# Aged Care: Challenges and Opportunities

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## Introduction

Community aged care is entering a significant period of transition. The new Aged Care Act and the Support at Home program both commenced on 1 November 2025, replacing the Home Care Packages Program and Short-Term Restorative Care Program. The Commonwealth Home Support Program remains in place for now, with transition scheduled for no earlier than 1 July 2027. The reform direction is broadly positive. It aims to create a more rights-based system, strengthen accountability, and support older people to remain at home for longer.

The new system places greater emphasis on the rights of older people, clearer accountability, and a more unified model of support at home. It replaces the previous mix of Home Care Packages and Short-Term Restorative Care with a single Support at Home program, alongside new contribution arrangements and stronger expectations around transparency and oversight. While this should improve consistency and consumer focus over time, it also creates a more complex transition for older people, families and providers in the short term.

The key issue is how the reforms are experienced in practice during implementation. In this region there is a risk of reform turbulence: older people and families struggling to understand entitlements, navigating new program arrangements, facing long waits, managing greater financial contributions, comparing provider-set prices, and trying to maintain continuity of care in a system that is still changing. In a rights-based framework, these are not minor process issues they go directly to whether people can actually realise those rights in daily life.

This matters because access to community aged care is not simply about eligibility. It is about whether people can obtain timely assessment, receive support before their needs escalate, understand costs, manage a package, compare providers, and remain connected to care over time.

Importantly it is also about whether carers can keep going, whether providers remain viable, and whether the broader health system avoids preventable deterioration, emergency presentations, and hospital admissions. Where access becomes slow, costly, or confusing, the system does not merely inconvenience people, it often shifts risk elsewhere onto families, providers, primary care, and hospitals.

Community aged care reform should be seen as a regional population health, equity, and system performance issue. Framed in this way, the question is whether the reform is landing fairly, safely, and effectively across a diverse metropolitan region.

## What is working?

Many elements of the reform appear to be functioning as intended, and some aspects of the transition appear to have gone more smoothly than originally anticipated.

- The rights-based framework of the new Aged Care Act has been broadly welcomed as an overdue step forward in dignity and accountability.
- Priority classification under Support at Home appears to have improved access for urgent and high-priority clients.
- Continuation of CHSP has provided a degree of continuity for people receiving lower-intensity support while broader transition is still underway.
- Larger and better-resourced providers have, in many cases, adapted to the new pricing and service agreement arrangements with less disruption than some expected.

The challenge is how to ensure that implementation works equitably across a growing, diverse, and increasingly complex regional population.

### The equity challenge in the region

The central and eastern Sydney region has characteristics that make reform turbulence a genuine equity risk. The CESPHN needs analysis reports that 14.9% of the population is aged 65 and over, projected to grow by 43.6% between 2024 and 2041. The population aged 85 and over is projected to grow by 101.8% over the same period. The region also has 33.5% of older people with a preferred language other than English, compared with 20.4% across NSW. Almost a quarter of older people live alone, and 11% of those living alone have poor English proficiency. Dementia prevalence, carer strain, and social isolation are also identified as significant concerns in the local needs analysis.

These factors heighten vulnerability to reform turbulence. A system that assumes consumers can readily understand funding categories, compare providers, interpret pricing, navigate reassessment and advocate for themselves will not land evenly across this population. It will advantage those with confidence, digital access, English fluency, and strong family support. It will disadvantage those without them. In a region like central and eastern Sydney, that is not a peripheral concern it is central to equitable access.

## Waitlists and why delay is not neutral

Waitlists are one of the clearest indicators of access pressure. Even before the new Support at Home arrangements were introduced, CESPHN's needs analysis reported that waitlists for all package levels had increased markedly across the region. In the first quarter of 2024, almost 600 people were waiting for a Level 3 package in the Inner West and around 1,600 in South East Sydney. This points to substantial unmet demand even before the current model has fully bedded down.

Nationally, Support at Home waiting times indicate waits of one month for urgent priority, one-and-a-half to two-and-a-half months for high priority, eight to nine months for medium priority, and ten to eleven months for standard priority. Even allowing for differences in priority, these are long periods in the life of a frail older person and waiting lists lack transparency.

The impact of this delay is not neutral. Older people do not necessarily remain stable while they wait. Function can decline. Falls risk can increase. Social isolation can deepen. Nutrition, medication management, and self-care may worsen. Provider frustration is real as unlike the previous assessment arrangements they cannot under the new system track an older persons waiting times and progression and advocate should a need for earlier intervention be required.

