



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

29 January 2026



Introduction

Juniper Aged Care is pleased to contribute to the Community Affairs References Committee's inquiry into the transition of the Commonwealth Home Support Program (CHSP) to the Support at Home Program (SaH).

The transition of CHSP into SaH represents a major structural reform in Australia's aged-care system. As the Senate Community Affairs References Committee examines this shift, it is timely and necessary to reflect on the far-reaching consequences, not only for older Australians who rely on in-home support, but providers and their workforce.

Under the Government's staged roll-out, SaH will first replace Home Care Packages and Short-Term Restorative Care from 1 November 2025, with CHSP transitioning no earlier than 1 July 2027.

This timeline was intended to give CHSP providers time to adapt their business systems, meet new regulatory requirements under the new Aged Care Act, and prepare for the new funding and service frameworks.

However, while the phased approach aimed to reduce disruption, the reform raised a number of critical issues including:

- Potential changes to waiting times for assessment and receipt of care
- Implications of the lifetime \$15,000 cap on home modifications under the Assistive Technology and Home Modifications (AT-HM) scheme
- Adequacy of End-of-Life Pathway time limits
- Vulnerability of thin markets, where very few aged-care service providers operate

Equally, there is a question of provider readiness, that is, whether CHSP providers have the workforce capacity, regulatory registration, and operational resilience to meet the demands of the new system.

In this submission, we explore these concerns in detail: assessing not just the projected impacts on Juniper's customers, but also the sector's capacity to deliver under the new framework.

We also consider other related matters, including risk management, equity of access, and long-term sustainability, in order to provide evidence-based recommendations to guide the Committee's deliberations.

We welcome the opportunity to discuss our concerns and solutions further. If you require any further information, please do not hesitate to contact us.

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About Juniper

Juniper is one of the largest not-for-profit aged care service providers in Western Australia with more than 2,000 employees, delivering both home and residential care throughout metropolitan, regional and remote areas in the Kimberley region to more than 7,000 people.

The breadth of Juniper's footprint in WA is unmatched in the State. In some remote locations, Juniper is the only aged care service provider.

Juniper currently has **1,396 customers** on the CHSP located across Perth and in the regions of Peel, the Great Southern, Wheatbelt, Goldfields and Kimberley. The CHSP with Juniper is all about keeping customers independent at home, enjoying what they love in life and connected to their community. It is an entry-level program for people 65 years or older (50 years or older for Aboriginal or Torres Strait Islander people) who can manage at home but just need a bit of support for some tasks.

Juniper offers a range of home care services under the CHSP designed to support a customer's independence and wellbeing. A customer's My Aged Care (MAC) assessment determines which services they can access to support their lifestyle and goals. Services include home support, such as personal care, meal planning and cleaning and household tasks; and social support, including companionship, transport and shopping.

The CHSP program also provides personalised clinical health services such as nursing, physiotherapy, occupational therapy and podiatry via one of Juniper's two metropolitan day therapy centres or, if eligible, in the comfort of the customer's home.

Timeline for the transition of the Commonwealth Home Support Program to the Support at Home Program

General observations

Under the government's staged roll-out, the Support at Home Program will first replace Home Care Packages and Short-Term Restorative Care from 1 November 2025, with the CHSP transitioning no earlier than 1 July 2027.

This timeline was deliberately intended to give CHSP providers time to adapt their business systems, meet new regulatory requirements under the new Aged Care Act, and prepare for the new funding and service frameworks.

Juniper staff worked hard to prepare for the new funding and service frameworks commencing on 1 November 2025, including regularly communicating the changes with customers to ensure they felt supported throughout the transition. They continue to work hard to bed in the changes and to prepare for the CHSP transition.

Throughout October 2025, Customer Care Leads (now referred to as Care Partners) visited every Home Care Package customer (649 people) to talk through what the changes would mean for them, and update budgets and plans to ensure continuity of care. We took the same approach with new and perspective customers, explaining the reforms clearly so they could understand their options and make informed decisions.

Juniper has more than 1,300 customers currently receiving services under the CHSP. Educating this large cohort about the changes coming in 2027 will require a substantial and sustained investment of time and resources.

The transition on 1 November went as smoothly as it could for Juniper, particularly given the scale of the SaH reforms and the late provision of detail by the Commonwealth to providers. Indeed, over the past 12 months, our industry has become accustomed to adapting quickly to new developments, including the delay of the new Aged Care Act to 1 November.

However, receiving information so close to the implementation date posed a number of challenges in ensuring all necessary training and preparations were in place.

