

Helping local government
build stronger communities.



LGA Submission

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

February 2026



Executive summary

LGA South Australia (LGA) welcomes the opportunity to provide a submission to the [Senate Community Affairs References Committee](#) on [The Transition of the Commonwealth Home Support Program to the Support at Home Program](#).

LGA strongly cautions that a rushed or poorly managed transition from the Commonwealth Home Support Program (CHSP) to the Support at Home (SAH) program will significantly impact older people, providers, and the broader aged-care and health systems. CHSP has long served as the foundation of Australia's aged care system, providing preventive, entry-level supports that enable older Australians to remain living safely and independently at home.

Local governments – as trusted, community-embedded providers – play a unique and essential role in delivering low-risk, community-based aged care supports including transport, social connection, meals, home maintenance, and volunteer-led activities. The proposed SAH model does not adequately accommodate this role.

LGA's key concerns outlined in this submission, reiterate many of those raised in previous submissions¹ and include:

Transition uncertainty and delays

Ongoing ambiguity about timelines, program design, and funding undermines workforce and financial planning. Running CHSP and SAH concurrently will create major administrative burdens and risks for service continuity.

Funding model risks

A shift to a fee-for-service approach threatens the viability of council-run services, particularly in thin markets. Loss of block funding may lead to service withdrawal, increased costs, and reduced equity for rural, remote, Culturally and Linguistically Diverse (CALD), and vulnerable communities.

Workforce and governance challenges

New 'Responsible Person' requirements under the Aged Care Act impose disproportionate risk and compliance obligations on council CEOs, senior staff, and elected members, prompting some councils to consider exiting aged care entirely.

Client impacts

Long wait times, funding gaps, unclear eligibility pathways, and capped supports (e.g.,

¹ <https://www.lga.sa.gov.au/news-and-events/news/submissions>

proposed \$15,000 home modifications, 12-week palliative limit) place older people at risk. Without clearer communication, many clients remain confused and anxious about reforms.

Digital, administrative and cost pressures

Councils face significant digital integration challenges, increased reporting requirements, and financial risks associated with technology upgrades, workforce training, and transitioning to individualised client budgets.

LGA urges the Commonwealth to **maintain, evolve, and expand CHSP as the primary, foundational tier of the aged care system**, complementing rather than subsuming it into SAH. Local government providers emphasise the importance of **ongoing block funding**, appropriate price setting, and a reform roadmap that protects service stability and community wellbeing.

Recommendations

The following recommendations are made to the Inquiry.

1. That the Department of Health, Disability and Ageing provides a commitment to **maintain, evolve and expand the Commonwealth Home Support Program** and formalise its position as Australia's foundational aged care program that complements SAH.
2. That the Department of Health, Disability and Ageing recognise the unique role of local government, as a partner in government, and **include an appropriately funded 'case management' component within an evolved and expanded Commonwealth Home Support Program (CHSP)**. Embedding this within CHSP would:
 - support older people to transition to the most appropriate level of care, whether that be Support at Home or Residential Aged Care
 - acknowledge and resource local government's long-standing role as trusted system stewards, often providing unfunded coordination and service navigation.
3. **Block funding be retained to the Commonwealth Home Support Program as a standalone foundational aged care program** or at a minimum, be retained for services including community transport, group social programs, meal delivery and centre-based meals.
4. **The timeframe for Commonwealth Home Support Program (CHSP) transition be clearly communicated through a comprehensive Reform Roadmap**, with a funding uplift to allow time for further consultation with the CHSP sector and older Australians.

5. That the Department of Health, Disability and Ageing **publish comprehensive unmet need and waitlist data by region to identify service gaps and inform evidence-based resource allocation decisions** before the integration of Commonwealth Home Support Program into Support at Home.
6. The Department of Health, Disability and Ageing should use that data to **develop a strategy to reduce wait-times** and ensure that older people receive timely, consistent care and are not left waiting months or years for essential support.
7. The Department of Health, Disability and Ageing should adopt a **flexible, needs-based funding model** for home modifications - with increased or removed caps, hardship exemptions, and indexation - to ensure all older people can access the essential home adjustments required to live safely at home.
8. The Department of Health, Disability and Ageing should **replace the rigid 12-week palliative care limit with a flexible, needs-based model** that ensures continuous support throughout the end-of-life period and prevents distressing gaps in care for families and clients.
9. The Department of Health, Disability and Ageing should **preserve and expand block funding or a funding supplement, in thin, regional, remote, and niche markets** to ensure stable, culturally safe, and equitable service access.
10. That the Department of Health, Disability and Ageing **urgently consider the consequences of the new governance arrangement related to 'responsible persons'** under the new Act and its impact on local government providers.

It is suggested that either:

- section 12 of the Act be amended to exclude the elected governing body of local governments from responsible person provisions, as is currently afforded to State and Federal Government providers, or
- make a Rule, in line with section 602(3)a of the Act that excludes elected members from responsible person provisions.

This would recognise the distinct statutory and democratic role of councils and ensure that elected members are not treated as responsible persons in the same way as board members of aged care providers who are responsible for executive decisions of the provider.

11. The Department of Health, Disability and Ageing **consider the readiness of the community and develop an appropriate education and communication campaign.**

12. The Department of Health, Disability and Ageing **provide interim funding increases for Commonwealth Home Support Program services to address widening price gaps.**
13. The Department of Health, Disability and Ageing **adopt a multi-pathway access model** that embeds telephone, in-person, paper-based, and assisted options alongside digital channels to prevent exclusion of older people with low digital literacy or poor internet access.

