Catholic Health Australia

Aged Care Pre-Budget Submission 2025–26

January 2025

Catholic Health Australia

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1. The urgent need for workforce solutions

Background

Workforce shortages in the health, aged care, and disability sectors are severely affecting service efficiency and effectiveness. These sectors are competing for the same workforce, both domestically and internationally. The shortages stem from poor workforce planning since the abolition of Health Workforce Australia in 2014, leading to ineffective use of health workforce data and uncoordinated state and territory initiatives. Additionally, attracting and retaining healthcare professionals is challenging due to high housing costs and wage stagnation, causing dissatisfaction and high turnover rates.

Recommendations

- **Expand Jobs and Skills Australia's focus and resourcing for the health and aged care sector**
- **In the longer-term, restore national leadership to health workforce planning through the re-establishment of Health Workforce Australia**
- **Design and implement a National Skills and Capability Framework & Matrix to establish a basis for workforce planning across health, aged and disability care sectors**
- **Subsidise rent for nurses by introducing additional salary packaging allowances when renting within a certain proximity to work**
- **Re-introduce exemptions of the fortnightly working hour cap for international students studying to receive a qualification in aged care**

2. Regional, rural and remote

Background

Access to aged care remains a challenge in regional, rural and remote areas. With an ageing population experiencing more complex care needs, and insufficient capital investment to meet demand or support refurbishment due to the sector's financial stress, the supply of aged care services will remain constrained in these areas. This means that older people are unable to access appropriate, quality aged care in these locations. In addition, while the pricing of aged care services does consider costs in rural and remote areas, the current model does not adequately address costs in rural mining towns like Broken Hill and Kalgoorlie.

Recommendations

- **Expand the Aged Care Capital Assistance Program and include staff accommodation in future grant rounds**
- **Explore and provide alternatives to the Modified Monash Model (MMM), reflecting the increased costs of providing services in rural and remote mining towns**

3. Adequately invest in Aged Care Act transition and Support at Home

Background

CHA is committed to working with Government to ensure the Support at Home (SaH) program expands the quality and availability of aged care services delivered in the home. This is critical to meeting the care needs of older Australians in the coming decades. While the intent of the reform is welcome, there are some critical barriers to the Governments' objective of supporting older people to remain at home.

Recommendations

- **Fund Support at Home to the extent that it meets demand for care delivered at home by increasing the number of packages available**
- **Allow up to 15 per cent of SaH packages to be used for care management to effectively deliver services to high-acuity older Australians**
- **Government subsidise aged care transition costs**
- **Monitor pricing from 1 July 2026 and consider if price caps from 1 July 2026 are appropriate**

4. The urgent need for safety nets in aged care

Background

Comprehensive safety nets should be designed and implemented to ensure that all older Australians can access quality care, whether they live in major cities, regional towns or rural areas. Specific provisions need to be in place to support the viability and sustainability of aged care providers to ensure that high quality aged care is available in sufficient quantities across all locations to meet future demand.

CHA is supportive of fair contributions to aged care costs for those who can afford it, while ensuring a safety net for others. CHA has some concerns with the proposed hardship provisions for Support at Home that need to be addressed through the Budget process so that older people with reduced means to be able to access the care they deserve in their old age. Means-tested contributions are necessary for high-quality care and should be considerate of groups of older Australians that might miss out if hardship provisions are inadequate or hard to access, especially with current cost of living pressures.

Recommendations

- **Accelerate the review of the accommodation supplement to safeguard supported residents and ensure it aligns with actual costs**
- **Implement additional safeguards to strengthen safety nets for older people experiencing financial hardship**

5. Address the issue of older people falling through the cracks at the health and aged care interface

Background

The interface between health and aged care services is complex and fragmented. Each system has its own operating context, governance structures, entry and discharge processes, and service providers. It is important that stakeholders across the health and aged care systems each play a distinct role in ensuring that both systems meet the care needs of older Australians. There needs to be equal accountability between all stakeholders to progress an integrated care and service delivery approach for older people. Collaboration across health and aged care systems must occur to ensure older people can receive quality care, at the right time and in the right place.

Recommendation

- **Commonwealth and state governments develop an implementation strategy to resolve the issue of delayed discharge of long-stay older people from hospital.**

1. The urgent need for workforce solutions

Background

Workforce shortages across the health, aged care, and disability sectors are significantly impacting the efficiency and effectiveness of essential services. These sectors are not only competing with each other for the same workforce but also with other countries facing similar challenges. These shortages exist for a variety of reasons.

Availability of affordable housing, cost of living pressures, pay and conditions, and competition from adjacent sectors continue to impact the ability of providers to attract and retain staff.[1] As a result, aged care services, particularly in regional, rural and remote locations are operating at well below capacity. Exacerbated by care minutes requirements and barriers to working towards the full scope of practice,[2] older people are experiencing delays in accessing services and the health system is being burdened by longstay older patients in hospitals.

CHA is supportive of changes that increase quality of care for all people. CHA appreciates the work the Government and Department of Health and Aged Care (the Department) have undertaken recently to understand the workforce issues aged care providers face, and the progress that has been made towards remedying these. This has included recognising the value of enrolled nurses (EN) through including an allocation in registered nurse (RN) care minutes and funding the outcomes of the Fair Work Commission (FWC) decisions that led to substantial pay increases for aged care workers. CHA is supportive of the Government's Migration Strategy that recognises the importance of a longer-term evidence-based approach to planning migration. While driven by Jobs and Skills Australia, it will require close collaboration with the states and territories to be effective.