Our teams also reported that communication from the Australian Government Department of Health and Aged Care was too general and didn't provide enough detail.

While we had concerns regarding the digital changes within our systems, we acknowledged the full impact would not be fully understood until several months after payments commenced following the delivery of services.

Planning and funding pressures

Data presented in the Senate Community Affairs References Committee report on Aged Care Service Delivery in October 2025 revealed alarming statistics regarding access to home care - more than 200,000 older Australians waiting for packages, many for extended periods.

Even prior to the introduction of SaH, there were insufficient Home Care Packages to meet demand, forcing many people to fall back on CHSP.

As a result, CHSP has increasingly been used as a last-resort safety net for people with complex or long-term care needs. However, CHSP services are designed as entry-level supports to help older people maintain independence at home, not to meet higher or ongoing care requirements.

As currently funded, CHSP is fully subscribed and has no capacity to meet rising demand. Service outputs have been capped for several years despite growing need, resulting in long wait times and insufficient support for those who need it most.

The transition to SaH is increasing demand on CHSP, placing pressure on planning and the ability to meet contractual outputs.

Existing funding arrangements allow only 50% flexibility to shift resources between service types, which is proving insufficient as demand grows in higher-need areas. As a result, there are requests to increase flexibility to 100% to better manage funding pressures and respond to changing demand under SaH.

While CHSP plays a critical role as a bridge for customers with more comprehensive care arrangements pending, it was never designed to absorb the current surge in demand. Consequently, many older Australians are experiencing unacceptably long delays in accessing essential care, which can cause, in many cases, deterioration, emergency department presentations and hospital admissions.

While CHSP recipients have been assured they will not lose services when the program transitions to SaH, and that the transition will be gradual, serious system pressures remain.

With all customers expected to transition to SaH by 1 July 2027, there is a real risk that no effective safety net will exist if CHSP cannot meet future needs. Simply converting the CHSP into SaH will not resolve the underlying capacity and demand issues across the system.

Without CHSP as a fallback ...

How do providers continue to support people whose needs **exceed** their Support at Home funding?

How are people with complex or fluctuating needs protected from funding reductions driven by automated assessment tools?

How do providers ensure someone is not worse off through this transition process?

Assessment and funding outcomes

The quality and outcomes of assessments, along with wait times for re-assessments is raising serious concerns.

Since the transition to the new Aged Care Act, Juniper has found 'efficiency-driven' assessments are becoming increasingly determined by an algorithm within MAC resulting in an over emphasis on informal care. This is resulting in automated or "robo" decisions that can't be explained, lack transparency and, in many cases, cannot be overridden by assessors despite clinical judgment suggesting an alternative outcome.

CASE STUDY

Unexplained automated "robo" decisions

A Juniper customer was referred for an ACAT assessment to review her eligibility for a higher level of SaH. The review was prompted by concerns she was predicted to exceed her SaH budget, despite receiving the minimum services necessary to support her independence.

Juniper is currently providing the customer one hour of personal care in the morning and 30 minutes in the afternoon, six days a week; and 2.5 hours of domestic assistance per fortnight. She also receives additional support from her son on the day Juniper doesn't visit.

Despite this support, the customer is facing a predicted budget overspend and has expressed concerns about her ability to financially cover the additional costs due to being a full pensioner.

Her goal was to reduce pressure on her family and ensure she received continued support for her declining mobility, including assistance with shopping and ongoing physiotherapy. Her medical history includes a range of serious health conditions including congestive heart failure and other issues affecting her mobility and overall health.

A face-to-face assessment was conducted in November 2025. **Following the review, the "robo" assessor recommended the customer's funding be reduced from her previous SaH Level 4 (HCPL4) to the lower SaH Level 5, resulting in a drop in funding of almost \$24,000.**

This decision was based on the assessed need for less intensive support, despite the customer's ongoing health challenges and request for additional services. The "human" assessor recommended the customer decline the offer of SaH Level 5.

This left the customer feeling unhappy and confused about the decision, as she felt she was already receiving the minimum support necessary to maintain her independence. The new level of funding would not adequately cover her needs, and she expressed her intention to appeal the decision through a MAC review.

A Juniper Care Partner is due to meet the customer to discuss the options further and work towards a solution that addresses the overspend while ensuring her needs are met.

This case highlights the challenges faced by older individuals in maintaining independence while navigating the complexities of SaH services. Despite the customer's minimal support needs, the reduction in funding presents significant challenges to meet her health and care requirements.