Contents

Executive summary	1
Recommendations	2
About LGA South Australia	7
Our submission	7
Terms of Reference	7
Local government and aged care services	8
LGA Policy	9
General feedback	9
Local government – a unique provider that doesn't fit the SAH model	10
Opportunity for system stewardship	12
LGA Recommendations	13
Mixed-Funding Model and Block Funding Needs	14
LGA Recommendation	15
Feedback on the Terms of Reference	15
a. The timeline for the transition of the Commonwealth Home Support Program to the Support at Home Program after 1 July 2027	15
Uncertainty and Delays	16
Dual systems complexity	16
Service interruptions	17
LGA Recommendation	17
b. the expected impact of this transition, including on:	17
(i) waiting periods for assessment and receipt of care	17
LGA Recommendations	18
(ii) the lifetime cap of \$15,000 on home modifications	19
LGA Recommendation	19
(iii) the End-of-Life Pathway time limits	19
LGA Recommendation	19

(iv)	thin markets with a small number of aged care service providers	19
	LGA Recommendation	20
c.	aged care provider readiness for the transition, including their workforce	20
	Governance and administrative burdens under the new Act.....	21
	LGA Recommendation	22
d.	Other local government provider concerns	23
	Workforce challenges	23
	Financial sustainability	23
	Digital capability and systems.....	24
	Equity and community impact.....	24
	Competition	25
	Partnerships.....	25
	Fixed costs	25
	Lack of information	26
	Local government elections	26
	Reputation risk.....	26
	LGA recommendation	26
e.	any other related matters.....	27
	Readiness of older Australians	27
	LGA recommendation	27
	Unit pricing and funding disparity.....	27
	LGA recommendation	28
	Digital access and literacy	28
	LGA recommendation	28
	Appendix 1	29

About LGA South Australia

At LGA South Australia our purpose is to help local government build stronger communities.

As the peak body proudly representing 68 councils across South Australia and the Anangu Pitjantjatjara Yankunytjatjara, we champion the needs of our members every single day.

Working for our members, we represent the interests of local government at both state and federal levels and provide robust and innovative solutions to local challenges.

Whether it's policy development, coordination on important issues or training and development, our work is about empowering local government to deliver a real, lasting impact for South Australians. Our trusted services also include tailored cover and risk services for the sector, and access to pre-qualified suppliers and panels to save councils time and money.

With a focus on leadership and representation, our work is driven by a shared passion for making a difference in the lives of the communities.

LGA welcomes the opportunity to provide a submission on [The Transition of the Commonwealth Home Support Program to the Support at Home Program](#).

Our submission

This submission to the [Inquiry on The Transition of the Commonwealth Home Support Program to the Support at Home Program](#) responds to the [Terms of Reference](#), as they relate to councils in their multiple functions as service providers, service planners and place-based stewards, and system advocates on behalf of older people and the service system. It also provides general feedback about the Commonwealth Home Support Program (CHSP).

This submission has been developed in consultation with South Australian councils via call for feedback; and a survey sent to members of the Local Government Ageing Well Network (LGAWN). LGAWN is a network of council staff working together to support older South Australians in their communities and includes staff funded by CHSP.

LGA would particularly like to acknowledge the Municipal Association of Victoria (MAV) and Local Government New South Wales (LGNSW) for their support and advice.

Terms of Reference

The transition of the Commonwealth Home Support Program to the Support at Home Program, with particular reference to:

- (a) the timeline for the transition of the Commonwealth Home Support Program to the Support at Home Program after 1 July 2027;
- (b) the expected impact of this transition, including on:
 - (i) waiting periods for assessment and receipt of care,
 - (ii) the lifetime cap of \$15,000 on home modifications,
 - (iii) the End-of-Life Pathway time limits, and
 - (iv) thin markets with a small number of aged care service providers;
- (c) aged care provider readiness for the transition, including their workforce; and
- (d) any other related matters.

Local government and aged care services

Local government wears many hats when it comes to providing services for older Australians. Councils run several services that maintain independence and contribute to positive experiences for older people – such as in-home aged care services. Others include:

- Planning – Ageing Strategies, Access and Inclusion Plans, Regional Public Health Plans and contributing an age friendly approach to broader strategy and planning
- Facilities and infrastructure - libraries, seniors centres, community centres, footpaths, public realm, walking trails, exercise equipment, compliance with *Disability Discrimination Act 1992 (Cth)*
- Social inclusion and wellbeing programs – excursions, community visitors, intergenerational activities, healthy lifestyle programs, exercise/cooking/computer/first aid classes, volunteering, grants, ageing well expos
- Community transport
- Housing - Independent living units, planning policy to promote housing choice and guide, siting and location for housing for older people
- Provision of information on various topics – information for visually impaired, acting as first point of contact for older residents
- Pensioner concessions
- Networks and partnerships – ageing taskforces, regional collaborations

Whilst not all South Australian councils deliver funded aged care services, all councils provide some element of the services listed above. For example, libraries are important first points of contacts. This clearly entrenches local government's relationship with older people in the community. Libraries reinforce local government's ability to recognise, understand and respond to the needs of the growing older population and contribute to the building of social capital in our communities.

LGA Policy

Existing LGA policy is as follows:

3.4.1 Ageing

Local government recognises that there is an ageing population in South Australia that will require governments to allocate more resources to ensure better outcomes for our communities as they age. Notwithstanding the significant obligations of federal/ state governments, councils should equitably contribute to meeting the needs of an ageing population.

General feedback

The Commonwealth Home Support Program (CHSP) and its predecessor, the Home and Community Care (HACC) program, have been the bedrock of the Australian aged care system since 1985.²

In 2023–24, approximately 1.5 million people received some form of aged care – over half were receiving home support through the CHSP (around 835,000 or 56%).³

The Commonwealth's chronic underinvestment over many years in aged care has created significant flow-on impacts for state governments - contributing to the ongoing hospital ramping crisis - as older South Australians are stuck in hospital waiting for an aged care bed.