CHA's workforce recommendations are designed to provide immediate support to the aged care workforce in Australia and to course-correct care sector workforce planning in the long term. It is CHA's expectation that without nationally-coordinated workforce planning and reform efforts, challenges in recruiting and retaining aged care staff will continue to persist. CHA believes that implementation of a coordinated package of short, medium and long term system-level changes such as those outlined below, will help to move the dial on this problem on a variety of fronts.

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1 Committee for Economic Development Australia (CEDA) (2023). *Duty of care: Aged-care sector running on empty*. Available at: ceda-duty-of-care-3-final.pdf.

2 Department of Health and Aged Care (DoHAC) (2024). *Unleashing the Potential of our Health Workforce.* Available at: Unleashing the Potential of our Health Workforce – Scope of Practice Review Final Report

Policy priorities

Expand Jobs and Skills Australia's focus and resourcing for the health and aged care sector, noting the re-establishment of Health Workforce Australia in the longer term.

Overview

CHA supports the efforts by Government to address workforce challenges through the establishment of Jobs and Skills Australia (JSA). Noting that the agency was newly established in 2022, CHA recommends that in the immediate term, the Government should expand the capacity of JSA to focus on health and aged care to address immediate workforce needs. In the longer-term, restoration of Health Workforce Australia (HWA) or a similar body as a national leading body for care workforce planning should be prioritised.

The healthcare and social support sector currently has the highest proportion of employment of any sector nationally, and this is projected to continue, according to 2029 and 2034 projections.[3] The largest number of emerging roles have been identified within the Health, Care, and Medical sectors.[4]

An example of the importance of adequate workforce planning and recruitment strategies (including with the tertiary sector and through skilled migration) is the severe lack of mental health professionals, impacting the national suicide rate. The AMA has noted that a range of health professionals are vital to helping those at risk of suicide but we are facing severe workforce shortages or inadequate staffing in our mental health system. AMA president Danielle McMullen notes that "In psychiatry alone, we have just under 4300 psychiatrists working in Australia, which is nowhere near enough. Psychiatrists are also unevenly distributed across the country, with close to 80 per cent in Melbourne, Sydney and Brisbane."[5]

About 3,000 Australians end their lives each year – about 8 people a day. Suicide is the main cause of death among people aged 15 to 49.[6]

JSA needs to be resourced to increase its focus on the health and aged care sector and develop regular dedicated reports providing workforce numbers, projections and proposals for achieving them in this sector, addressing psychiatry and other medical professionals, as well as aged care workers. Resourcing is also needed to drive change in response through engagement with education and immigration Ministers and their sectors at state and federal levels.

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3 Jobs and Skills Australia (2024). *Better Together: The Jobs and Skills Report 2024*. Available at: Better Together - The Jobs and Skills Report 2024 page 72.
4 Ibid, page 87.
5 Australian Medical Association (2024). *Workforce critical to reducing suicide rates*. Available at: Workforce critical to reducing suicide rates | Australian Medical Association
6 DoHAC (2024). Suicide in Australia. Available at: Suicide in Australia | Australian Government Department of Health and Aged Care

Risks and implementation

As well as its size and extent of emerging roles in this sector, unlike some other fields, there are significant health and safety risks in the care economy if these workforce gaps are not filled expeditiously. There needs to be an increased focus on workforce planning and implementation in order for this to occur.

In the longer term, restore national leadership to health workforce planning through the re-establishment of Health Workforce Australia to encompass other caring professions

Overview

In Australia, no central agency has sufficient oversight of either current or future workforce needs in Australia's health and care sectors.

It is impossible to train adequate numbers of staff in the disciplines that will be required in the future without an understanding of the composition and attributes of the current workforce and a view of what is over the horizon.

This structural deficiency has led to our current situation where state and territory governments announce workforce incentives and development initiatives without a clear idea of how additional promised health care workers will materialise. It is important to note the efforts of the Commonwealth Government in establishing the Health Workforce Taskforce. The Taskforce is focused on delivering the national health workforce strategy and early engagement with the sector has been promising.

Health Workforce Australia (HWA), or a similar workforce planning body encompassing health, aged care and disability, should be reestablished to ensure the care workforce meets the current and future healthcare needs of the population, though planning, coordination and policy advice. This workforce planning body would collate, analyse, and utilise workforce data from the health, aged care, and disability sectors to inform evidence-based policies and strategies, enabling decision-makers to proactively and efficiently adapt to changing healthcare demands and ensure that all Australians have access to high-quality healthcare.

It should also use this data to produce evidence-based national supply and demand projections for various professions based on a range of alternative planning scenarios. This will ensure that Australia has a workforce — with the right skills and in the right locations — to meet community needs and demand.

In addition to its functions in research, planning, and coordination, the workforce planning body should assist with reducing the state-based politicisation of workforce and training incentives in the short term. This practice inevitably means workforce gaps are shifted between states and territories as opposed to being addressed.

Risks and implementation

An analysis of the strengths and weaknesses of Health Workforce Australia should be performed so learnings can be applied to the new workforce planning body. The body must also have a high degree of autonomy to function effectively, and be insulated from political influence to make unbiased decisions based on data and healthcare needs. The body should be considered by the Health Workforce Taskforce as part of its program of work, and its governance should fall under the Commonwealth and state and territory health ministers.

Design and implement a National Skills and Capability Framework & Matrix to establish a basis for workforce planning across health, aged and disability care sectors.