Carers may take on more and more without adequate relief contributing to carer fatigue. By the time formal support arrives, the person may require more intensive intervention than would have been necessary earlier. Waitlists therefore act not only as a service access issue, but as a mechanism that can convert manageable need into higher-acuity need.

There is also a clear equity dimension. People with resources often have a greater ability to bridge the waiting period through private purchase, assertive advocacy, or family support. Others do not. In that sense, waitlists widen inequalities not only because some people wait, but because some people are better able than others to survive the wait.

## Affordability and package complexity

Affordability is one of the strongest concerns emerging under the new arrangements. Under Support at Home programs, participants do not contribute to clinical care, but most contribute to independence and everyday living services. Clinical care includes services such as nursing, physiotherapy, occupational therapy and other allied health support to manage health needs and maintain function. Independence and everyday living services include the practical supports that help people live safely and well at home, such as personal care, showering, dressing, cleaning, meal preparation, shopping, transport and social support.

For a full pensioner, standard contribution rates are 0% for clinical care, 5% for independence supports, and 17.5% for everyday living services. Providers also set their own prices within the broader framework and there are reports of $170 for the cost of a shower.

For older people on fixed incomes, even modest co-contributions can influence decisions to obtain care, particularly when combined with housing costs, utilities, food, transport, and other healthcare expenses. The risk is not only overt financial hardship. It is quieter behavioural change: reducing cleaning, cutting back personal care, postponing support, declining services perceived as too expensive, or trying to make do with family help until the situation deteriorates.

There is also a second issue beyond cost itself: the ability to manage a package. A package is only useful if the older person and family can understand and use it. In practice, that may require interpreting service agreements, comparing provider prices, choosing what to prioritise, understanding reassessment, managing statements and invoices, and making decisions in circumstances of frailty, stress or cognitive decline. Under the previous system, providers received more flexible funding to coordinate and administer packages.

Under Support at Home, care management for ongoing services is funded through a capped allocation of 10% of the participant's quarterly budget, potentially limiting how much coordination can be provided and making it more important that support is targeted well. For some older people and families this is manageable. For many others, especially those living with dementia, limited English, low digital literacy or weak advocacy support, complexity becomes a barrier in its own right.

The Minister has since announced that showering, dressing and continence care will be reclassified as clinical care from October 2026. These services were previously treated as personal care and attracted client contributions, so the change should reduce out-of-pocket costs for some older people, while also illustrating that affordability concerns in the new model remain live and significant.

A full pensioner receiving a typical package that includes personal care and domestic assistance may still face monthly out-of-pocket costs of several hundred dollars once provider pricing and contribution arrangements are considered. For people on fixed incomes, that is not a minor administrative matter and may compromise a person's exercise of the very rights that the new aged care system seeks to promote.

### Implications for older people, families, and the workforce

For older people, the combined effect of waitlists, greater financial contributions and package complexity can be profound. Support that is technically available may still feel inaccessible if it arrives too late, costs too much, or requires too much administrative effort to manage. In those circumstances, people may reduce service use, lose trust in the system, or delay asking for help until a crisis point and access to residential care is not guaranteed due to costs and reduction in number of care places.

For carers and families, the consequences are immediate. When formal support is delayed, confusing or unaffordable, families typically absorb more of the work. They manage appointments, shopping, medication prompts, transport, supervision, household tasks, and emotional support. This often occurs while carers are themselves ageing, working, or managing health issues of their own. Carers are part of the workforce of care. When the formal system is hard to access, the unpaid workforce expands to fill the gap. That may keep people going for a time, but it often does so at significant personal cost.

Unpaid care capacity cannot simply be assumed to stretch indefinitely. A practical implication is that community aged care reform may increase hidden care burdens before it improves formal care access. Carer exhaustion is often one of the tipping points that drives crisis presentations, hospital admission, or earlier transition to residential aged care.

The workforce implications should also be understood broadly. They do not sit only within the formal aged care workforce. They extend across community service providers, care managers, support staff, primary care clinicians, hospital staff, and unpaid carers. For providers, reforms increase the amount of navigation work alongside direct care. Staff spend more time explaining prices, clarifying entitlements, troubleshooting invoice issues, responding to family confusion, and helping people understand new arrangements. This is real work, but it can be poorly recognised and difficult to sustain when workforce supply is already tight.