As recently as 6 February, the Federal Minister for Health, Disability and Ageing, the Hon Mark Butler MP, stated that "Australia needs to build a new aged care facility every three days for the next 20 years" (in order to meet projected demand).⁴

² [Sydney Community Collaborative \(2025\), Older and Connected, Inner Sydney Voice](#)

³ Commonwealth Home Support Programme (CHSP) Fact Sheet 2023-2024 https://www.gen-agedcaredata.gov.au/getmedia/a91b8ca1-51a6-44f8-bd37-31241cb85f92/Commonwealth-Home-Support-Programme-fact-sheet_2023-24.pdf

⁴ <https://omny.fm/shows/mornings-with-graeme-goodings/federal-health-minister-joins-graeme-goodings>

South Australian councils have a long history of providing funded aged care services to their local communities, despite it not being a core function of local government.

CHSP funding made it easier for older people to access and receive aged care services and support in their home by funding delivery of services such as transport, social support, home modifications and domestic assistance. Just over half the people in this program receive only one type of service – while a small minority receive five or more services.⁵

The Inquiry title - The transition of the Commonwealth Home Support Program to the Support at Home Program suggests that the transition of CHSP into SAH is not a matter of if but when. Fundamentally, LGA does not agree that this should be the way forward for the CHSP, for the reasons outlined in this submission.

Local government – a unique provider that doesn't fit the SAH model

As the level of government closest to communities, councils entered the provision of aged care services on the assumption that they would be providing entry-level care to help their residents remain in their home for longer, build social connections and ensure that their older citizens do not become socially isolated.

A recent LGA survey⁶ identified that

- transport
- social support – group
- social support - individual

are the 3 most common service types provided by SA's 22 council providers.

Local government centre-based programs, which focus on social connection, have complemented CHSP services through reconnecting, reablement and fostering community connections, networks and friendships between local people.

Beyond the delivery of care, councils create supportive environments and enable communities to age well, building social capital and connections for older people.

Many councils are also proactive in ageing well initiatives, and whilst the level of investment and scope differs between councils, the need to support the health and wellbeing outcomes for older residents is consistent.

⁵ Duckett, S., Stobart, A., and Swerissen, H. (2020). [Reforming aged care: a practical plan for a rights-based system. Grattan Institute.](#)

⁶ LGA pulse check survey – currently 12 of the 22 CHSP providers responded

Councils' involvement in and responsibility for emergency management has been and will continue to be of significant interest to the aged care sector.

Councils highlight the critical role of volunteers, who significantly expand service capacity and help keep essential supports (such as community transport) affordable for older people by stretching limited federal funding. They also emphasise the importance of group socialisation and wellness activities, noting that a clear process is needed to ensure local governments can continue delivering and strengthening these valuable community-based programs.

For example, a survey across 11 South Australian councils, including two regional councils, in 2016 (and not since repeated) provided the following statistics for volunteer involvement in aged care services:

903 volunteers provided 187,158 hours of service. The Productivity Commission calculates the value of volunteer service at \$27.42 per hour, so this equates to \$5.2m of unpaid service in those 11 local communities.

In today's environment that figure would be closer to \$9.4 million of unpaid service to those communities.⁷

As Age Discrimination Commissioner, Robert Fitzgerald AM, recently reflected, the most effective delivery will come from community-based providers such as local government, neighbourhood centres and not-for-profits, noting these organisations are better positioned to harness trust, relationships and local knowledge - qualities the market-driven model cannot replicate.⁸

Local government providers in South Australia believe that the future of CHSP at its core, should be maintained and funded as the primary entry level care step of the aged care system, this sentiment was reinforced by the LGA Board of Directors at their meeting in January 2026.

Previous communication from the Department of Health, Disability and Ageing (the Department) noted:

... local government providers play a crucial role in delivering aged care services, and that the government is committed to supporting you to continue delivering aged care".⁹

LGA urges the Department to not underestimate the critical role councils play in the aged care system. Councils provide strong local leadership, trusted advocacy, deep community connections, and frontline support that directly influences population wellbeing outcomes.

⁷ Using current figures provided by [Volunteering SA/NT](#) this dollar figure now sits at \$50.50 per hour.

⁸ <https://www.invox.com.au/news-resources/reimagining-the-future-of-chsp>

⁹ Local Government Roundtable Friday 7 February 2025 Slide Notes (can share upon request)

This position has been communicated to the Department over several submissions and letters to the relevant Ministers, as noted in Appendix 1.¹⁰

Funded aged care is the foundation that enables this work. Without it, many councils would be unable to sustain the services that communities rely on, creating a significant cost shift onto local government or resulting in council choosing to no longer provide the services.

Continued Commonwealth funding is essential to ensure councils across Australia can maintain their long-standing role in delivering low-level, preventative aged care services that strengthen community wellbeing, support ageing in place, and build social capital.

LGA echoes the calls of the CHSP Alliance, led by Paul Sadler, and Professor Kathy Eagar AM, who call for CHSP to be maintained and funded as the primary care tier of the aged care system. They suggest that just as the health system would be dysfunctional and much more costly without a strong primary health care tier, so aged care would be without a strong primary aged care tier.

Case study – City of Marion

The ever-changing timelines on this transition have impacted this council's desire to remain in aged care. The lack of information in a timely manner, the changing nature of that information and the limited ability to plan appropriately has meant that this service area of council has been, and remained, under-prepared for changes that would be put in place and fundamentally out of their control.