Overview

The Aged Care Royal Commission (2021) recommended progression towards a national aged care worker registration scheme,[7] to which a similar process is being implemented as part of the new Aged Care Act (2024), known as the Aged Care Worker Screening Check.[8] The Check is welcome, as it will consider more information than police checks so that there are increased protections for older people, and support workers to move between disability and aged care sectors as well as between different geographic locations.

However, more work is required to increase career mobility for health, aged care and disability care workers. As outlined in the Unleashing the Potential of our Health Workforce report (2024),[9] there is a limited understanding of the scope of practice boundaries and range of skills and capabilities that are relevant to a range of health care contexts. This has contributed towards a limited recognition of the transferrable skills and capabilities of the care workforce, which further hinders workforce flexibility and agility. Care workers are unable to effectively transfer skills from one care sector to another. This produces inefficiencies when it comes to recruiting and on-boarding new staff, or re-training staff from a different care sector to address existing workforce gaps.

CHA recommends that Government look to designing a National Skills and Capability Framework & Matrix, as proposed in the Unleashing the Potential Report, to improve understanding of health professional skills and capabilities and establish a basis for workforce planning. Care workers will have visibility over the necessary skills, qualifications, and training requirements needed to move into specific types of work in different components of the care industry. Canada, the UK, Victoria and South Australia have developed such matrices.[10] With reference to the Professional Framework for Aged Care Workers,[11] the matrix would support an increase in career pathways for people in the care and support economy, as well as building recognition of any leadership positions and opportunities across the health, aged and disability workforce. If developed as part of the National Skills Taxonomy (NST),[12] it should proactively engage with health and aged care stakeholders and have an appropriate focus on this sector.

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7 Royal Commission into Aged Care Quality and Safety Report (2021). *Care, Dignity and Respect*, Volume 3A, Recommendation 77.
8 Screening requirements for the aged care workforce | Australian Government Department of Health and Aged Care
9 DoHAC, *Unleashing the Potential of our Health Workforce*. Unleashing the Potential of our Health Workforce – Scope of Practice Review | Australian Government Department of Health and Aged Care
10 Legislated scopes of practice across Canada: Registered nurses | CIHI; Employability-skills-matrix.pdf; Introduction to the capability framework | health.vic.gov.au; and ASHO+Allied+Health+Advanced+Clinical+Practice+Statewide+Framework.pdf.
11 Professional FrameWork – to build and strengthen the aged care workforce | Australian Government Department of Health and Aged Care
12 National Skills Taxonomy | Jobs and Skills Australia

The investment in the National Skills and Capability Framework & Matrix will generate significant returns by increasing workforce productivity and workforce planning, in which training and compliance requirements are streamlined (as per the existing worker screening checks),[13] strategically planned to meet future care needs, and ultimately improve the quality of care delivered for all people.

Risks and implementation

National Skills and Capability Framework & Matrix

The National Skills and Capability Framework & Matrix should consider alignment with existing worker screening requirements, ensuring that on-boarding requirements, core competencies, compliance and qualification requirements are consistent with broader workforce planning goals for health, aged and disability professions. It should also align with the NST developed by JSA to prevent inconsistencies with workforce planning in other health-adjacent industries.[14]

Costing

Development of the matrix is anticipated to cost $400,000 to develop, including consultation.

Subsidise rent for nurses by introducing additional salary packaging allowances when renting within a certain proximity to work.

The increasing cost of housing across Australia (no longer limited to major metropolitan areas) is contributing to challenges in recruiting and retaining nursing staff in aged care. Many aged care services are clustered in suburbs where affordable housing and rental properties are not available. Nurses and other aged care workers need to travel significant distances to get to work each day, which is a disincentive to retention of qualified nurses in clinical staff teams. Alternatively, aged care services are required to employ agency staff or incur significant costs for fly-in-fly-out models to meet care minutes requirements.

CHA recommends that the Government subsidise suitable accommodation close to where nurses work. This could be implemented by introducing additional salary packaging allowances for nurses renting within a certain proximity to work.

This investment would deliver a pay advantage to a workforce that is falling behind general market rates for equivalent university graduate roles and is struggling to attract new entrants. It would alleviate a key barrier that not-for-profit aged care providers face in recruiting staff. Further, incentivising nurses and other aged care staff to work at facilities local to them may lead to a reduction in the appeal of leaving stable work for costly agency roles.

Risks and implementation

This program could be piloted in select regions to assess the effectiveness and feasibility of the program. Clear eligibility criteria would need to be established for nurses to qualify for rent subsidies to ensure the program targets those most in need. A robust monitoring and evaluation framework would be required to ensure the program is sustainable and prevent distortion of the local housing market.

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13 DoHAC (2024). Professional FrameWork – to build and strengthen the aged care workforce. Available at Professional FrameWork – to build and strengthen the aged care workforce | Australian Government Department of Health and Aged Care

14 JSA (2024). *National Skills Taxonomy.* Available at: https://www.jobsandskills.gov.au/data/national-skills-taxonomy

Re-introduce exemptions of the fortnightly working hour cap for international students studying to receive a qualification in aged care

International students on visas studying for a qualification in aged care should be exempt from the fortnightly working hour cap,[15] as an interim solution to address the shortfall of direct aged care workers in the sector and support growth in demand from an ageing population.[16] The exemption would be consistent with previous practices to address acute workforce shortfalls, such as during the COVID-19 pandemic.[17]

There are a range of reasons supporting the re-introduction of unrestricted fortnightly working hours for international students, which includes:

- **Enhance continuity of care:** Consistent staffing rosters will help residents build stronger relationships with their care team, enhancing resident wellbeing and overall experience of aged care.[18] Additional aged care workers, such as international students, will increase the availability of more specialised staff to deliver tailored care to older people with more complex care needs.
- **Growing a quality future-ready aged care workforce:** Unrestricted working hours will enable students to gain valuable experience in aged care settings, support them to obtain the necessary qualifications to deliver specialised care, and generally contribute to a more skilled aged care workforce.[19] This is important for delivering consistent, high-quality and person-centred care for older people, particularly as care needs and preferences change over time.
- **Enhancing diversity of the aged care workforce:** International students can bring diverse perspectives and practices as part of the residential aged care home, as well as multilingual skills that can significantly enhance care. This will help enrich the care environment for residents, while promoting innovative practices within and inclusivity of the aged care workforce.

