Submission to the Senate Community Affairs References Committee

Inquiry: The transition of the Commonwealth Home Support Program (CHSP) to the Support at Home (SaH) Program

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Maroochy Home Assist has been a provider of Home Modification and Maintenance services through Government funded programs since 1999. We provide these services annually to over 8000 eligible clients.

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Executive Summary

I strongly oppose the transition of the Commonwealth Home Support Program (CHSP) into the Support at Home (SaH) Program (no earlier than 1 July 2027). The staged reforms to in-home aged care, while well-intentioned, are already producing longer waiting periods resulting in consumer and carer stress, market instability, and provider readiness concerns under SaH Stage 1 (commenced 1 November 2025). Extending this model to CHSP risks exacerbating unmet need, particularly in thin markets and for people requiring timely assessment, home modifications beyond a proposed lifetime cap, and dignified, flexible in-home and end-of-life care. The evidence below highlights material risks and proposes mitigations that preserve CHSP's strengths while improving access and quality under SaH.

1) Timeline after 1 July 2027

The Government has confirmed a staged implementation of SaH: Stage 1 (1 November 2025) replaced Home Care Packages (HCP) and Short-Term Restorative Care (STRC); CHSP will transition to SaH no earlier than 1 July 2027. This deferral was adopted specifically to reduce disruption and allow providers time to adjust business systems and payment arrangements. However, "no earlier than" is not a schedule—there remains no detailed, binding pathway for CHSP's absorption with milestones, safeguards, or contingency triggers in case the sector is not ready.

The Royal Commission recommended simplifying and streamlining in-home care services and assessment pathways, while ensuring CHSP continues without disruption. However, long wait times for Support at Home packages are causing strain on CHSP, as no additional funding has been provided to manage the increased demand. As a result, clients with approved needs are being turned away despite their eligibility.

2) Expected impacts of the transition

Over 810,000 Australians currently rely on CHSP services. A key concern is that this figure excludes those who might be eligible but have given up due to a system that is difficult to navigate. Many in this cohort are unfamiliar with online processes or phone-based applications, or they feel uncomfortable sharing highly personal information with a stranger over the phone—something they are routinely warned against in other contexts.

Without a clear, actionable plan for transitioning these clients to SaH, the system risks collapsing under pressure. The challenges faced by the 275,000 HCP clients who moved to SaH in 2024—marked by severe backlogs and bottlenecks—could easily triple. Right now, older Australians are waiting more than six months for assessments or reassessments

because the workforce is overwhelmed. Immediate action is critical to prevent further delays and ensure equitable access to care.

The following subsections outline key risks and impacts.

a) Waiting periods for assessment and receipt of care

Since SaH Stage 1 began, multiple sources report significant delays in assessments and service commencement, with large backlogs and widespread use of interim allocations at only 60% of assessed need. Relying on phone interviews to speed up assessments is proving problematic, as clients often present a very different picture than what an in-person visit would reveal. This gap highlights the limitations of remote assessments and the need for more accurate, face-to-face evaluations.

Extending SaH to CHSP—without first resolving these bottlenecks—would likely shift CHSP's entry-level clients into the same backlog, increasing risks of avoidable hospitalisations and carer strain.

b) The lifetime cap of $15,000 on home modifications

Under SaH's Assistive Technology & Home Modifications (AT-HM) scheme, funding tiers include $500 (low), $2,000 (medium), and a proposed $15,000 "high" tier, with indications that home modifications access may be capped at $15,000 per lifetime. This cap risks forcing premature entry to residential care and increasing preventable falls. For example, a client might initially use $15,000 towards removing a bathtub and installing a shower to reduce the risk of falls. Later, they may need additional modifications—such as replacing steps with a ramp or installing a stairlift—but no further funding is available.

c) End-of-Life Pathway time limits

SaH's End-of-Life Pathway offers ~$25,000 over 12 weeks, extendable up to 16 weeks if funds remain. Rigid time limits are misaligned with clinical uncertainty and cultural preferences, risking care discontinuity if reassessments or transitions are delayed.

d) Thin markets with a small number of aged care service providers

Government has announced Thin Markets Grants to support viability in rural/remote or specialised markets, but prior rounds were oversubscribed and short-term. CHSP's stable local networks are at risk if SaH entry requires cost structures thin-market providers cannot bear.

3) Provider readiness and workforce

SaH imposes new regulatory categories, strengthened Quality Standards, care-management pooling, and ICT changes. Providers report ongoing workforce and systems issues, including compliance and recruitment challenges.

4) Any other related matters

Consumer protections and price transparency remain incomplete under SaH. Assessment reforms and claims processing are still bedding down, risking dual compliance burdens for CHSP providers.

Many CHSP clients do not use services on a regular basis but rely on CHSP for essential safety tasks, such as climbing a ladder to change light bulbs or clearing gutters. Clear guidelines are needed to determine how these clients will be supported under the Support at Home (SaH) model.

Conclusion

CHSP remains the entry-level backbone of community support—cost-effective, locally embedded, and responsive. Extending SaH to CHSP without meeting specific, verified performance thresholds will harm older Australians, carers, and communities—especially outside metropolitan areas.

Recommendations

- Permanently cease the proposed transition of CHSP to SaH.
- If the transition must go ahead then conditional, region-by-region CHSP transition only when independent metrics on assessment timeliness, backlog reduction, provider readiness, and workforce capacity are met and published. Quarterly would be advisable.
- If the transition must go ahead then providers must be able to access immediate funding to assist clients in an emergency situation. Currently, if a person is hospitalized and requires home modifications to enable discharge, a CHSP provider can deliver this assistance immediately using available block funding. Hospital Occupational Therapists and Social Workers can help with My Aged Care registration to ensure eligibility is met. Under the Support at Home (SaH) model, with no clear guidelines and no block funding, providers would need to wait until SaH arrangements are finalized before claiming for services. This uncertainty around timeframes would prevent many providers from completing the work promptly, creating additional pressure on hospitals through longer discharge delays or shifting significant financial burden onto clients.

- Removal of the lifetime $15,000 cap on home modifications; replace with needs-based clinical prescriptions and revisit rights as conditions progress.
- Flexible End-of-Life extensions beyond 16 weeks with a fast-track to ongoing SaH classifications; formal integration with state palliative services.
- Multi-year thin-market loadings and earlier price-cap protections for critical services in rural/remote and specialised cohorts; transparent travel loadings.
- A CHSP Workforce Transition Fund and mandatory independent readiness audits before providers accept CHSP clients under SaH.

References

- Department of Health – Support at Home overview; CHSP transition timing.
- Aged Care Quality & Safety Commission – Transition obligations.
- MinterEllison – SaH analysis (wait time goals, interim allocations).
- CareVision / AgedCareMadeEasy – Backlogs and interim allocations.
- Australian Ageing Agenda / MOD.A – Critique of proposed $15,000 lifetime cap.
- My Aged Care – End-of-Life Pathway design and eligibility.
- Palliative Care Australia – End-of-Life Pathway position statement.
- Department of Health – Thin Markets Grants design and funding amounts.
- Services Australia – SaH claims commencement (1 December 2025).