Professor Kathy Eagar AM
Adjunct Professor
School of Clinical Medicine
Faculty of Medicine and Health
University of New South Wales
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Submission from Professor Kathy Eagar AM

Introduction

This is a submission to the Community Affairs References Committee on Aged Care Service Delivery. This introduction summarises my professional and academic background. The following sections then address the Terms of Reference.

I am Adjunct Professor of Health Services Research at the University of New South Wales and at the Queensland University of Technology. I am also the Director of my own consulting, evaluation and advisory company.

I was the inaugural Professor of Health Services Research and Foundation Director of the Australian Health Services Research Institute (AHSRI) at the University of Wollongong, positions I held from 1997 until my retirement from the University of Wollongong at the beginning of 2023.

In 2008 I was awarded an Honorary Life Fellowship of the Australasian Faculty of Rehabilitation Medicine for my contribution to the development of rehabilitation in Australia. In 2010 I was awarded an Honorary Life Membership of the Australian Healthcare and Hospitals Association for my contributions to the Australian health system. In 2015 I won the Professional Award of the Health Services Research Association of Australia and New Zealand for my services to the profession of health services research.

I am a Member of the Order of Australia for my contribution to the community through my research and development work. I am on the Board of NSW Meals on Wheels and on the NSW Older Women's Network.

I have undertaken extensive work in the aged care system over the last two decades. I designed the national funding model for residential aged care (the AN-ACC) and worked as an adviser to the Aged Care Royal Commission.

I have authored over 600 articles, papers and reports on wide-ranging health service and health system issues including health care management, health outcomes, information systems and funding of the Australia and international health and community care systems.

I am internationally recognised in particular for my work in funding system design, consumer/patient reported outcome measurement and value-based health and social care. I am well known for my cutting-edge work in palliative care, rehabilitation, mental health and aged care.

I believe that my broad experience of over more than 40 years, in combination with the specialist work I have done in aged care in recent years, makes me qualified to provide an expert opinion on the matters under consideration.

I make the following comments in relation to the Terms of Reference for the committee.

1 The impact of the delay on older Australians waiting for support at home, including unmet care needs and the wellbeing of seniors and their carers

There can be no question that delays in receiving necessary care and support at home have adverse consequences both for the older person and for their family carers. The international evidence is strong and consistent on this and has been for several decades.

These adverse consequences include, but are not limited to,:

- A decline in functional capacity and independence, ultimately accelerating severe frailty and cognitive decline and hastening death.
- An increased risk of adverse events such as falls, medication errors and malnutrition.
- Increased carer stress and burnout.
- An increased risk of hospital presentations and admissions.
- An increased risk of admission to residential care.

The specific impacts caused by delays in rolling out Support at Home (SAH) vary by cohort:

- There is little or no impact on people already in receipt of a Home Care Package (HCP) and whose needs are relatively stable.
- People already in receipt of a Home Care Package (HCP) but whose needs increase in ways that cannot be met by their current Home Care Package are severely affected. The Commonwealth data collection is not good enough to quantity the size of this cohort with any level of confidence.
- There is a significant adverse impact on those either on the waiting list or trying to get onto the waiting list and who were not already receiving Commonwealth Home Support Program (CHSP) services. Again, the Commonwealth does not publish data to allow for the quantification of the size of this cohort with any level of confidence.
- People needing or already in receipt of CHSP and who do want to transition to SAH are also adversely affected as the CHSP budget is strictly capped and has not been increased to take account of the growing numbers of people needing CHSP while

waiting for SAH. The CHSP cohort are thus competing with the SAH cohort for access to capped services and funds.

2. The capacity of the Commonwealth Home Support Programme to meet increased demand for support at home prior to 1 November 2025

The CHSP budget is capped and has been growing at a much slower rate than either HCPs or residential aged care for more than a decade. While there were some CHSP budget increases in 2024/25, these increases were simply a partial catchup on the funding that CHSP would have received if its budget had increased at the same rate as HCPs during the last decade. There has been no real net growth, particularly as population growth and ageing more than absorbed the budget increase in 2024/25.

CHSP has no capacity to absorb the increased demand. Like all services with capped capacity and increased demand, CHSP services are making daily decisions to ration services and allocate care to those with the greatest needs. Inevitably an increasing number of older people are waiting for services or getting less services than they need to live safely at home.

A further issue is that CHSP is regarded by the Commonwealth as a program for people with only entry level or low level needs. In practice, this is widely interpreted to be a maximum of 6 hours a week without the need for case management. Many of the people awaiting SAH need more support than this.

In my opinion, the Commonwealth has neglected CHSP since 2015 when it progressively took over what was previously the Home and Community Care (HACC) program and services from the states and territories. It has done no meaningful planning to estimate current and future demand and it has even failed to implement a basic CHSP minimum data set. We thus have no reliable estimates of current or projected demand, met need or unmet need.

The CHSP sector (both care recipients and providers) is very unsettled by threats to abolish CHSP and force all older people into SAH. Minister Butler has given an assurance that CHSP will be maintained until “at least 2027”. This was an excellent decision on his part. But it does not go far enough. Care recipients need to know what their longer-term options will be. Further, CHSP providers need to be able to do long term planning and make strategic capital investments. The decision on the long term future of CHSP needs to be made now.

3. The impacts on aged care service providers, including on their workforce

I will leave service providers to provide expert comment on this issue. The only comment i would make is that there has been no national workforce planning undertaken to ensure that the sector has sufficient staff either for the new SAH program in particular, the broader aged care changes in general or the large number of baby boomers heading into old age.