The impact though, has been on the council's residents, and a service provided by council via CHSP funding. This has led to complaints against the council for Commonwealth decisions and service restrictions. The timeline for the transition from CHSP to SAH on 1 July 2027 currently has very little information regarding the financial model for this, making it impossible for providers to predict future sustainability of this service area, noting escalating contractor costs are not aligned to very minor increase in funding from Commonwealth through contractual agreements.

Opportunity for system stewardship

An increasing number of councils have invested in functions that complement and strengthen the aged care system. These include community connector roles and service navigation supports. Several councils have also been commissioned by the Adelaide Primary Health

Network (PHN) to deliver the [Care Finder](#) program, reflecting their growing role in early engagement and system access.

Councils are frequently the first point of contact for older people and their families. As a result, they provide substantial coordination, support, and informal case management - often without dedicated funding. Current unit prices for services do not reflect the true cost of service delivery, and councils are absorbing activities that fall outside funded outputs.

The time required to manage and coordinate services for 'active' clients continues to rise, largely due to increasing complexity in the needs of people entering the aged care system.

Since mid-2023, one council reported that its team has been tracking hours spent on general enquiries, handling nearly 600 requests during this period. These interactions are rarely brief; assisting an older person to navigate My Aged Care and explaining assessment and service pathways can require significant staff time and specialised knowledge.

There is a clear opportunity for councils to continue and expand this system stewardship role - provided that sustainable, appropriate funding is made available. Evidence shows that councils are well-placed to support early intervention, reduce system fragmentation, and ensure older people can access the right services at the right time.

LGA Recommendations

1. That the Department of Health, Disability and Ageing provides a commitment to **maintain, evolve and expand the Commonwealth Home Support Program** and formalise its position as Australia's foundational aged care program that complements SAH.
2. That the Department of Health, Disability and Ageing recognise the unique role of local government, as a partner in government, and **include an appropriately funded 'case management' component within an evolved and expanded Commonwealth Home Support Program (CHSP)**. Embedding this within CHSP would:
 - support older people to transition to the most appropriate level of care, whether that be Support at Home or Residential Aged Care
 - acknowledge and resource local government's long-standing role as trusted system stewards, often providing unfunded coordination and service navigation.

Mixed-Funding Model and Block Funding Needs

CHSP is an effective investment, servicing 60% of the people for 9.7% of the funding, with Residential Care Facilities (RCFs) servicing only 16% of people with 66% of the funding as noted in Table 1.¹¹

Table 1: Public Expenditure on Aged Care, Australia 2023-24

	CHSP	HCP (SAH)	RCFs
Total Service Users	834,981	335,535	225,679
Commonwealth Funding p.a.	\$3.02b	\$7.53b	\$20.59b
Commonwealth Funding per person p.a. ^(a)	\$3,624.63	\$22,444.40	\$91,229.58
Commonwealth Funding per person per week^(a)	\$70	\$432	\$1,754

Source: Productivity Commission Report on Government Services (ROGS) 2025;

<https://www.pc.gov.au/>

(a) Calculations: M. Fine.

Councils support a mixed-funding model, consistent with the Royal Commission into Aged Care Quality and Safety recommendations and remain concerned about shifting to a NDIS-style, fee-for-service approach as is found in SAH. This was echoed in LGA's submission [A new Aged Care Act: Exposure Draft Consultation Paper No.2](#) in March 2024.

Councils warn that such a model increases administrative burden, lacks clarity on client contributions, and is particularly difficult for local governments, for which aged care is not core business and already requires significant council co-investment.

A purely fee-for-service model also places rural, remote, Indigenous, and small niche providers at high risk because activity-based payments cannot cover fixed costs such as staffing, vehicles, and infrastructure.

'Block funding', the traditional funding model where the government provides grants to approved providers to deliver community service programs, offers essential stability for services with fluctuating demand—such as social support groups impacted by pandemics, extreme weather, or seasonal changes. It enables providers to cover fixed costs like infrastructure, vehicles, and a trained workforce, ensuring services can continue regardless of attendance levels.

¹¹ [Productivity Commission Report on Government Services \(ROGS\) 2025](#); taken from *Developing a Vision of Accessible, Affordable and Sustainable Aged Care for Older People in Australia for the 21st Century* Michael Fine, Honorary Professor, Macquarie University, Sydney, 2025.

Without block funding, organisations reliant on significant fixed assets (for example, buses, community facilities), or staff employed under Enterprise Bargaining Agreements would face substantially increased financial risk. This could force providers to adopt more commercial, profit-driven models, undermining their ability to prioritise client needs and deliver high-quality, community-focused care, or exit the market.

Councils note that limited information about SAH financial settings makes planning or modelling impossible. As local government budgets are set well in advance, certainty and guaranteed funding are critical for councils to continue offering preventive, community-based aged care. If funding becomes fully individualised, it may not cover current CHSP-funded management structures, forcing councils to subsidise operations or reconsider their involvement in aged care altogether.

At a minimum, councils call for ongoing block funding for social support groups, community centres providing meals, delivered meals services, and community transport, as these rely on stable funding to maintain essential infrastructure and cannot be effectively delivered under an individualised SAH model.

LGA Recommendation

3. **Block funding be retained to the Commonwealth Home Support Program as a standalone foundational aged care program** or at a minimum, be retained for services including community transport, group social programs, meal delivery and centre-based meals.

Feedback on the Terms of Reference

a. The timeline for the transition of the Commonwealth Home Support Program to the Support at Home Program after 1 July 2027.