Risks and implementation

Safeguards need to be considered to ensure international students are adequately supported to meet their study requirements while working.

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15 upGrad. (2023). *Australia reintroduces allowable working hours for international students*. Available at: Australia reintroduces allowable working hours for international students - upGrad GSP

16 Committee for Economic Development Australia (CEDA) (2023). *Duty of care: Aged-care sector running on empty*. Available at: ceda-duty-of-care-3-final.pdf.

17 Bansal Immigration. (2024). *Unlimited Work Hours for International Students in Aged Care.* Available at: Working Hours Extended of Students in Aged Care | Bansal Immigration

18 Bakerjian, Debra. (2024). *Continuity of Care for Older Adults.* Available at: Continuity of Care for Older Adults - Older People's Health Issues - MSD Manual erer Version

19 Aged Care Quality and Safety Commission. *Topic guide: Workforce Management and Planning.* Available at: https://www.agedcarequality.gov.au/media/97297

2. Regional, rural and remote

Background

Access to aged care remains a challenge in regional, rural and remote areas. Despite over a third of older Australians living in these locations, only 21% of residential care services are located in rural, remote or very remote areas (Modified Monash Model (MMM) 4–7). The level of frailty in these areas is expected to increase at a faster rate compared to metropolitan areas.[20] With an ageing population and a dearth of capital investment in the sector due to financial stress, the supply of aged care services will remain constrained in these areas. This means older people will be unable to access appropriate aged care equitably.

Aged care providers incur significantly higher operating costs in regional, rural and remote areas. Increased costs for food, laundry, maintenance, cleaning and workforce due to geographical isolation and competition from adjacent industries significantly impact costs of service provision.[21] Limited access to essential health services and infrastructure further restricts options to expand service offerings or achieve efficiencies through economies of scale. Older people are also unable to get sufficient access to complex wraparound supports and specialist allied health professionals to respond to their needs.[22] This means that older people in some areas need to travel long distances to receive appropriate, timely care that meets their changing care needs. CHA is supportive of IHACPA's pricing methodology continuing to explore and account for these differentiated costs in its pricing advice, however capital is significantly underfunded.

Policy priorities

Expand the Aged Care Capital Assistance Program and include staff accommodation in future grant rounds.

Overview

The investment of $385 million for capital in regional, rural and remote aged care through two grant rounds of the Aged Care Capital Assistance Program (ACCAP)[23] is welcome but needs to be significantly expanded. This funding is one eighth of demand in the sector based on applications received to date[24] and a small proportion of the projected $72 billion investment required in the sector over the next seven years.[25] The residential aged care sector has been operating at a $5 billion operating loss over the last five years.[26] This has deterred investment in capital infrastructure upgrades and technology uplift, particularly in regional, rural and remote locations.

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20 Royal Commission into Aged Care Quality and Safety Final Report (2021). *Care, Dignity and Respect,* Volume 2, Section 2.3.1.

21 Ibid, Section 4.6.2.

22 Ibid, Section 2.2.4.

23 Through GO6989 ($250 million for 52 projects of $1.766 billion applied for) and GO6593 ($135 million for 76 projects of $1 billion applied for), both in 2024.

24 DoHAC (2024). Aged Care Capital Assistance Program. Available at: Aged Care Capital Assistance Program | Australian Government Department of Health and Aged Care, including feedback and data on application numbers.

25 Grant Thornton (2023). Key considerations for a capital model to support sustainability in the aged care sector. Available at: Aged care sector needs $72.34b in the next seven years | Grant Thornton Australia

26 StewartBrown (2024). Aged Care at the Crossroads. Available at: 2024 07 Aged Care At The Crossroads Report

CHA acknowledges the commitment by Government to invest $666 million under the ACCAP until 2028. However, much more is needed to respond to the critical infrastructure needs in regional, rural and remote areas. CHA recommends the ACCAP be increased by at least $297.63 million per year, to support a sustainable aged care sector in regional, rural and remote areas.

Risks and implementation:

If not expanded, aged care services in regional, rural and remote areas will not keep pace with demand, creating both an equity issue and forcing people in regional, rural and remote areas to move to urban centres.

Significant parts of the sector are facing challenges with attracting and retaining staff. Part of an expansion to the ACCAP could cover staff housing to address critical staff shortages in the sector. In practice, this means that:

- Investors may be influenced to consider acquiring apartment complexes that would operate as quasi 'aged care workers' homes in geographical locations with high barriers to entry
- Where aged care facilities provide homes themselves, they could receive similar taxation advantages enjoyed by other community housing providers.
- Due to proximity, staff can more easily build camaraderie with both junior and senior colleagues outside of their immediate work area.

Costing

The $297.63 million p.a. proposed to address this problem equates to a modest half of the amount requested through applications (i.e., an indicator of unmet demand),[27] such as: 0.5 x ($1.766 billion - $250 million) + ($1 billion - $135 million) = $1,190,500 over 4 years or $297.63 million p.a.