Assessments are also not reflecting functional complexity or fluctuating needs. We have seen customers with cognitive impairment, behaviours of concern or multiple comorbidities receiving lower-than-expected support levels. The fact that these assessments are not aligning to a customer's complex or 'real-world' needs contradicts the new Aged Care Act, which aims to put older people at the centre of aged care.

Care for older people is a fundamental human right, as reflected in the new Act, which places dignity, respect, choice, and autonomy at the centre of care through a clear Statement of Rights and a strong human-rights-based approach. The use of automated assessment algorithms reduces the rights of older people contrary to the Act.

Because these rights depend on understanding an individual's unique needs, preferences, and circumstances, decisions about the level of care an older person receives should be made through human judgement and genuine consultation based on what was observed in the home, not by relying on an algorithm.

We are concerned that these problems reflect a system that remains unsteady, incapable of meeting demand and an assessment engine that is undermining confidence in the outcomes it produces. These mismatches are also creating more work, more disputes and more delays. Because there is no ability to override the algorithm, providers need to lodge Support Plan Reviews for inappropriate outcomes.

Limitations of the current Support Plan Review process

Support Plan Reviews are essential, but they are constrained by existing system settings. Customers are often required to exhaust surplus funds before a new plan or assessment can be approved, delaying access to appropriate care.

While it is still too early to examine the full impact, Juniper has already received several requests for a Support Plan Review which have subsequently been knocked back by MAC. Collectively, this will inevitably result in a backlog of review requests, clogging the system and delaying services further.

It also creates a significant additional burden for Care Partners (who have been advised by MAC that managing customers is their responsibility) with substantial flow-on impacts for administration both financially and in terms of workforce productivity, notably:

Third party management

- Renegotiation of supplier contracts to align with SaH pricing structures
- Additional invoice checking and validation for subcontracted services
- Increased oversight of third-party providers to ensure compliance

Increased billing and claims administration

- More complex claiming rules and validation requirements
- Additional staff time to review, reconcile, and resubmit rejected or adjusted claims
- Parallel billing processes during transition periods (legacy programs and SaH)

Care management and service coordination administration

- Separation of care management and service delivery requires more tracking and reporting
- Increased documentation to demonstrate eligibility, service alignment, and compliance
- Additional follow-ups with clients to explain service changes and funding impacts

My Aged Care portal/website

- Two-monthly updates on most common prices

System implementation and ongoing system administration

- Implementation of new care management systems (e.g. AlayaCare)
- Ongoing configuration changes to align with evolving SaH rules
- Increased IT support, licensing, and data management costs
- Staff time for data cleansing, migration, and quality assurance
- Additional financial costs to support

Workforce administration

- Additional rostering and scheduling complexity due to new service categories and funding rules
- More frequent adjustments to rosters to align with client budgets
- Increased payroll checking to ensure services are correctly matched to funding streams

CASE STUDY

Support Plan Review limitations

A customer in Hopetoun - 590 km south-east of Perth and 160 km west of Esperance in Western Australia's Goldfields region – had a fall in December 2025.

She was hospitalised and stayed with her family for a short period. She has since returned home and wishes to remain there. However, she requires increased support to do so, including welfare checks and meals. She currently receives seven hours of support per week.

Juniper has reflected her increased needs in her budget, which has increased significantly. While higher funding is available, **MAC rejected her request within a matter of hours due to unspent surplus funds, which are expected to be exhausted within two months.**

Additional services are currently in place to support her at home while a Care Partner will visit her at home to reassess her needs and identify where services can be reduced and what cutbacks can be made to ensure her money lasts a bit longer.

However, the timeframe for reassessment remains uncertain meaning there will likely be a gap in service provision. There is some concern this will lead to the customer's health declining further and her being unable to stay in her own home.

Challenges in regional and remote areas

Customers in regional and remote areas of WA are experiencing even greater challenges with the transition compared to those in metropolitan Perth.

Service and travel costs are much higher in regional and remote areas, making it difficult for providers to operate efficiently and affordably.

Under the new SaH payment structure, providers now only receive 10% of each customer's quarterly budget to cover care management. This has resulted in providers having to increase costs to break even.

Smaller regional providers risk becoming financially unviable, which could force them to cease operations and result in a loss of services in areas that desperately need them.

This could mean many older people with SaH approvals in these areas are left without access to the services they need.

Communities in these areas require additional attention and tailored solutions to address the unique challenges they face, ensuring they are not left without viable service options or forced to go without essential support.