Notwithstanding the comments made above, councils have provided feedback to LGA that the constant delays, lack of information, late information, uncertainty, dual system complexity and funding gaps are of real concern. Transferring to SAH may prevent many willing service providers from remaining in CHSP beyond 1 July 2027.

Uncertainty and Delays

Councils have provided feedback to LGA that highlight that the extended, and continually shifting, timeline for transitioning from the CHSP to SAH is creating significant uncertainty for providers, clients, and local government decision-makers.

There is no clear date for when CHSP will fully transition. Emerging commentary suggests that the outcomes of the current inquiry may lead to further delays beyond 2027, leaving providers unable to plan with confidence.

Repeated changes to the transition timeline have become a major source of stress and anxiety for both council staff and clients, who are unsure about future program arrangements and eligibility.

Conversely, there is also a risk that if the Commonwealth opts for a shortened transition period later, this may create implementation pressures, particularly given the need to:

- Enact the new Aged Care Act
- Maintain system stability and
- Address longstanding structural issues relating to equity and access.

Council providers emphasise that they need detailed guidance now to begin workforce, budget, and service planning, and to determine whether they can sustainably continue providing CHSP services in the long term.

Dual systems complexity

Councils are concerned about the operational challenges of running CHSP and SAH concurrently over an extended period.

Maintaining two separate program structures creates administrative duplication, including parallel systems for intake, assessment, reporting, invoicing, and compliance.

The additional administrative burden will divert already stretched resources away from direct service delivery. Councils are already observing that clients are choosing to remain on CHSP rather than move to SAH, primarily because:

- SAH entails higher or more structured fees, and
- Clients perceive CHSP as more affordable and less administratively complex.

The current indicative prices on the Department's website show that SAH is significantly more expensive per hour of service than an equivalent hour of CHSP service.^{12,13}

¹² https://www.health.gov.au/sites/default/files/2025-10/appendix_e_-_chsp_national_unit_price_ranges_and_guide_to_the_national_chsp_client_contribution_framework.pdf

¹³ <https://www.health.gov.au/resources/publications/summary-of-indicative-support-at-home-prices?language=en>

This client behaviour undermines early SAH uptake and complicates workforce and financial planning.

Service interruptions

Without a clear and detailed interim plan, councils warn that the transition period could create risks for service continuity. If program boundaries are not clearly defined, some clients may experience disruptions in access to essential services.

Councils consider the current reform pathway poses risks to both providers and clients due to:

- persistent uncertainty about timelines and program design
- the inefficiency of operating CHSP and SAH in parallel
- unclear interim arrangements potentially leading to service interruptions.

Council providers are seeking certainty, clarity, and actionable guidance from the Commonwealth to ensure they can plan responsibly and continue delivering safe, equitable community support services during the transition.

LGA Recommendation

4. **The timeframe for Commonwealth Home Support Program (CHSP) transition be clearly communicated through a comprehensive Reform Roadmap**, with a funding uplift to allow time for further consultation with the CHSP sector and older Australians.

b. the expected impact of this transition, including on:

(i) waiting periods for assessment and receipt of care

Councils report that waiting times for assessment and access to aged care services are unacceptably long, leading to a high volume of client complaints.

Many older people wait months or years for services they have already been assessed as needing, with some experiencing deterioration in health while waiting for support.

Key drivers for these delays include limited-service availability, thin markets, insufficient interim funding, workforce shortages (particularly in rural areas), sector capacity constraints, and long wait lists for specific services.

Councils have reported that clients using other service providers are also experiencing inconsistent or sub-standard service provision, sometimes forcing them to re-enter waiting periods.

Many councils have closed their books on My Aged Care preventing the intake of new clients, show widespread and growing pressure across councils.¹⁴ These closures fluctuate and can often be for extended periods - yet they continue to receive referrals and direct calls, resulting in long internal waiting lists - often exceeding 100 people. In extreme cases, terminally ill clients have contacted Mayors or MPs after being assessed as needing care but waiting more than 12 months for a service.

A fundamental system issue is that assessments do not guarantee service availability. Long delays are compounded by slow allocation of SAH funding, driven by the points-based algorithm used to determine priority. This means clients can wait one to two years or are left receiving only intermittent, short bursts of support. As a result, clients who once received weekly services now accept sporadic, fortnightly, or monthly assistance due to limited provider capacity.

As one council put it:

"We are already seeing CHSP clients experience significant delays in accessing assessments, along with inconsistencies in assessment outcomes, including whether clients are directed to Support at Home or remain within CHSP. If all existing CHSP clients will require an income/assets and assessment prior to transition to SAH, this may create risk/delay and service gaps ahead of the transition. This is significant when considering the timing of the transition as CHSP makes up about 75% of at home aged care services".

With an ageing population, the demand for care is only going to increase, which is a real concern for councils, coupled with the fact that there is no current system in place to assess the waiting times for CHSP.

LGA Recommendations

5. That the Department of Health, Disability and Ageing **publish comprehensive unmet need and waitlist data by region to identify service gaps and inform evidence-based resource allocation decisions** before the integration of CHSP into Support at Home.
6. The Department of Health, Disability and Ageing should use that data to **develop a strategy to reduce wait-times** and ensure that older people receive timely, consistent care and are not left waiting months or years for essential support.

¹⁴ LGA pulse check survey – currently 12 of the 22 CHSP providers responded

(ii) the lifetime cap of \$15,000 on home modifications

Councils are concerned that the proposed lifetime cap for home modifications may be too low to cover major accessibility upgrades, leaving many clients unable to afford essential changes that would allow them to remain at home. Within CHSP, required co-contributions already create barriers for people who cannot pay, resulting in some clients forgoing necessary home adjustments altogether.