Explore and provide alternatives to the Modified Monash Model (MMM), reflecting the increased costs of providing services in rural and remote mining towns

Overview

Australian Government funding for residential aged care under the Australian National Aged Care Classification (AN-ACC) guide is weighted higher depending on MMM category, and funding for Support at Home will similarly be adjusted depending on rurality. CHA is supportive of the principles and intent of (the pricing advisor) IHACPA's pricing methodology to account for differentiated costs of service provision in its pricing advice, including through MMM categorisation. However, currently some mining towns are not adequately funded due to their low MMM categorisation and as a result, aged care services in these towns are running at a substantial loss, with significant risks to their viability. The funding model and associated MMM categorisation in regional, rural and remote areas needs to account for market distortions in some mining towns.

27 DoHAC (2024). Aged Care Capital Assistance Program. Available at: Aged Care Capital Assistance Program | Australian Government Department of Health and Aged Care

For example, Broken Hill in NSW and Kalgoorlie in WA are both classified as MMM 3 yet face challenges due to being geographically isolated (6 and 6.5 hours drive from the nearest metropolitan centres), with limited access to essential services such as primary and allied healthcare, residential aged care, and respite care, at more significant risks and costs. Providers typically experience a higher cost of labour and accommodation due to competition with the mining industry, travel costs which are typically by air, and increased costs and availability of all other goods and services.

Alternatives to MMM categories to be sought in the medium to long-term

It is recommended that the Government, with support from IHACPA, explore alternatives to the MMM categories currently allocated to accommodate the increased costs of providing services in large regional, rural and remote mining towns such as Broken Hill and Kalgoorlie. The National Disability Insurance Scheme approach should be adopted - modifying the MMM categories where a location is remote or very remote.[28] Medium to long term, a costing study could be undertaken to better understand the pricing influences of service delivery in these contexts. Funding improvements would help address the disparity in service availability compared to urban areas and reduce risk of further bed closures in these regions.

Exemption from MMM categorisation

In the short-term, aged care providers should be able to seek an exemption from allocated MMM categorisations in certain rural areas, such as a mining town like Kalgoorlie and Broken Hill, to acknowledge the differing market conditions that operate in these areas. The exemption could support providers to then access options for market adjustment (such as through grants targeting rural areas) and ensure viability and continuity of service provision for older people in these areas.

Risks and implementation

Unless these funding discrepancies are addressed in Kalgoorlie and Broken Hill, aged care services in these towns are at risk, threatening service provision for older people in these areas.

Cost

The costing study and exploration of alternatives to MMM categories is estimated to cost $300,000 including research into how other sectors have addressed the issue; comparing prices for labour and services in these areas to others; and consultation. IHACPA and the Department should be able to implement an exemption from allocated MMM categorisations in these areas without cost given that the uptake of this exemption would be so small compared to aged care spending and it would be within the existing AN-ACC appropriation.

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28 National Disability Insurance Scheme (NDIS). *Pricing Arrangements and Price Limits 2024-25*. Available at: https://www.ndis.gov.au/providers/pricing-arrangements, see page 28 describing the Isolated Town Modification.

3. Aged Care Act transition and Support at Home

Background

The Support at Home (SaH) program will be transformational for the aged care system in enabling older Australians to age in place. CHA and its members recognise that expanding aged care services delivered at home is critical to meeting demand in the coming decades. Wherever possible, older Australians who wish to remain at home should be supported to do so with dignity and respect. This is to the benefit of the older person, their families, and the financial sustainability of the aged care system.

CHA strongly supports the inclusion of SaH in the new *Aged Care Act* (2024) and our members are working towards its implementation. While the intent of the reform is welcome, there are some critical barriers to the Governments' objective of supporting older people to remain at home. These barriers include:

- **Overall access:** There are still limits on how many packages are delivered through the system, which may be exacerbated by the reduced care management cap which imposes limitations on providers' ability to support older people to manage services.
- **Implementation of SaH:** The scale and complexity of ICT build, workforce and operational implementation requirements will be challenging for providers and requires substantial investment and resourcing.

Policy priorities

Government fund Support at Home to the extent that it meets demand for care delivered at home by increasing the number of packages available.

CHA and its members are very concerned that they will be put in a difficult situation whereby they are not funded to provide adequate services for an interim budget individual, yet they have a duty to provide high quality care to the individual under the enhanced Aged Care Quality Standards, and how the Commission will approach this. While it is acknowledged that this approach is intended to provide some care rather than none while an individual is awaiting the allocation of a package, it entails risks for care recipients and providers and, by definition, fails to provide the individual with sufficient funding to access the high-quality care they need and deserve.

Risks and implementation

The risk and suboptimal approach could continue for many months as an individual awaits their full package allocation, during which time the person's frailty and health may deteriorate further.

This may then lead to:

- Further widening of the gap between required services and the type of services received;
- Many older Australians needing to wait for more than 3 months up until July 2027;

- Providers being disincentivised to accept interim budget individuals due to risk of enforcement action where quality standards may not be met; and
- Reduced access to care for older people.

Increasing Commonwealth Home Support Programme (CHSP) funding

The Government could look to increase CHSP funding until CHSP providers join SaH no earlier than July 2027, noting that this is allowed only in the short-term under the CHSP Program Manual. However, in practice, there may be increased complexity in the funding arrangements between home care packages (HCPs) and CHSP, while not fully addressing the problem for care recipients or providers.

