Submission by the Australian Nursing and Midwifery Federation

Transition of the Commonwealth Home Support Program to the Support at Home Program

13 February 2026

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 356,000 nurses, midwives, and care-workers across the country.

2. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We collaborate with them to improve their ability to deliver safe and best practice care in each one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The Australian Nursing and Midwifery Federation (The ANMF) welcomes the opportunity to provide this submission to the inquiry examining the transition of the *Commonwealth Home Support Programme (CHSP) to the Support at Home program.*

6. The ANMF represents nurses and care workers across residential aged care, home care, and community settings. This submission reflects the experiences of our aged care members to date.

Overview

7. The ANMF supports reform that improves access, equity, and quality of care for older people. However, reform must proceed on a workforce-first and safety-first basis.

8. The ANMF's central position is that the expansion of entitlements under Support at Home must not proceed unless and until system readiness is established. System readiness must be evidenced through measurable indicators relating to workforce supply and skill mix, assessment capacity, provider viability, and materially reduced waiting times. The Royal Commission into Aged Care Quality and Safety concluded that chronic understaffing was a primary cause of substandard care and warned that reform without sufficient workforce capacity would fail to deliver improved outcomes (Royal Commission into Aged Care Quality and Safety, Final Report, 2021).

9. The Commonwealth Health Support Program (CHSP) currently functions as a critical safety net for older people experiencing prolonged waits for assessment and higher-level care. In 2024–25, approximately 838,694 people accessed CHSP services nationally, many while waiting for assessment or package allocation, confirming its role as a de facto buffering mechanism within the aged care system (Department of Health and Aged Care, Report on the Operation of the Aged Care Act 1997, 2024–25).

Workforce-First and Safety-First Reform

10. Across multiple aged care reforms, government policy has proceeded on assumptions of workforce availability, skill mix, and surge capacity that are not supported by current labour market conditions. National workforce projections indicate that the aged care sector requires at least 17,000 additional direct care workers each year to meet existing demand, before accounting for growth associated with reform and population ageing (Committee for Economic Development of Australia, 2023).

11. When workforce capacity is insufficient, risk is displaced onto individual workers through excessive caseloads, unpaid labour, and accountability for failures arising from system design rather than professional conduct. The ANMF has consistently advised that reform settings which expand obligations without funding staffing capacity embed unsafe workloads and normalise unpaid labour, increasing psychosocial hazard and accelerating workforce attrition.

Transition Timing and System Readiness

12. Support at Home commenced on 1 November 2025, with the transition of the CHSP proposed no earlier than 1 July 2027. The ANMF emphasises that the phrase “no earlier than” must function as a safety threshold, not an assumed start date, meaning the transition should proceed only if workforce, assessment, and market capacity are demonstrably in place at that time.

13. Transition should occur only once government can demonstrate that workforce demand and supply gaps have materially narrowed at national and regional levels, that assessment capacity can deliver timely access within clinically appropriate timeframes, and that provider viability is not dependent on insecure employment practices or service withdrawal.

Continuity of Care and Waiting Periods

14. There remains insufficient clarity regarding how continuity of care will be maintained for existing CHSP clients and those awaiting assessment or higher-level services during the transition period.

15. Government reporting confirms that waiting periods for assessment and care frequently extend for many months and exceed twelve months for higher-level supports. As at mid-2025, more than 87,000 people were waiting for a Home Care Package at their approved level, with medium-priority waits commonly reported in the range of eight to twelve months and longer for higher levels of care (Department of Health, Disability and Aged Care, 2025).

16. During these waiting periods, the CHSP often provides the only practical assistance available to older people. Weakening this interim support risks functional decline, increased reliance on unpaid carers, and avoidable hospitalisation.

Assessment System Design and Workforce Conditions

17. Fragmented assessment arrangements within community aged care, including partial privatisation and reliance on time-limited contracts, have weakened accountability and contributed to assessment backlogs and inconsistent access. Insecure employment arrangements undermine workforce retention and continuity, compounding delays rather than resolving them.

18. The immediate risk arising from these settings, is access failure. Secondary risks include increased reliance on unpaid carers, avoidable hospital presentations, premature entry to residential aged care,

and intensified workload pressure as providers compress visits within constrained funding and time envelopes.

Home Modifications and Lifetime Cap Risks

19. The proposed lifetime cap on high-tier home modifications presents foreseeable equity and safety risks. Ageing-in-place involves cumulative and progressive needs, particularly for people with frailty or degenerative conditions. A significant proportion of older Australians reside in housing constructed prior to contemporary accessibility standards, increasing the likelihood that multiple modifications will be required over time (Australian Bureau of Statistics housing stock data, 2021).

20. A fixed lifetime cap of $15,000 incentivises delay in essential modifications, increasing falls risk, injury, and functional decline, while shifting costs to hospitals and emergency services. Falls remain one of the leading causes of preventable injury-related hospitalisations among older Australians, and delayed environmental modification is a recognised contributor to this risk (Australian Institute of Health and Welfare, 2023).

21. The ANMF supports replacing rigid lifetime caps with a clinically led, needs-based access model supported by clear guardrails, independent clinical review, and periodic reassessment.

End-of-Life Pathways

22. End-of-life care delivered in the community must be flexible to respond to changes in an individual's condition, preferences, and support needs over time. Care pathways that are clinically responsive, rather than fixed by time or funding limits are necessary. End-of-life trajectories are inherently unpredictable, with periods of stability and rapid deterioration requiring timely adjustment of care intensity and supports

23. Time or funding-limited end-of-life pathways delivered in community and home-based care, risk service discontinuity, unsafe discharge, crisis escalation, and avoidable hospitalisation. The ANMF has consistently advocated for holistic, person-centred end-of-life care that recognises clinical, psychosocial, cultural, and spiritual needs as inseparable components of safety and quality.