Some regions, such as the Goldfields, don't have access to service providers with CHSP. In Hopetoun, for example, Juniper is the only provider that has the CHSP and SaH.

While we are waiting to confirm if we have been successful in our request for 100% flexibility provisions in our CHSP contract, customers who need additional support are currently unable to access it.

Funding classifications

Upholding the promise that older people already on packages will not be worse off under SaH is proving difficult with customers already aware changes to funding classifications and price rises are going to leave them paying more.

The funding classifications for CHSP are different to the pricing structure for SaH. CHSP is task-focused and subsidised on a per-service basis, while SaH services are much broader.

Under the changes, all home care recipients will be means tested and may have to pay a co-contribution for services such as showering, cleaning and gardening. These changes to co-contributions mean customers who rely on short, essential visits to stay independent are being asked to reduce services or contribute more than they can comfortably afford.

Since Juniper opened its portals at the beginning of January, we have seen an influx of CHSP referrals. In one week, there were 69 referrals just for domestic assistance alone. In contrast, the number of SaH referrals hasn't been anywhere near as many as we were expecting.

We have been tracking those impacted under the changes and found the primary reason for customers turning down SaH is because it is more expensive. They are simply asking, “Why would I transition to Support at Home if I have to pay more?”

This will be more pronounced after the transition of CHSP to SaH given the nature of services delivered under CHSP are closely aligned to everyday living support services and often do not include a co-payment.

As a result, the proposed transition risks alienating poor and vulnerable older Australians who, due to their financial circumstances will need to make difficult choices. People who cannot afford home care may delay or avoid support, running the risk of being admitted or readmitted to hospital, not because care is necessary but because ongoing home-based support is out of reach financially.

The SaH pricing structure is also difficult to apply across long distances, meaning customers in regional and remote areas are likely to be worse off. The often-significant driving distances between customers and care along with cost of services has not been considered in the SaH model in contrast to CHSP grant agreements.

Expected impact of the transition

Waiting periods for assessment and receipt of care

Customers who choose not to transition to SaH because they don't want to or don't have the means may apply for hardship.

However, requests for hardship consideration are progressing very slowly. While we can assist customers with submitting an Aged Care Claim for Financial Hardship Assistance form (SA462) to Services Australia, we haven't seen any approvals since 1 November 2025.

The application itself is a 16-page document, and many customers don't know where to begin. This creates additional administrative work for our Care Partners, when their focus should be on care management hours. It also means people from a non-English speaking background or those who have literacy problems are locked out of making the application in the first place.

It also creates financial risk while awaiting hardship decisions as, if applications are declined, Juniper may be required to recover accumulated client contributions that would have been payable during the assessment period.

Customers are also reluctant to commence support while waiting for the outcome of a hardship application due to the risk of having to pay if it is declined.

“Why would I transition to Support at Home if I have to pay more?”

One Juniper customer assessed as Level 2 SaH, is receiving CHSP funding for meals, transport, domestic assistance and social support. However, Level 2 SaH couldn't support these services, and the customer can't afford any contributions so has decided to remain on the CHSP.

Another Juniper customer in the metropolitan area chose to keep his existing CHSP service and pay for podiatry privately, as he is still financially better off under CHSP.

A couple from regional WA applied for hardship assistance twice but were declined both times. They told us they had no access to funds, their only asset was the home they live in, and they couldn't afford to make any contributions.

Delays in the process again can lead to deterioration in the health and well-being of customers and, in some cases, even lead to death. These delays also have a broader impact on hospitals already under pressure.

Lifetime cap of \$15,000 on home modifications

The lifetime cap of \$15,000 on home modifications is unrealistic and risks driving poorer outcomes and higher downstream costs.

Home modifications are rarely installed in isolation; they commence with an Occupational Therapy assessment and then typically require significant reconfiguration of rooms to safely accommodate functional decline, mobility aids and changing care needs.

In practice, customers almost always require additional supports and care alongside modifications. Without these, the risk of falls, functional deterioration and hospital readmission is not mitigated and remains high.

Based on our experience, the **true cost of delivering effective, safe home modifications is closer to \$50,000**, particularly for people with complex needs.

While customers can access clinical funding for initial assessments, once Assistive Technology and Home Modifications (AT-HM) funding is required, options become constrained and fragmented. At the same time, our teams are seeing a marked increase in the number of customers with complex needs, including those coming through programs such as CoNeCT and the Transition Care Program.