Funding SaH to meet demand for care delivered in the home

It is recommended instead that the Government fund SaH to the extent that it is needed in the community using demand modelling. The modelling would also account for an increasingly ageing population and older peoples' preferences to age well at home. This would reduce the need for waiting periods, consistent with Royal Commission recommendation 39b and recommendations from advocates for older people. It would also generate cost advantages given older Australians assessed as needing care can experience higher (and more expensive) needs if their care provision is delayed.

Government and IHACPA should closely monitor uptake in first 12 months of implementation of SaH to ensure that older people are not forgoing specific supports given the introduction of a new service list. CHA remains concerned that price signals in the co-contribution scheme could lead to unintended case-mix changes that impact the appropriateness of care older Australian's receive and the financial sustainability of the sector.

Allow up to 15 per cent of SaH packages to be used for care management to effectively deliver services to high-acuity older Australians.

Overview

The Government should consider flexible options to allow for up to 15 per cent of packages to be utilised for care management where providers (particularly smaller ones) encounter a case mix of individuals with significant clinical acuity or other high care needs. Greater flexibility in the care management allocation is consistent with the overall purpose of SaH – to enable higher acuity older Australians to be cared for in their homes for longer.

CHA and its members are concerned about the planned reduction of the care management cap from 20% to 10%, as care management currently constitutes about 17% of packages. The Government has advised that the care management amounts are based on 1-6 hours needed per month for providers without an extra supplement; and 2-7 hours per month for providers to meet the needs of aged care recipients from certain diverse backgrounds via an extra supplement, noting that only 2-4 hours a month are typically needed for these cohorts. IHACPA will need to set prices to reflect accurate costs so that this essential care component is adequately funded.

Risks and implementation

It is the understanding of CHA and its members that the proposed halving of the care management caps introduces significant risk of deteriorating quality and availability of care for older people that is typically received through the care management allocation.

The proposed allotment of funding to care management is potentially insufficient and would result in significant changes in provider behaviour, such as:

- A reduced focus on care management;
- Decrease in service availability due to inadequate compensation for lost care management revenue;
- Providers potentially avoiding higher-acuity clients to protect their service mix; and
- Experienced care managers leaving the sector.

To mitigate these risks, CHA recommends that Government increase the care management allocation up to 15 per cent of the SaH package to support aged care provides to effectively deliver services to high-acuity older Australians.

Government subsidise aged care transition costs

Overview

The cost of implementing reform, particularly for smaller providers and those in regional, rural, and remote areas, is substantial. The aged care market is diverse, and not all providers have the infrastructure or resources to adapt to the proposed policy and regulatory changes. Smaller providers, often the sole providers of critical care support in less accessible areas, will need additional time to implement the new Act. Even larger providers will face significant operational and funding changes. Adequate transitional arrangements are critical in order to maintain and increase confidence of the community towards the delivery of aged care services under the new Act. It is the experience of CHA and its members that even small ICT changes typically require 24 weeks to implement from the date all required information is available.

Risks and implementation

Direct subsidisation of transition costs

Direct subsidisation of transition costs via grants is appropriate to support providers to upgrade their systems prior to the commencement of the SaH – noting that ICT changes require at least 24 weeks. This support should be weighed based on need, for example, the level of funding could reflect the size and complexity of the provider organisation. CHA is available to work with the Government on how this can be implemented.

Subsidisation of transition costs as part of IHACPA pricing

Fundamentally, the funding model must meet the true costs providers face to provide a high-quality service, meet regulatory requirements and invest sustainably. If the Government does not offer transition funding directly, the only alternative is for the costs of transition to be incorporated into the IHACPA pricing of services.

This option distributes a portion of transition costs to older people. This means that aged care recipients may need to pay more for their care in the short-term until transition is complete. Additionally, this option also risks making the consultation process around pricing changes more challenging for providers, which may increase the time required to implement any changes.

Monitor pricing from 1 July 2026 and consider if price caps from 1 July 2026 are appropriate

Overview

CHA welcomes the removal of price caps for Support at Home for the first 12 months of implementation. CHA brought this proposal to Government and appreciate the Government's pragmatic approach to reduce implementation risks for Support at Home. Throughout the first twelve months of the Program, the Department and IHACPA should closely monitor any differences between actual prices and indicative IHACPA prices.

Gaps between actual prices and IHACPA prices over the course of the first 12 months may imply that price caps should be suspended beyond 1 July 2026. It took several years for IHACPA to develop the comprehensive pricing model that serves the public hospital system. If the aged care pricing model IHACPA is developing is implemented before it is fully mature, it could impact service availability, investment and viability. In a system where prices are controlled based on a list of services, competition among providers is likely to focus primarily on reducing costs, rather than offering the highest-quality service offerings. Price caps are also likely to stifle innovation. For example, where a provider wishes to offer a specific higher-cost model to suit the needs of older Australians in a specific area, they are likely to conclude this is not possible under the intended price cap settings.

Risks and implementation

Other potential negative outcomes of capping prices include:

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

The urgent need for safety nets in aged care

Background

The new Aged Care Act introduces major changes to how the aged care system is funded, including increased co-contributions for those who can afford it. CHA is supportive of fair contributions to aged care costs for those who can afford it, while ensuring a safety net for others.

However CHA has some concerns with the proposed hardship provisions for Support at Home and funding arrangements under residential aged care which could impact access to care for people with limited means or assets. Comprehensive safety nets are needed to ensure that all older Australians can access quality care, whether they live in major cities, regional towns or rural areas.

Policy priorities

Accelerate the review of the accommodation supplement to safeguard supported residents and ensure it aligns with actual costs.