There is also a risk of moral strain. Staff may be able to see clearly what an older person needs but be unable to secure timely or affordable support. That gap between need and what can be arranged can be demoralising, especially for frontline workers repeatedly placed in the position of explaining why support is delayed or reduced.

## System-wide implications

The pressures created by reform turbulence do not stay contained within the aged care system. They shift risk and workload across the broader regional health and community system – see Table 1. For older people and carers, the immediate pressures are waitlists, contribution costs, package complexity, and language barriers; the downstream risks are reduced service use, functional decline, carer exhaustion, and crisis presentations.

For community providers, the pressures include transition fatigue, pricing pressure, workforce strain, and demand volatility; the downstream risks are narrowing service offers, withdrawal from complex clients and reduced regional capacity.

The hospital implications are particularly important. When older people cannot obtain timely support at home, the system often responds later and at higher cost. A person may deteriorate physically or functionally while waiting for support. Falls risk may increase. Carer exhaustion may become acute. Medication management or nutrition may worsen. A preventable situation can then become an emergency department presentation, a hospital admission, or a longer and more complex inpatient stay.

Hospitals also feel the pressure on discharge. A patient may be medically ready to leave hospital, but not practically safe to return home without community supports. Where home care is delayed or unavailable, lengths of stay can extend, and readmission risk can rise.

When home-based care is delayed or too hard to use, more holding work falls back onto primary care without addressing the underlying gap. GPs and practice teams often become the place where families bring concerns about deteriorating function, confusing service arrangements, carer strain, and inability to access help. Yet general practice cannot substitute for a functioning community aged care system.

Table 1 System Implications

| | Immediate pressures | Downstream risks |
|---|---|---|
| Older people & carers | Waitlists, contribution costs, package complexity, language barriers | Reduced service use, functional decline, carer exhaustion, crisis presentations |
| Community providers | Transition fatigue, pricing pressure, workforce strain, demand volatility | Narrowing service offer, withdrawal from complex clients, reduced regional capacity |
| Primary care & GPs | Rising navigation and holding work; families presenting with system confusion | Reduced capacity for clinical care; GP workforce sustainability |
| Hospitals & LHDs | Delayed discharge where community supports are unavailable or delayed | Longer stays, increased readmission, avoidable ED presentations |

The common thread is simple: when home-based care is delayed, unaffordable or too complex to use, the costs do not disappear. They shift onto older people and carers, onto community providers, onto general practice and onto hospitals.

## Who is most at risk in the region?

The groups most likely to experience the downside of reform turbulence are those with the least capacity to absorb complexity. In CESPHN, this includes older people living alone, particularly those with poor English proficiency; culturally and linguistically diverse communities, for whom navigation, pricing and service agreement literacy are more challenging; people living with dementia or frailty, for whom package management may be beyond practical capacity; carers already under strain; and those with limited financial flexibility, for whom even modest contributions can alter service uptake behaviour.

The equity question is therefore local and practical: who is being left behind, where, and through what mechanism? Is it wait time, cost, language barriers, assessment friction, provider scarcity, or digital exclusion? Identifying the specific pathways to unequal access is central to an effective regional response.

## What this means

CESPHN is not the regulator or direct aged care funder, but it does have an important and legitimate regional role. At minimum, that role includes building stronger situational awareness of what providers, GPs, hospitals, advocates and community organisations are seeing on the ground; identifying early warning signs such as consumer confusion about pricing, longer discharge delays, more reports of carers struggling, or lower uptake of supports in communities at higher risk; and using its partnerships to bring together aged care providers, LHDs, general practice and the community sector to reduce fragmentation and improve local response.

The issues outlined in this paper align closely with the CESPHN Healthy Ageing Strategy, particularly its focus on supporting older people to age well at home, improving equitable access, and strengthening coordination across the regional health and community system.

Community aged care reform is not just an operational aged care matter. These are population health, equity, and system performance issues. When access to support at home becomes harder, the costs do not disappear. They shift elsewhere — to older people, carers, providers, hospitals, and general practice.

## Summary

The new Aged Care Act and Support at Home reforms are important and necessary changes. Their intent is sound: to create a more rights-based, accountable, and home-focused aged care system and to prepare Australia for it a sustainable transition to an ageing society. There are genuine signs of progress, and many in the sector have worked hard to implement these changes well. At the same time, periods of reform are periods of risk — especially in a region with a growing, diverse, and increasingly complex older population.