A lifetime cap also risks creating inequity, particularly for people with complex or progressive conditions who may need multiple rounds of equipment or home modifications over time. Rising construction and materials costs further compound the problem, meaning that capped funding may no longer provide value for money or meet the level of support older people genuinely require.

LGA Recommendation

7. The Department of Health, Disability and Ageing should adopt a **flexible, needs-based funding** model for home modifications - with increased or removed caps, hardship exemptions, and indexation - to ensure all older people can access the essential home adjustments required to live safely at home.

(iii) the End-of-Life Pathway time limits

Councils are concerned that a strict 12-week limit for palliative care does not reflect the unpredictable nature of end-of-life paths. Clients may stabilise and decline multiple times, making it impossible to align support needs with a fixed timeframe.

A rigid cutoff risks leaving families without essential care while they are already under significant emotional strain. Ending funding before the client's actual needs cease may create distress and exacerbate pressure on both families and providers.

LGA Recommendation

8. The Department of Health, Disability and Ageing should **replace the rigid 12-week palliative care limit with a flexible, needs-based model** that ensures continuous support throughout the end-of-life period and prevents distressing gaps in care for families and clients.

(iv) thin markets with a small number of aged care service providers

The transition creates significant risk for thin markets - particularly in regional, rural, and remote areas, as well as for providers serving CALD and First Nations communities.

Uncertainty about future funding threatens financial viability, increasing the likelihood that providers will withdraw, especially in small or isolated communities. Peri-urban areas may also be disadvantaged if their needs are not accurately reflected in the Modified Monash Model,¹⁵ leading to poor planning and resourcing.

These pressures heighten the chance of service gaps and unmet needs. In thin markets with very few providers, individualised budgets offer limited benefit because there are not enough suppliers available to deliver the required services. Block funding remains essential in these contexts, supporting service stability, culturally safe care, workforce retention, and flexible, community-responsive models that individualised approaches cannot replicate.

Even in metropolitan areas, where large numbers of providers appear to exist, the true capacity is much smaller. Only a limited proportion of providers can take on new clients under current funding levels, creating a false impression of supply. As a result, many clients - both new and existing - cannot access the services they need or increase their support because provider capacity is insufficient.

LGA Recommendation

9. The Department of Health, Disability and Ageing should **preserve and expand block funding or a funding supplement, in thin, regional, remote, and niche markets** to ensure stable, culturally safe, and equitable service access.

c. aged care provider readiness for the transition, including their workforce

Local government providers face several significant challenges should they need to transition to the SAH, and these must be carefully considered by the Commonwealth.

Further to LGA's comments in 'General Feedback', about funding models, council budget processes differ to the not-for profit and commercial sectors as they are authorised by elected members months before a new year starts. Additionally, the governance and administrative burdens under the new Act related to 'responsible persons' are extremely problematic for councils.

¹⁵ <https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm?language=en>

Governance and administrative burdens under the new Act

Councils report that the new governance requirements¹⁶, particularly the broadened definition of 'Responsible Person', are one of the most significant concerns arising from the new *Aged Care Act 2025 (Cth)*. LGA's concerns have been verbally communicated to staff from the Department, the Aged Care Quality and Safety Commission and via correspondence to the Minister for Aged Care and Seniors, Hon Sam Rae MP.

Unlike the former Aged Care Act's definition of 'key personnel', the new definition captures council CEOs, senior managers, and elected members, exposing them to personal liability, mandatory screening, Code of Conduct obligations, due-diligence duties, and potential disqualification.

Councils have also raised concerns about potential quorum loss and governance paralysis arising from elected members being classified as 'responsible persons' under the new aged care governance rules. If an elected member fails to meet worker-screening or suitability requirements and is therefore unable to participate in aged-care decisions, the council may be left without a sufficient number of eligible members to lawfully transact business — creating quorum risks and exposing the council to legal and governance challenges with the *Local Government Act 1999 (SA)*.

This is causing considerable anxiety, with many elected members unwilling to assume such risks for low-risk, entry-level services traditionally delivered by councils. The inability to use delegations further intensifies the burden, and any suitability finding against an elected member could cause reputational damage and legal uncertainty.

Further, it is contrary to the advice released by the Department in July 2025 which noted "*It is unlikely CHSP providers will experience any material change in their obligations and responsibilities*".¹⁷

These requirements are seen as disproportionate to the low-risk nature of Category 1–3 services. Two South Australian councils have already decided to exit delivering CHSP due to this element, with others potentially following suit.^{18,19}

LGA is aware other councils are also now actively considering withdrawing from CHSP - an outcome that would remove critical community-based supports, particularly in regional and

¹⁶ Letter to councils – from Assistant Secretary Robert Day, Harmonisation and Regulatory Strategy Branch, Department of Health, Disability and Ageing dated 31 October 2025

¹⁷ *The new regulatory model – Guidance for CHSP providers – July 2025.*

<https://www.health.gov.au/resources/publications/the-new-regulatory-model-guidance-for-chsp-providers?language=en>

¹⁸ City Of Unley website <https://www.unley.sa.gov.au/Community-services/Senior-services-support/Government-support-and-My-Aged-Care>

¹⁹ City of Marion website <https://www.marion.sa.gov.au/assets/meetings/GC251209F11.1-Report.pdf?v=1765346003>

remote areas where councils are often the sole provider. Conversely, it may also prevent them from delivering aged care services in the future should their community require it.

Councils are also concerned about the added administrative load from new incident management, complaints, feedback, and whistleblower systems, as well as unclear guidance from the Department.

Key documents, templates and program updates were released by the Department late, leaving councils unable to plan or assess long-term viability. Many CHSP clients - previously receiving small, simple supports like occasional transport or meals - will now face complex service agreements, creating further administrative and client confusion.