Overview

The accommodation supplement is an important mechanism to ensure people who can't contribute to the costs of their accommodation are able to access care. Under current arrangements, the 40% threshold has acted as a critical incentive for aged care providers to deliver residential aged care to higher ratios of supported residents.

The new Act introduces changes to accommodation funding mechanisms, such as retentions, minimum, Maximum Permissible Interest Rate %, indexation of DAPs. By adjusting pricing contribution to the costs of accommodation, these changes will ensure the sector moves to a more sustainable footing. However, the Accommodation Supplement has not be subject to the same changes.

The average accommodation price with a full RAD, is approximately $500,000 with an equivalent DAP of $114.79 per day. The highest maximum accommodation supplement is $69.49 for providers meeting the criteria as set out in the Schedule of Subsidies and Supplements.[29] This means the gap between funding for a supported resident and a non-support resident is widening to $45.30 per day. This means providers are financially penalised and must absorb costs to care for residents who cannot afford to contribute to the cost of their care.

CHA recommends that the review of the accommodation supplement be accelerated and an interim increase be provided to ensure there are adequate incentives within the system to care for supported residents. Doing so would also make it more viable for aged care providers to invest in new residential aged care facilities.

29 DoHAC (2024). Schedule of Supplements and Subsidies, effective 1 January 2025. Available at: Schedule of Subsidies and Supplements for Aged Care | Australian Government Department of Health and Aged Care

Risks and implementation

The delayed completion of the review, as well as the misalignment of the accommodation supplement with the actual costs of accommodation poses several financial viability risks to the sector, all of which will compromise a supported resident's access to timely, quality care:

- Not-for-profit providers, such as CHA member organisations, will be disproportionately affected as they support a greater volume of supported residents;
- Uncertainty around providers' capacity to re-invest in upgrading or expanding residential infrastructure, which may hinder their capacity to meet complex care needs; and
- Potential for providers to shift their case-mix by reducing bed capacity for supported residents in favour of increasing availability for non-supported residents (where there is increased funding for accommodation costs under the new Act), which reduces access to care for supported residents.

To address these issues, CHA recommends:

- **Complete accommodation supplement review** by 1 December 2025;
- **Increase accommodation supplement** within 3 months of completion of the review based on review recommendations; and
- Provide an **interim increase to the accommodation supplement** to address shortfalls and to mitigate the risk of significant changes in provider behaviour that negatively impacts supported residents, while the review is underway.

Implement additional safeguards to strengthen safety nets for older people experiencing financial hardship

Overview

CHA has long advocated for fairer individual contributions to the daily living expenses for those who can afford it, while retaining a safety net for others. The introduction of means-tested contributions from older Australians to their aged care under Support at Home is necessary to ensure high quality aged care is available in sufficient quantities in all regions to meet future demand. Hardship provisions need to be sufficient in coverage for individuals unable to contribute to the cost of their care and/or find the process to access or apply for hardship support challenging. This is a crucial safeguard to prevent some older Australians from missing out on quality care when they need it. It is the experience of CHA and its members that the current provisions for Support at Home are insufficient in practice, due to the following:

- **Inconsistencies between residential care and Support at Home:** Application for a fee reduction supplement to address financial hardship involves reaching the required threshold of $44,000 in assets (1.5 times the full pension), whereas the equivalent threshold in residential aged care is 2.25 times the full pension. This discrepancy is compounded by the long wait times for assessment to receive an allocated Support at Home package. In these circumstances, an individual accessing Support at Home may likely be worse off than older people looking to access residential aged care.

- **Significant barriers to access and apply for financial hardship:** The current communications regarding eligibility for financial hardship also lacks detail and evidence requirements are onerous. This is unacceptable for such a vulnerable group in our society.

Risks and implementation

There are several implications relating to the risk of failing to address this issue in this Budget:

- Older people and their loved ones lose trust and confidence in aged care services in being able to support and care for them;
- Older people are required to draw down their savings to minimal amounts to afford additional services which would improve their quality of life;
- Deterioration in quality of life and/or wellbeing is like to result in more complex care needs, which may then lead to hospitalization and/or premature entry into high care in permanent residential care.

These implications are inconsistent with the Government's intent of a new, rights-based aged care.

To counteract these risks, CHA recommends the following:

- **Implementation of hardship provisions** should occur from 1 July 2025. CHA would be pleased to work with Services Australia and the Department to develop an implementation plan and costings.
- **Hardship application timeframes** should be included in quarterly Services Australia statistics with a 14-day Key Performance Indicator so that there is transparency of the timeframes in which hardship applications are being assessed.

Health and aged care interface

Background

The interface between health and aged care services is complex and fragmented. Each system has its own operating context, governance structures, funding mechanisms, entry and discharge processes, and service providers. The interface is made more complex by overlapping roles and responsibilities between Commonwealth and state governments. It is important that stakeholders across the health and aged care systems each play a distinct role in ensuring that both systems meet the care needs of older Australians. There needs to be equal accountability between all stakeholders to progress an integrated care and service delivery approach for older people. Collaboration across health and aged care systems must occur to ensure older people can receive quality care, at the right time and in the right place.

Fragmentation at the interface of health and aged care systems has resulted in more than 50,000 older people experiencing delayed discharge from hospital (sometimes called 'bed blockers'). In general, this is characterised by failure of discharge planning and a shortage of available alternative forms of care.[30] This is having a detrimental effect on many of these older people, as well as creating delays in access to hospital beds for people in need, including for emergency care. Regional, rural and remote areas are especially affected, where the number of people awaiting hospital discharge almost tripled between December 2021 and June 2022.[31] CHA understands that this issue has been significantly grown since mid-2023.