The main risk is that cost, delay, and complexity may shift risk onto those least able to bear it: older people with limited means, carers already stretched, providers facing transition fatigue, and hospitals responding to avoidable deterioration. Waitlists matter not just because they are long, but because some people worsen while waiting. Costs matter not just because they exist, but because they may quietly change behaviour. Complexity matters not just because it is frustrating, but because it can become a barrier to exercising rights in practice.

This is why the issue warrants attention. The right question is not whether the reforms are good or bad. It is how CESPHN and its partners respond practically and equitably to ensure that a rights-based model does not produce unintended access gaps during implementation.

## Discussion questions

- Which older people in the region are most at risk of poorer access under current aged care reforms, and why? (prompts below)
  - Which groups are least able to navigate a more complex system without help?
  - Are there particular suburbs or communities where these risks are likely to be concentrated?
  - How exposed are older people living alone, especially those without strong family support?
  - How does frailty, dementia or cognitive impairment change a person's ability to use and manage a package?
  - Are people on lower incomes more likely to reduce services because of out-of-pocket costs?
  - Are some carers already carrying so much that any further delay or complexity creates real risk?

- Which risks are most about eligibility, and which are really about affordability, navigation, and service availability?
  - What would we see first if older people were quietly scaling back services?
  - Are providers reporting more questions or confusion about service agreements, invoices or pricing?
  - Are GPs or hospitals hearing more from families who cannot get support in place?
  - Are carers reporting higher levels of stress because services are delayed or unaffordable?
  - Are older people declining lower level supports like domestic assistance, transport or social support because of cost?

  - Are there signs that people are using less care than they have been approved for?
  - Are there communities where uptake appears lower than expected, suggesting hidden barriers?
  - What data or intelligence would give us an early “no surprises” view of emerging problem?

- What are the earliest warning signs that waitlists, pricing, or package complexity are causing people to reduce or delay care?
  - What extra work is falling onto carers because formal support is delayed or harder to use?
  - What does workforce strain look like in practice for community aged care providers?
  - Are staff spending more time on explanation, navigation and troubleshooting than on care delivery?
  - Is there evidence of moral strain, frustration or burnout among frontline workers?
  - Are smaller or community-based providers under particular pressure compared with larger providers?
  - Are providers becoming more reluctant to take on complex clients because of workload or viability concerns?
  - Where is unpaid care filling the gap, and how sustainable is that?

- How are these pressures affecting carers, the workforce and community service providers in practice?
  - What happens when an older person deteriorates while waiting for support?
  - How much extra “holding work” is falling onto general practice because aged care access is delayed?
  - Are hospitals seeing delayed discharge because community supports are not ready or not available?
  - Could constrained home-based care contribute to avoidable ED presentations or admissions?
  - Is earlier entry to residential aged care becoming more likely for some people?
  - Which of these downstream impacts are already visible, and which are likely to emerge later?
  - Where are the main pressure points between aged care, hospitals and general practice?

- What are the likely downstream impacts on general practice, hospitals, and discharge pathways if access to home-based care remains constrained?
  - What happens when an older person deteriorates while waiting for support?
  - How much extra “holding work” is falling onto general practice because aged care access is delayed?
  - Are hospitals seeing delayed discharge because community supports are not ready or not available?
  - Could constrained home-based care contribute to avoidable ED presentations or admissions?
  - Are there impacts on falls, medication management, nutrition or carer exhaustion that then present to hospital?
  - Is earlier entry to residential aged care becoming more likely for some people?
  - Which of these downstream impacts are already visible, and which are likely to emerge later?
  - Where are the main pressure points between aged care, hospitals and general practice?

- What practical actions should CESPHN and its partners prioritise to minimise access gaps and unintended consequences during implementation?
  - Where can CESPHN add the most value without duplicating the role of providers, LHDs or government?
  - What local intelligence or monitoring should be put in place now?
  - What if any are early warning indicators should CESPHN and partners agree to track?
  - Are there particular communities or cohorts where targeted action is needed first?
  - How can navigation be improved for people with limited English, cognitive impairment or no family advocate?
  - What partnerships need to be strengthened between providers, GPs, hospitals and community organisations?
  - Are there quick wins that could reduce confusion, improve continuity or support carers?
  - What actions should be addressed locally through coordination?