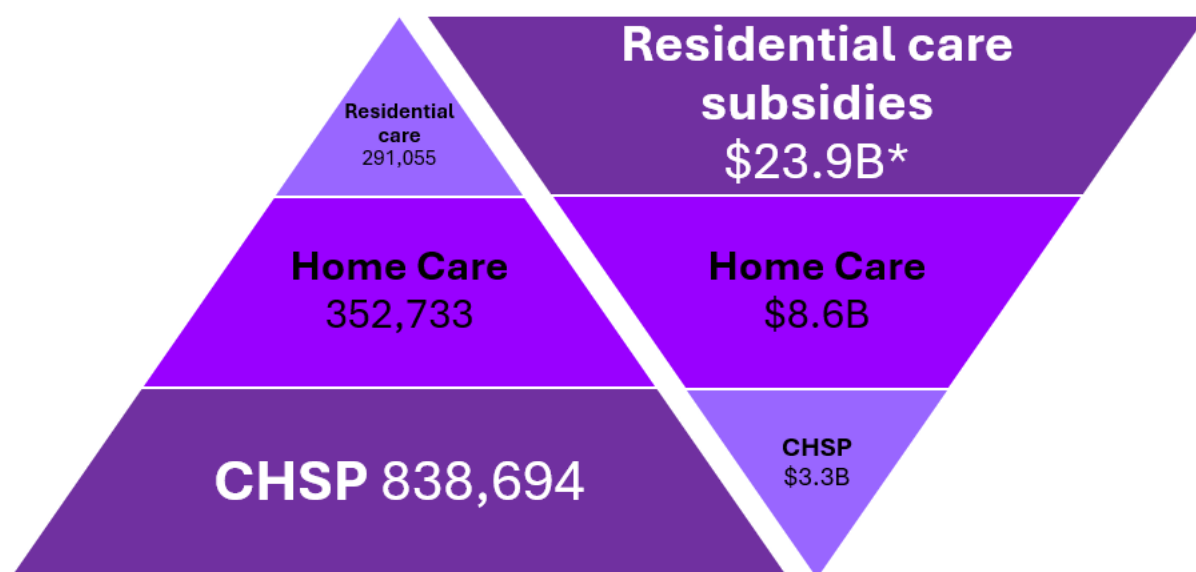
<sup>16</sup> Royal Commission into Aged Care Quality and Safety (2021) [Final Report: Care, Dignity and Respect — Volume 3A: The New System](#), p. 145.



Increased investment in entry-level CHSP services could deliver significant savings to the aged care budget by delaying or reducing entry into more expensive forms of acute aged care

With annual Commonwealth expenditure on aged care services nearing \$40 billion, it is worth noting that, despite supporting more than half of the aged care client cohort, CHSP comprises only approximately 8 per cent of total Commonwealth aged care expenditure, compared with residential care which accounts for approximately 61 per cent (see Figure 1).

Simply put, residential care is monumentally more expensive than entry-level home support, with entry-level services potentially able to deliver significant savings to the aged care budget by enabling older people in Australia to stay at home and out of more expensive forms of acute care for longer.



**Figure 1:** Aged care clients compared with Commonwealth expenditure on aged care services, 2024–25 financial year

**Source:** Adapted from data of the Department of Health, Disability and Ageing (2025) [Aged care data snapshot—2025](#).

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

In addition, given that the sole intent of the CHSP is to prevent acute ageing, enabling older people to live independently and safely at home for longer, it stands to reason that investing in lower cost entry-level supports and services through CHSP could potentially deliver a significant cost saving to the overall aged care budget, enabling the limited funding available to support an increasing number of older people.

Investing in CHSP also aligns with the well-established preferences of older people in Australia to remain living independently at home and in their communities for as long as possible, even as their care needs increase and become more complex.<sup>17</sup>

<sup>17</sup> See, for example, Australian Institute of Health and Welfare (2013) [The desire to age in place among older Australians](#), p. 2; Tune, D (2017) [Legislated Review of Aged Care 2017 Report](#), p. 23; Hatcher, D, Chang, E, Schmied, V and Garrido, S (2019) [Exploring the Perspectives of Older People on the Concept of Home](#), Journal of



**However, whilst the CHSP remains the primary avenue through which older people access aged care services and supports (approximately 55 per cent of the total aged care cohort), this proportion has decreased by more than 10 per cent in recent years, despite the convergence of population ageing and increasing unmet demand for the program.<sup>18</sup>**

Since establishment, the block grant funding arrangements in place which limit the provision of CHSP services and constrain program growth, appear to have capped participant numbers well below previous levels of utilisation proportionate to the number of older people in Australia over the age of 65. For example, in 2018-19 approximately 840,984 older people received CHSP services, a similar number to the 838,694 people who received CHSP services in 2024-25. This is despite the overall number of people over the age of 65 increasing by an additional 883,891 in the same period. This is likely to have driven an increasing number of older people into higher cost and more intensive models of care, as can be partially seen by the exponential growth of the former Home Care Packages program over the same period.

The Inspector-General proposes the benefits of investing in a stronger CHSP as a cost-effective, primary prevention program specifically aimed at enabling more people to age in place and delaying entry into more expensive forms of acute aged care.

**The Inspector-General recommends the Australian Government fund an independent cost-benefit analysis of the CHSP, weighing the potential benefits of expanding CHSP against the cost of delivering higher level care at the tertiary end of the system if the delivery of entry-level home care supports is further constrained. The final report of this analysis should be made public.**

## Conclusion

This submission highlights a range of concerns regarding the proposed transition of the CHSP to Support at Home, specifically the lack of clarity and detail that has been made public to support sector planning and transition preparedness. However, it also raises important questions around the policy logic underpinning the decision to transition CHSP in the first place. CHSP is currently the Australian Government's primary vehicle for preventing acute ageing, supporting older people's preferences to age in place and keeping people out of higher cost and more intensive tertiary aged care and hospitals. It is absolutely critical that entry-level home support, by way of CHSP or under an alternative model, remains a core feature of the Australian aged care system, providing a potential opportunity for government to refocus its thinking on appropriate funding models and additional investment in prevention and early intervention.

The Inspector-General remains unconvinced that transitioning CHSP to Support at Home realises the intent of recommendation 25 of the Royal Commission into Aged Care Quality and Safety. However, if the proposed transition is to be successful and conducive to upholding the rights of older people in need of care services and supports under the *Aged Care Act 2024*, there is a need to clarify how the transition will uphold these rights. The Inspector-General considers it vital that the government embed core principles of the CHSP in Support at Home – enabling flexible and equitable access to entry-level non-clinical services, prioritising preventative interventions that support older people to remain living independently, and honouring the intent of the Royal Commission. Making CHSP subject to current Support at Home co-contributions is likely to put this at risk.

---

Ageing Research, pp. 1–10; and National Seniors Australia (2024) [How to remain living independently at home for longer](#).

<sup>18</sup> Department of Health, Disability and Ageing (2025) [Aged care data snapshot—2025](#).



Further, there is a serious and urgent need to provide clarity to older people and the sector regarding the timeline and detail of the proposed transition, which is currently in a state of uncertainty and causing widespread concern and confusion. There are too many unanswered questions about the proposed transition from CHSP to Support at Home to be confident that it would be a positive step in the aged care reform process.

The department should publicly release the evidence that has informed decision making about the transition from CHSP to Support at Home. This would give the sector confidence that the proposed transition timeline is practical, and potentially achievable, for most CHSP providers and clients.

Existing issues with the rollout of Support at Home also need to be resolved, and the evidence informing key decisions must be made clearer to the sector and the public before any additional programs or functions are moved into Support at Home.