Policy priorities

Commonwealth and state governments develop an implementation strategy to resolve the issue of delayed discharge of long-stay older people from hospital.

Overview

It is not acceptable that older people are not able to access the right level of care in an appropriate setting, or in some cases, living in hospital for months as they await care. When in hospital, patients are at risk of catching infections,[32] losing mobility,[33] and can lead to delays in other patients being able to access acute and emergency care as illustrated by recently reported problems with ambulance ramping, particularly in South Australia,[34] the Illawarra region of NSW[35] and Queensland.[36]

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30 Lopez et al. (2019). *Factors associated with bed-blocking at a university hospital*. Available at: Factors Associated with Bed-Blocking at a University Hospital (Cantabria, Spain) between 2007 and 2015: A Retrospective Observational Study – PMC

31 CEDA (2023). *Duty of Care: Aged Care sector running on empty, p10.*

32 Jeon et al. (2012). On the role of length of stay in healthcare-associated bloodstream infection. *Infection control and hospital epidemiology*, 33(12), 1213–1218. Available at: On the Role of Length of Stay in Healthcare-Associated Bloodstream Infection - PMC

33 Geyskens et al. (2022). Patient-related risk factors for in-hospital functional decline in older adults: A systematic review and meta-analysis, *Age and Ageing*, Volume 51, Issue 2, February 2022, afac007, https://doi.org/10.1093/ageing/afac007

34 Rix, Ethan (2023). *National overhaul of health system only way to improve ambulance ramping, experts say*. Available at: National overhaul of health system only way to improve ambulance ramping, experts say - ABC News

The problem of timely emergency care appears to be getting worse, with NSW public hospitals failing to keep up with emergency demand;[37] and NSW, WA, SA and the NT all had worse Urgent Emergency Department performances in 2022-23 compared to the previous year.[38] Indeed the 2022–23 national average of patients seen on time was the lowest figure in the past ten years across the four categories of Emergency (68% seen on time), Urgent (58% seen on time), Semi Urgent (68% seen on time), and Non-Urgent (88% seen on time).

However addressing the issue of the delayed discharge of older people from hospital is not simple. It is a symptom of failures across both the health and aged care systems. Some of the key factors which impact the ability of older people to exit hospital include:

- Availability of rehabilitation services delivered by the health system
- Communication breakdown between hospital and aged care settings
- Availability of specialist dementia care for people with very severe behavioural and psychological symptoms of dementia
- Level of funding within the mainstream residential aged care system to support people living with complex behavioural and psychological symptoms of dementia and people with other complex health needs
- Availability of trained and qualified staff within the aged care sector to support people living with dementia and people with other complex health needs.

Risks and implementation

If this issue is not addressed now, the health and wellbeing of more than 50,000 older people will deteriorate as they languish in hospital, while resources needed for emergency care is expended on them.

Medium-to-Long term recommendation

Federal and State Governments should work together to develop and implement a strategy to address the issue, with work to include:

- Developing nationally consistent data between states, including hospital coding of long stay patients in hospital;
- Understanding regionally-based issues using data and intelligence;

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35 Burfitt, Penny (2023). *Illawarra, Shoalhaven hospitals have worst aged care bed block in nation, and there's no easy fix.* Illawarra, Shoalhaven hospitals have worst aged care bed block in nation, and there's no easy fix - ABC News

36 Miles, Janelle (2023). Queensland spending millions on hospital care for people not sick enough to be there, data shows Available at: Queensland spending millions on hospital care for people not sick enough to be there, data shows - ABC News

37 Australian Medical Association (2024). *2024 Public Hospital Report Card.* Available at: Clear the hospital logjam | Australian Medical Association, page 13.

38 Ibid, page 12.

39 Ibid, page 33.

- Developing a series of user-tested state and regional factsheets for discharge planners outlining supports in the community; and
- Partnering with providers to increase investment in innovative transitional care models delivered by health and aged care providers with capacity.

In parallel, the Department should review the impact and adequacy of current policy settings to respond to the issue and their ability to support the needs of older people transitioning between hospital and residential aged care. This should specifically consider the challenges currently faced by both health and aged care providers to enhance their capacity to meet the care needs of older people.

CHA understands that Government is investing in a new scheme to support older people with dementia transitioning to age-appropriate care.[37] Other areas that should be reviewed to ascertain unintended impacts on older people stuck in hospitals include: Restrictive practice Rules; the Transition Care Programme; the AN-ACC tool; the National Dementia Support Program; and the Specialist Dementia Care Program. State and territory health departments should also regularly review hospital discharge protocols and community health protocols to ascertain whether modifications are required, and relevant programs such as the availability of rehabilitation, to prevent this problem.

Short-term recommendation

Discussion regarding patient flow in hospitals should be added as a standing agenda item to the Health Ministers' Forum. Importantly, the discussion of patient flow in hospitals will ensure that long-stay older people experiencing delayed discharge remains a priority issue for resolution through health reform. This is consistent with current priorities for health reform.[40]

A specific indicator of success for discussion could be the proportion of people experiencing wait times longer than 8 hours in emergency departments, with the target of 10% of patients in this category as per recommendations from the Australasian College for Emergency Medicine (ACEM) to maintain patient safety.[41]

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40 Cockburn, Paige (2025). *Emergency wait times blow out as hospitals struggle to discharge patients*. Available at: Emergency wait times blow out as hospitals struggle to discharge patients - ABC News

41 DoHAC (2024). Health Ministers Meeting. Available at: Health Ministers' Meeting (HMM) | Australian Government Department of Health and Aged Care