Thin Markets and Structural Failure

24. Rural, remote, culturally specific, and specialist service contexts continue to experience provider scarcity, constrained workforce pipelines, and high travel and coordination costs in aged care. Government reporting demonstrates persistent service gaps in outer regional and remote areas, particularly for specialised and culturally safe services.

25. Short-term grants and pilot programs do not address these structural conditions. Where markets fail to deliver essential care, governments must intervene directly to ensure continuity and equity of access in aged care.

26. Where services are withdrawn or reduced, workforce insecurity follows through job losses, reduced hours, and increased casualisation. In thin markets, areas or service types with few providers, limited workforce supply, or low service viability, directly accelerates workforce exit, increases unsafe workloads for remaining staff, and further undermines service continuity, particularly for priority population groups.

Provider and Workforce Readiness

27. Regulatory and administrative requirements are advancing faster than workforce supply, skill mix development, and clinical governance capacity. Expanded roles for all staff employed into aged care, increased caseloads, and rising care complexity are already evident in community settings.

28. Without corresponding growth in national and international workforce recruitment, investment in staffing, secure employment, and governance capability, these changes will increase clinical risk and accelerate workforce attrition. The experience of mandated care minutes in residential aged care demonstrates that regulatory intent alone does not translate into safe staffing outcomes without effective enforcement and workforce investment.

Workforce Readiness Statement

29. The ANMF calls for the introduction of a publicly available Workforce Readiness Statement prior to each transition phase for the Support at Home program A workforce readiness statement will assess workforce supply, assessment capacity, and market viability against reform demand, and identify whether conditions are in place to proceed safely or require corrective action. This statement should

be prepared by the Department of Health, Disability and Aged Care in consultation with workforce peak bodies, including the ANMF, and published at least six months prior to any transition decision.

30. The statement should document projected workforce demand versus supply at national and regional levels, assessment capacity, waiting time trends, employment security indicators, and identified risks in thin and priority markets, together with mitigation strategies.

Pricing and Program Design

31. Pricing must fund the full costs of care, including direct service delivery and indirect time associated with travel, documentation, coordination, and clinical escalation.

32. Where indirect time is unfunded, shorter and or less frequent visits and unpaid labour become normalised. This leads to increased psychosocial hazards, error risk, and workforce turnover. The ANMF has repeatedly identified this pattern across aged care and health sectors, including through member surveys and regulatory submissions.

Oversight and Safety Culture

33. System integrity requires stronger, clinically informed oversight rather than lighter regulation in the Support at Home Program. Incident and complaints data should be interpreted as indicators of safety culture, recognising the risk of under-reporting associated with fear, inadequate training, or weak governance.

34. Aged care regulators must be resourced with sufficient clinical expertise to identify risk, enforce standards, and intervene promptly, consistent with the findings of the Royal Commission into Aged Care Quality and Safety.

Lessons from the National Disability Insurance Scheme

35. Experience from the National Disability Insurance Scheme demonstrates that entitlement expansion without coordinated workforce planning, system design, and effective oversight leads to fragmentation, administrative burden, price inflation, and inconsistent quality. The National Disability Insurance Scheme Review (2023) identified these outcomes as consequences of rapid rollout without sufficient system stewardship.

36. Support at Home must avoid repeating these failures by prioritising safety, workforce sustainability, and system integrity over rollout speed.

Workforce Indicators

37. The ANMF supports the inclusion of workforce indicators as part of reform monitoring, noting that regular reporting assists in identifying emerging risks to workforce sustainability and safe care delivery. These indicators should include turnover, vacancies, employment mix, labour hire reliance, visit compression, unpaid overtime, psychosocial hazards, and employment security.

Conclusion

38. The ANMF would like to thank the Community Affairs References Committee for the opportunity to contribute to the inquiry examining the transition of the *Commonwealth Home Support Programme (CHSP) to the Support at Home program.* The ANMF opposes current implementation settings that expand entitlements ahead of funded workforce growth, assessment capacity, and market readiness, and without clear accountability mechanisms and enforceable safety safeguards, creating a foreseeable risk to safety, continuity of care, and workforce sustainability.

39. Safe care, workforce sustainability, and equity are inseparable. Failure in any one domain undermines outcomes for older people, families, and the workforce.

References

Australian Bureau of Statistics. (2021). *Housing stock data.* Australian Bureau of Statistics. https://www.abs.gov.au/statistics/industry/building-and-construction/estimated-dwelling-stock

Australian Institute of Health and Welfare. (2023). *Falls-related injury hospitalisations among older Australians.* Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/injury/falls

Committee for Economic Development of Australia. (2023). *Workforce projections for the aged care sector.* CEDA. https://www.ceda.com.au/getmedia/a7bc2f9e-4999-4c6b-9795-0eff89f0b94b/Duty-of-Care-Aged-Care-Sector-in-Crisis.pdf

Department of Health and Aged Care. (2024–2025). *Report on the Operation of the Aged Care Act 1997.* Australian Government. https://www.health.gov.au/resources/publications/2024-25-report-on-the-operation-of-the-aged-care-act-1997-roaca

Department of Health and Aged Care. (2025). *Home Care Package wait time data.* Australian Government.

National Disability Insurance Scheme Review. (2023). *National Disability Insurance Scheme Review: Final report.* Australian Government. https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final-report.pdf

Royal Commission into Aged Care Quality and Safety. (2021). *Final report: Care, dignity and respect.* Australian Government. https://www.royalcommission.gov.au/aged-care/final-report