4. The impacts on hospitals and state and territory health systems

State and territory public hospital emergency departments (ED) and hospital wards are always the safety net under all Commonwealth funded health, aged care and disability services that fail to adequately meet community need. The states and territories all hold data showing that public hospital use by older people is increasing at a rate that outstrips the Commonwealth contribution to states and territories via the Health Reform Agreements. No doubt this demand will increase before 1 November as older people wait longer for support at home.

Moving beyond 1 November, I anticipate that potentially preventable demand for public hospitals will increase as will demand for residential aged care.

I do not believe that the Commonwealth prediction that demand for residential care will fall is credible. I also do not accept predictions that demand for public hospital services will fall. There are two key reasons. The first is that the population is ageing, the proportion of the population who are 85+ is getting larger, and people are living longer but with more chronic conditions and absence of a cure for dementia. Going forward, there will be a growing demand for residential aged care, even when there are more older people receiving care in their own homes.

The second is that, in my opinion, the design of the Support at Home program is fundamentally flawed. Consumer co-payments are too high, assessment is a bottleneck, package wait times post-assessment then create a further bottleneck and there is not sufficient capacity to flex services up and down in response to changing needs. It is inevitable that demand for both public hospitals and residential aged care will increase because the Support at Home program itself is so badly designed.

5. The feasibility of achieving the Government's target to reduce waiting times for Home Care Packages to 3 months by 1 July 2027, in light of the delay

In my opinion there is no possibility that the Government will achieve its target to reduce waiting times for Home Care Packages to 3 months by 1 July 2027 unless two changes are urgently made:

- The Government maintains and develops the CHSP as per my recommendations at the end of this submission. The current system requires anyone needing more than entry level services to transition to HCP/SAH even if they do not wish to do so. Providing older people and their families with a genuine choice is essential to both meeting their needs and reducing waiting times for SAH.
- The Rules be changed to make SAH more flexible, allow a person to carry over more funds from one quarter to the next and allow a person to receive additional or different services if they require it without having to be constantly reassessed.

6. The adequacy of the governance, assurance and accountability frameworks supporting the digital transformation projects required to deliver the aged care reforms on time

No comment.

7. The implementation of the single assessment system and its readiness to support people to access a timely assessment now and beyond 1 November 2025

SAH will extend waiting lists for months and years as the system collapses under its own weight due to mandatory reassessment whenever someone needs more or different services. While the new assessment agencies can approve a minor variation without a reassessment, they are only paid if they elect to do a reassessment. They are thus financially incentivised to trigger everyone for reassessment.

The assessment system is already a bottleneck and, for this and other reasons, it can be expected to get worse between now and 2027. More flexibility is required and the payment model for assessment agencies needs to be changed so that it does not incentivise comprehensive reassessment.

8. Any other related matters

There are two additional comments I wish to make:

Consumer fees and charges

I have no problem with older people paying for aged care if they have the resources to do so. But, in my opinion, the proposed SAH consumer co-payments model is badly designed and should be rejected. Consumer co-payments should be linked to the person's capacity to pay and not the quantum of service they require to live safely in the community. A more efficient and more equitable option is a consumer fees policy whereby maximum consumer co-payments are set as a percentage of income per fortnight (say, 10% or 15%) and not as a percentage of the cost of services a person needs. Such a maximum consumer co-payment model would negate the need for the proposed lifelong cap on fees for support at home.

Projected budget costs and savings

The full financial impact of the 2024 Aged Care Bill was set out in the December 2024 MYEFO statements. It projected that the "once in a generation reform" would achieve a budget saving of $18.8 billion over the forward estimates. The delay until November 1 is projected to cost the budget an extra $1 billion. This extra $1 billion is what the Government estimated consumers would be paying if not for the four month delay.

In my view the projected budget savings are unrealistic and will not be realised. They are based on unverified assumptions of the capacity of older people to pay for their care and

have not been sufficiently scrutinised. These projections have driven the design of important aspects of SAH but the whole design is based on wildly overestimated assumptions of capacity to pay.

This issue cannot be explored in the time available. But it is sufficiently important to justify further investigation by a subsequent Community Affairs References Committee inquiry.

Suggested recommendations

Recommendation 1: That the government give an immediate commitment to maintain and significantly expand CHSP as a program separate to, and complementing, SAH.

Recommendation 2: A new CHSP policy be introduced that defines CHSP as a program that has three distinct but overlapping roles:

1. A support program for people with entry or low level needs, defined as people requiring 6 hours or less a week of support. This cohort should be able to be referred directly to local service providers without having to navigate My Aged Care and without having to undergo a full aged care assessment.
2. A support program for people with higher level needs and who are waiting to access SAH
3. A program for people with high needs who elect to receive services via CHSP and not via SAH. This requires that care recipients are given a genuine choice, that CHSP service hours be uncapped and that CHSP can provide a case management service for those who require it.

Recommendation 3: This CHSP policy be in place before 1 November and be incorporated into the Aged Care Rules as a permanent feature of CHSP thereafter.

Recommendation 4: A new CHSP funding model be introduced to reflect this broader role.

Recommendation 5: CHSP funding be significantly increased for 2025/26 and ongoing commensurate with this broader role.

Recommendation 6: The proposed SAH consumer co-payments model be rejected. Consumer co-payments should be linked to the person's capacity to pay and not the quantum of service they require to live safely in the community. This requires that a new consumer fees policy be introduced whereby maximum consumer co-payments are set as a percentage of their income per fortnight (say, 10% or 15%) and not as a percentage of the cost of services they need. This maximum consumer co-payment model would also replace the proposed lifelong cap on fees for support at home.

Recommendation 7: Community Affairs References Committee establish a subsequent Inquiry to investigate the projected cost savings of the aged care reforms, the assumptions behind them, likely variations from the projections and how the Government proposes to deal with these.