Additional worries include the need for new reporting systems and ICT upgrades, alongside confusion caused by the interaction between the Act's whistleblower requirements and the *Public Interest Disclosure Act 2006 (SA)*, which creates duplication and a risk of non-compliance with one or both regimes.

If these governance and administrative issues are not urgently addressed and aligned with State and Commonwealth frameworks, many councils - especially in regional, rural, and remote areas - may exit aged care services altogether, risking significant service gaps for communities that rely heavily on local government as their primary or only provider.

Councils emphasise that the pace of changes, late amendments, and the disproportionate regulatory burden have created a situation where continued participation in aged care may no longer be viable without urgent reform.

LGA Recommendation

10. That the Department of Health, Disability and Ageing **urgently consider the consequences of the new governance arrangement related to 'responsible persons'** under the new Act and its impact on local government providers.

It is suggested that either:

- section 12 of the Act be amended to exclude the elected governing body of local governments from responsible person provisions, as is currently afforded to State and Federal Government providers, or
- make a Rule, in line with section 602(3)a of the Act that excludes elected members from responsible person provisions.

This would recognise the distinct statutory and democratic role of councils and ensure that elected members are not treated as responsible persons in the same way as board members of aged care providers who are responsible for executive decisions of the provider.

d. Other local government provider concerns

Other concerns relate to the following:

Workforce challenges

- Ongoing workforce shortages mean demand for skilled staff is outpacing recruitment and training capacity.
- New requirements under the Act, including monthly reminders and individual penalties for breaches, risk deterring both frontline workers and experienced managers from working in the sector.
- Existing staff are already showing signs of burnout, particularly in the early rollout of SAH.
- Increased compliance and training obligations will place additional pressure on both paid staff and volunteers.

Financial sustainability

- There is concern that if councils are not paid appropriately under SAH, local ratepayers may end up subsidising what should be Commonwealth-funded services. With no guarantee of client numbers or income and without adequate funding cannot rely on ratepayer funds to cover service gaps or sustain staffing levels where demand is uncertain. This cost shift is unsustainable.

In February 2025, the Federal Inquiry into local government Sustainability's [Interim report into local government sustainability](#), highlighted the increased expectations to provide aged care services and the strain local government is under to meet legislated roles, or be the provider of last resort.

- The SAH model introduces individualised budgets and pricing caps that may not align with council cost structures.
- It is unclear how the program will operate when multiple suppliers enter the market and whose role is it to oversee the client's budget to make sure there is sufficient money to pay the provider.
- As mentioned previously, loss of block funding will threaten the viability of community-based programs such as social support, meals and transport. For these providers, a blended model of fee for service/aged care funded consumers will no longer be permitted under SAH, impacting older community members and segregating groups and services.

- Service viability and cost to run services in isolation (services only for SAH clients and services only for non-SAH clients) will increase costs for both clients and reduce the potential of a viable service model.
- The costs of adapting systems, updating technology and training staff may strain providers, particularly smaller councils and not-for-profits, potentially causing market exits and worsening thin market issues.
- The ongoing uncertainty around the future of funding continues to be a challenge for councils in terms of long-term program planning, staffing, morale and service capabilities. It is likely that this will be a key contributing factor as to whether local government will continue to be a provider of aged care services in their community.
- Therefore, some guarantees on the funding will be essential for councils to commit to the various services that they provide to their community.

Digital capability and systems

- Providers may struggle to meet new digital compliance and reporting expectations.
- The risk of penalties or loss of accreditation is heightened by the lack of suitable aged care software that fully integrates with My Aged Care and Data Exchange (DEX) to ease administrative load.
- Smaller councils without dedicated IT capacity face an even greater risk of falling behind.
- Council providers have reported that there is a potential conflict in managing financial hardship processes, given that fees will be set by the Commonwealth rather than providers with differing rules for aged care funded clients versus local government residents.
- The management of invoicing and payments will become significantly more complex, requiring multiple fee structures and schedules based on individual client statuses and assessed contribution percentages. As a SAH provider, providers will be required to manage the budgets and services for each client, rather than only the service they are delivering (as is with CHSP). To accommodate these changes, entire business models will need to change.

Equity and community impact

- At present, there has been some degree of choice for clients between CHSP and SAH (formally HCP) pathways, without choice, clients may opt out of aged care all together due to fixed pricing/complexity of service access. This will create additional pressure on local government to provide support to older residents.

- Vulnerable groups - including CALD communities, Aboriginal people, and residents in rural and remote areas - are at heightened risk of reduced service access if councils withdraw from aged care delivery. Anecdotally, LGA is aware that many metropolitan councils provide services to clients who are perceived to be 'too hard' for other providers. This will cause some clients to 'fall through the gaps'.
- Councils will need to maintain advocacy and referral functions to prevent further isolation and unmet needs in these communities.
- Providers will require additional support to meet the needs of clients with higher or complex requirements, such as people experiencing hoarding and squalor, individuals with low literacy, those with episodic mental health conditions, and people living with dementia.

Competition

- The transition to SAH will create a competitive market environment – which is not aligned with the role or mandate of local government.
- This is a challenge for councils as South Australia's Competitive Neutrality Policy requires government entities (which includes local government) to apply the principles of competitive neutrality to their business activities. This is to ensure significant government businesses compete fairly in the market.
- Councils operate 'community services' and do not operate like 'private businesses'.

Partnerships

- Commonwealth expectations around partnerships and consortiums may disadvantage smaller providers, who fear being overshadowed or losing the bespoke, community-focused nature of their service delivery.
- Councils may be forced to shift from direct service delivery to broader facilitation and advocacy roles, requiring different skills, relationships and funding structures.

