Open Submission to the Senate Home Care Review

January 2026

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Executive Summary

Murrindindi Shire Council (MSC) welcomes the opportunity to contribute to the Senate Standing Committee on Community Affairs Inquiry into Aged Care Service Delivery.

We represent a large rural municipality in north-east Victoria (Hume region), spanning 3,880 km² with 15,600 residents across dispersed “tiny towns”. This geography, combined with limited transport and housing, creates significant access barriers to home care.

The key health partners in the Shire include, Alexandra and District Health, Yea Memorial Hospital, residential aged care facilities Darlingford Upper Goulburn Nursing Home and Kellock Lodge, Menzies Support Services, Omnia Community Health (formerly Nexus Primary Health), and Murrindindi Shire Council. Collectively we collaborate to progress health outcomes for our community. We secured funding to undertake a Health and Care services plan for the region.

Through the Murrindindi Health Network (MHN), local hospitals (Alexandra District Health, Yea Memorial Hospital), aged care providers (Darlingford, Kellock Lodge, Omnia), and MSC co-designed a comprehensive Health & Care Services Plan. The MHN Plan provides an evidence-based, place-based model that directly addresses the Inquiry’s Terms of Reference, particularly the transition to Support at Home (commencing 1 November 2025) and the withholding of additional Home Care Packages.

Key findings

- Rising demand with a rural workforce crisis: projected need for a 60% increase in aged-care beds and a 40–70% increase in allied health capacity by 2036, with shortfalls across GPs, nursing, and disability support.
- Fragmented, inequitable access: dispersed geography, limited transport, constrained accommodation for workers and students, and digital exclusion.
- Avoidable system costs: ~$87–90 million annually, ~1,050 preventable hospital admissions and ~450 delayed discharge bed-days each year linked to gaps in home care.
- Under-reporting and unserved cohorts: historic provider contracting over large areas led to service targets being met in higher-density locations, leaving small rural communities behind.

This submission maps evidence and recommendations to each ToR item. We propose funded, integrated, locally-led models with navigation and coordination, workforce and accommodation solutions, digital inclusion, transport, and measurable outcomes to reduce hospitalisations, improve equity, and meet national wait-time targets.

About Murrindindi Shire

Murrindindi is 48% National Parks and Reserves, with settlements widely dispersed. The practical reality is long travel times, limited public transport, sparse provider coverage, and constrained local housing. These factors materially affect home care access, provider viability, and the feasibility of timely hospital-to-home transitions.

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Alignment with the Senate Inquiry's Objectives

a. Impact of the delay on older Australians: unmet needs and wellbeing

The delay to Support at Home and withholding of additional Home Care Packages intensifies unmet needs for older residents in dispersed towns. We already observe:

- Delayed hospital discharge due to absent home supports.
- Earlier entry to residential care than clinically necessary.
- Carer strain and reduced wellbeing where CHSP task-based support cannot bridge higher-level needs.
- Reluctance to "register" when services are known to be unavailable, depressing demand signals and masking true need.

b. Capacity of CHSP to meet increased demand prior to 1 Nov 2025

CHSP's task-based model lacks flexibility, coordination and sufficient hours to substitute for higher-level packages in rural settings and the need to travel. Without augmentation, reliance on CHSP drives higher hospitalisations and poorer outcomes. MSC recommends targeted CHSP enhancements (navigation, care coordination, transport brokerage, telehealth support) pending Support at Home commencement.

c. Impacts on providers, including workforce

Providers face recruitment and retention challenges (clinicians, support workers) compounded by travel, thin markets, and accommodation shortages. Agency reliance and vacancies remain high. A regional Health & Learning Hub coordinating placements, supervision, and micro-credentialing across providers is essential, alongside funded short- and medium-term accommodation for key workers and students.

d. Impacts on hospitals and state/territory health systems

Fragmented home care contributes to avoidable admissions and delayed discharges. In Murrindindi, modelling indicates ~1,050 preventable admissions and ~450 delayed discharge bed-days annually—costs borne by hospitals and patients alike. Integrated, rural-tailored discharge pathways and local navigation reduce bed-pressure and improve outcomes.

e. Feasibility of achieving 3-month HCP wait times by July 2027

Rural feasibility depends on three levers: (1) sufficient package supply and front-loaded release at transition; (2) funded local navigation and coordination to convert approvals into services quickly; (3) workforce and accommodation solutions to deliver care in thin rural markets. With these in place, 90-day waits are achievable; without them, rural backlogs will persist despite nominal targets.