These customers often require a multidisciplinary approach, including intensive care coordination as well as social work and mental health support. For example, one customer lives in a hoarding and squalor environment that is unsafe for Juniper staff to provide personal care. The customer has multiple complex needs, including aggressive behaviour, which poses significant risks to staff safety and restricts the delivery of in-home services.

CASE STUDY 1

Limitations on lifetime cap of \$15,000 on home modifications

A Juniper customer has complex bowel management requiring daily nursing support.

Current care practices did not align with best practice (including the use of anal stimulation), and the customer was experiencing progressive health deterioration. A referral for a Level 3 package was submitted; however, this was declined on the basis that the bowel management approach was not considered best practice or supported, and the available funding was insufficient to safely meet the required level of care.

CASE STUDY 2

Limitations on lifetime cap of \$15,000 on home modifications

A Juniper customer was approved for Level 4 SaH has significant clinical needs and requires support with all daily activities but is unable to contribute to the cost of his care.

Weighing 200kg, he needs a two or three person assist. However, his home lacks the appropriate equipment (bariatric bed), which is essential for nursing staff to provide care safely.

His care needs to be carried out on a bed to ensure his care team can access under his abdominal apron and roll him to access his back and sacral area. Without the proper equipment, the care process became difficult and unsafe for him and his care team.

Additionally, there was insufficient funding for necessary nursing and allied health assessments, as well as daily nursing support. The customer also struggled with personal care, as he was unable to access the shower and needed assistance on the bed, which posed safety risks for the care team.

Juniper attempted to facilitate a review for Level 7 and Assistive Technology and Home Modifications (AT-HM). However, the customer had to be transferred back to hospital, and we were unable to source loan equipment for his care as the expectation was that the required equipment would be funded from his package.

These pressures are further exacerbated by inflexible funding arrangements, inconsistent co-contribution practices, and limited ability to shift funding between service “pots” to respond to a customer’s actual and evolving needs, ultimately undermining safe, coordinated and effective care delivery and removing consumer choice and control contrary to the human rights focus of the Act.

The absence of early, flexible intervention, such as adequate domestic assistance or timely home modifications, means people deteriorate, fall, or end up in hospital or higher-level care unnecessarily.

These early, flexible interventions have traditionally occurred within the CHSP service suite. The transition from CHSP to SaH in its current form means these interventions will no longer occur resulting in higher costs within the health system as a result of preventable incidents in the home like falls.

This is particularly concerning given that according to the Australian Institute of Health and Welfare, falls are the leading cause of hospitalised injuries and injury deaths among older Australians, making up 77% of all injury hospitalisations and 71% of injury deaths in this age group.

In 2019–20, falls among people aged 65 and over resulted in:

- 133,000 hospitalisations; 3,228 per 100,000 population
- 5,000 deaths; 122 per 100,000 population
- 2 in 3 falls hospitalisations were for females

One in two falls that resulted in hospitalisation occurred in the home and one in five occurred in a residential aged care facility.

Juniper strongly recommends greater flexibility during and beyond the transition period, including 100% approval where clinically justified, to prevent avoidable harm, reduce hospital demand, and ensure the reforms deliver value for money by investing earlier in the supports that keep people safe and independent at home.

End-of-Life Pathway limits

From Juniper's perspective, the proposed end-of-life pathway time limits under Support at Home risk undermining continuity of care, consumer choice and the ability for people to die at home. In Western Australia, end-of-life and palliative care is largely delivered through state-funded programs, with Silverchain the predominant provider.

The SaH single service model designates a main provider to manage a client's care, funding and administration.

This single-provider model, combined with rigid time limits, means people may be unable to remain at home in their final weeks and instead will be pushed into hospital, contrary to their wishes and at a time when hospital beds are already under pressure.

More broadly, these changes exacerbate long-standing issues with nursing under CHSP, where services are locked to one provider and providers cannot respond flexibly when clients develop acute or complex needs, despite clear demographic shifts toward higher acuity in the community.

Although the reforms emphasise consumer choice, in practice choice is being stripped away, with customers unable to retain their preferred clinicians (such as physiotherapists) and forced through third-party arrangements.

This is inconsistent with the principles of the new Aged Care Act which places an emphasis on individual care and the right to choose. The Act states older people have the right to make decisions about their own life, including the care and services they receive.

Without greater flexibility, genuine choice, and better integration with state-funded end-of-life care, the new pathway risks poorer outcomes for people at the end of life and increased reliance on hospital care.

While Juniper could potentially support people at end of life, this would require clarity on scope, funding alignment with state programs, and flexibility in provider arrangements.