Fixed costs

- Local government providers also carry significant fixed costs, including staffing, vehicles and infrastructure, which require stable and predictable funding and underpins its viability.
- Council budget cycles are fundamentally different from smaller private or not-for-profit providers, with long lead times and formal approval processes by elected members.

Lack of information

- Clarity is required regarding opportunities for councils to exit or withdraw as providers if the CHSP to Support-at-Home transition timelines are released, and do not align with council timelines (e.g. will providers/clients be automatically deemed and rolled over to SAH?)
- Councils have noted it is still unclear whether existing CHSP providers will automatically transition to Support at Home providers, and how clients will be informed and supported through these changes.

Local government elections

- In South Australia, the caretaker period between September and November 2026, and the following Christmas break in formal proceedings, may impact decision making timeframes for local governments prior to further information being provided by the Commonwealth.

Reputation risk

- Several councils, particularly in Victoria, have faced negative media attention after withdrawing from funded aged care services.
- Councils may find themselves *“damned if they do and damned if they don’t”* – as remaining in service delivery may attract criticism for perceived cost-shifting, while exiting may create perceptions that councils are ‘walking away’ from older residents.
- There is a significant risk that councils will be unfairly blamed for any issues relating to service continuity or affordability, despite these responsibilities sitting with the Commonwealth.
- In South Australia, 35% of councils, mostly remote and regional, were found to be potentially unsustainable, as assessed by the independent regulator (ESCOSA). This limits their capacity to contribute to any additional funding to non-core services, irrespective of whether they want to provide services.

LGA recommendation

The above concerns highlight that the current system needs to be working effectively before any transition of CHSP to SAH. Refer to recommendation 4.

e. any other related matters

Readiness of older Australians

The transition of CHSP to SAH also impacts older people themselves. Councils are hearing that many older people are confused with the reforms and unsure about if they will be better off. There has not been enough information or education from the Government ahead of the rollout to SAH. Requiring providers to step in and provide that information, at additional costs. It is suggested that a communication and education campaign be developed to provide further clarity on SAH to current CHSP clients and repeated ahead of any potential transition.

LGA recommendation

11. The Department of Health, Disability and Ageing **consider the readiness of the community and develop an appropriate education and communication campaign.**

Unit pricing and funding disparity

There are long-standing funding inequities in CHSP, with significant variations in unit prices for the same service types across providers and across states. The Department does not provide transparent data on how many providers fall into the lower, middle, or upper funding ranges for each activity, making it difficult to understand or address these disparities.

Councils report that current unit prices often do not cover the real cost of delivering services, forcing them to rely on client contributions and, in many cases, subsidise services through council rates.

South Australian councils say they are rarely funded at the upper end of national rates, which has increased cost-shifting onto local government. This is leading many councils to reconsider their involvement in service delivery, particularly in lieu of sufficient information regarding client contributions and supplementary grants for providers in thin markets and geographically isolated clients.

For example, council staff have advised that SA councils receive around \$55 per home-maintenance unit, compared with approximately \$110 in Queensland. These gaps are even more pronounced in rural and regional areas, where costs are higher, but funding does not reflect this reality.

Prices therefore need to represent the true cost of delivery. In transport services, for instance, funding should account for distance and regional context, such as recognising that an 80-kilometre trip from Victor Harbor to Adelaide is fundamentally different from a short trip within a metropolitan area.

Local government providers further note that:

- CHSP pricing has not increased beyond CPI for years
- Costs of service delivery (especially staffing, vehicles, insurance, and compliance) have risen considerably and
- The price gap between CHSP and SAH is widening.

There is a genuine risk that CHSP may run out of funds before the transition is complete, threatening service sustainability for councils and continuity of support for vulnerable clients.

LGA recommendation

12. The Department of Health, Disability and Ageing **provide interim funding increases for CHSP services to address widening price gaps.**

Digital access and literacy

The Department should ensure that any future service or funding model does not rely solely on digital access or digital literacy for clients to engage with the program. To maintain equitable access, alternative non-digital pathways must be built into the system. This should include options such as telephone-based interactions, in-person support, paper-based information, and assistance from service providers for clients who cannot use online systems.

Additionally, the Department should implement targeted supports for people with limited internet access or unreliable connectivity - particularly those in rural, regional, or remote areas - to prevent exclusion from essential services. Without these safeguards, a digital-first model risks creating systemic barriers for older people who are not online or digitally confident.

LGA recommendation

13. The Department of Health, Disability and Ageing **adopt a multi-pathway access model** that embeds telephone, in-person, paper-based, and assisted options alongside digital channels to prevent exclusion of older people with low digital literacy or poor internet access.

Appendix 1

LGA has submitted several submissions and letters to relevant Ministers highlighting local government's concerns with the reforms and the impacts to local communities including:

- Submission to the Aged Care Royal Commission – August 2019
- [LGA Submission - Aged Care Program Redesign: Services for the Future – Consultation Paper – January 2020](#)
- [A new Aged Care Act Exposure Draft Consultation Paper – March 2024](#)
- [LGA Submission - A new program for in-home aged care – November 2022](#)
- LGA co-signed, with MAV and LGNSW, a letter to Minister Anika Wells MP in October 2022 – which highlighted local government's concerns with the changes to the CSHP funding model
- LGA wrote to Minister Sam Rae MP in December 2025 calling for urgent action related to retaining block funding and reviewing governance arrangements in Aged Care to ensure councils can deliver

**Helping local government
build stronger communities.**

GPO Box 2693
Adelaide SA 5001
T (08) 8224 2000
E lgasa@lga.sa.gov.au

lga.sa.gov.au