f. Governance, assurance and accountability for digital transformation

Digital reforms must acknowledge rural realities: variable connectivity, lower digital literacy, and multiple local systems. We propose shared outcomes frameworks and rural access KPIs, interoperability with local provider systems, and funded community digital literacy and device support to ensure reforms deliver timely, safe, and equitable access.

g. Single assessment system readiness

Assessments must be timely, culturally safe, and connected to local navigation, with clear hospital-to-home templates and authority for navigators to coordinate across boundaries. In rural settings, thin capacity can stall assessments and service activation; we recommend resourcing regional assessor pools, tele-assessments with in-home support, and rapid referral pathways aligned to MHN protocols.

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h. Any other related matters (Rural equity and micro-market dynamics)

Funding and contractual models should explicitly incentivise rural equity, recognising travel time, outreach, and activation costs in small communities. Reporting should be sufficiently granular to identify small geographies left behind and enable corrective action.

MHN's Integrated, Place Based Model

The MHN Plan is a single integrated service model connecting hospitals, primary care, aged care, disability, mental health, and community services. It is designed to:

- Keep care local; reduce fragmentation; enable smooth transitions between hospital, home, and residential care.
  Deploy community navigators and care coordinators as the clear entry point and "glue" across services.
- Standardise hospital-to-home discharge templates; support My Aged Care applications; prepare for Support at Home; and integrate NDIS coordination.
- Operate a Health & Learning Hub to coordinate placements/training across providers, building a local pipeline and aligning with the Regional University Study Hub program to broaden reach.

Evidence of Impact (Projected)

Within five years of full implementation:

- 10–15% reduction in preventable admissions and delayed discharges, yielding ~$420,000–$630,000 in annual savings and improved quality of life.
- 20–30% reduction in vacancies and agency reliance through collaborative workforce planning and local training pipelines.
- Improved community confidence via proactive education, digital literacy support, transport coordination, and visible service resourcing in rural towns, leading to higher registration and earlier activation of supports.

Recommendations

1) Support integrated, rural place-based models (ToR a, d, e, h)

- Fund MHN-style integrated models linking health, aged care, disability, and community services at local level, with specific rural loadings for travel/outreach.
- Front-load the release of packages at and immediately after 1 Nov 2025 to clear rural bottlenecks and support 90-day targets.
- Embed granular rural access KPIs (e.g., service activation times by town/SA1).

2) Invest in navigation and care coordination (ToR a, b, g)

- Provide dedicated funding for community navigators and care coordinators with authority to coordinate across hospital, primary care, aged care, disability, and mental health.
- Resource rapid hospital-to-home pathways and single-assessment system integration (templates, referral protocols, in-home tele-assistance).

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3) Address workforce and retention (ToR c, e)

- Expand regional Health & Learning Hubs, placements, supervision, and micro-credentials across providers.
- Fund short-/medium-term accommodation for workers and students; incentivise rural practice (allowances, scholarships, bonded placements).
- Support international recruitment and re-entry pathways, with rural onboarding and mentoring.

4) Improve access and equity (ToR a, b, d, f)

- Invest in transport coordination, telehealth infrastructure, and community digital literacy to reduce access barriers.
- Tailor Support at Home and My Aged Care processes to rural realities (streamlined assessments, outreach activation, navigator support).
- Explicitly fund outreach to dispersed small towns and micro-markets.

5) Strengthen governance, performance monitoring and accountability (ToR f, h)

- Require shared outcomes frameworks across funded rural networks, focusing on preventable admissions, delayed discharges, service activation times, and client experience.
- Mandate granular public reporting at small-area levels to reveal and remedy gaps.
- Ensure digital transformation programs include rural user testing, interoperability with local systems, and funded community education.

Conclusion

Rural communities like Murrindindi Shire, experience the sharp edge of home care delays: fragmented access, stretched workforce, and avoidable hospital use. The MHN integrated, place-based model offers a practical, evidence-based blueprint to meet the Inquiry's objectives, deliver equitable access, and achieve national wait-time targets. With targeted funding for navigation, workforce, accommodation, transport, and digital inclusion, Support at Home can deliver on its promise for rural Australia.

Attachments

- Current and Future State Analysis
- Health Network Plan

For further information:
Andrew Paxton, Director Community & Development
Murrindindi Shire Council

Cc: Dr Helen Haines MP

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Image below: Highlighting Murrindindi Shire Council