Thin markets with a small number of aged care service providers

The transition from the CHSP to the SaH model is likely to have a significant impact on thin markets where there are only a small number of aged care providers. Under CHSP, block funding has given providers a level of financial certainty that supports long-term planning, coordination of services, and reduced administrative burden. This funding structure has been particularly important for smaller and locally based organisations that operate with limited resources.

In contrast, the move to individualised, package-based funding under SaH may reduce that stability. In thin markets, demand can be unpredictable and service volumes low, making a fee-for-service approach less viable. Without the guaranteed income that block funding provides, some providers

may struggle to sustain operations, especially where travel distances are large or service delivery costs are high.

As a result, communities in regional, rural, and remote areas – already experiencing limited choice - face a higher risk of service gaps or market failure during the transition.

Aged care provider readiness for the transition, including workforce

Observations on impact of changes on workforce

The transition from Home Care Packages and CHSP to SaH already has had a significant impact on the workforce. Staff are experiencing change fatigue due to the scale, pace and ongoing nature of reforms, compounded by increased pressure to manage tighter budgets, heightened client expectations, service changes and additional administrative requirements.

The increased complexity of service delivery, funding arrangements and compliance requirements has contributed to higher stress levels, particularly within rostering and scheduling functions, resulting in increased turnover. Staff are managing a growing number of difficult conversations with clients regarding assessment outcomes, reduced services, budget limitations and increased pricing, which have further impacted morale and workload.

There are also substantial hidden workforce and organisational costs, including increased time required per client for administration, documentation and reviews, as well as additional resourcing for project team support, care management system configuration, and ongoing implementation, evaluation and system changes to meet SaH requirements.

Workforce pressures have been further exacerbated by an increase in client complaints and ongoing issues with approvals in the MAC system and alignment with Services Australia approvals, leading to additional administrative burden, delays and financial impacts.

Conclusion and recommendations

CHSP was created to assist older Australians who need low-level support to live independently in their own homes. Through these services, older people are supported to remain independent, maintain their social and emotional wellbeing, and stay engaged with their local community.

Access to CHSP services can also help prevent the need for more intensive home care, delay admission to residential aged care, and reduce the likelihood of hospitalisation.

This submission demonstrates that while the transition from CHSP to SaH is well-intentioned, the system is not yet stable, flexible, or sufficiently resourced to safely absorb CHSP's role as a critical safety net for older Australians.

Despite extensive preparation by providers such as Juniper, late policy detail, limited guidance, and immature system settings have created significant operational, financial and workforce pressures. These challenges are already impacting customers, particularly those with complex, fluctuating or emerging needs, and risk worsening as the transition progresses toward 1 July 2027.

CHSP has increasingly been relied upon to compensate for long wait times and insufficient capacity within home care, despite never being designed or funded for this purpose. The transition to SaH,

without addressing these underlying capacity constraints, risks removing one of the few flexible entry points into care.

Algorithm-driven assessments, inflexible funding classifications, delays in reassessment, and limited ability to apply clinical judgement are resulting in mismatches between assessed need and funded support, leaving some older people worse off. These outcomes undermine the intent of the new Aged Care Act, particularly its human-rights-based focus on dignity, choice, autonomy and care that reflects real-world needs.

The impacts are magnified for vulnerable cohorts, including people with limited financial means, those in regional and remote communities, and individuals requiring complex or end-of-life care. Increased co-contributions, slow hardship processes, unrealistic caps on home modifications, and rigid end-of-life pathways risk pushing people out of home care and into hospital or residential care unnecessarily, at greater cost to the health system and contrary to customer wishes. Without early, flexible interventions traditionally delivered through CHSP, preventable deterioration, falls and hospitalisations are likely to increase.

Finally, the transition is placing unsustainable strain on the aged care workforce. Change fatigue, rising administrative burden, system inefficiencies, increased complaints and difficult conversations with clients are driving stress and turnover, particularly in care coordination and rostering roles. These pressures, combined with unfunded implementation and system costs, threaten provider viability and service continuity, especially in thin markets.

Juniper strongly recommends greater flexibility during the transition, including clinically justified funding adjustments, improved assessment governance, and adequate transitional funding, to ensure the reforms achieve their stated objectives and do not leave older Australians without timely, appropriate and affordable care at home.

Juniper welcomes the opportunity to collaborate with all stakeholders to find practical solutions to address these challenges and ensure all older Australians receive the support and care they need, now and into the future.