# Submission to Senate Standing Committee on Community Affairs Inquiry, 2026

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

From: Anna Howe PhD, Honorary Professor, Department of Sociology, Macquarie University.

Date: 20 January 2026.

## 1. A strategy for transition

### 1.1 Context

In this submission, the current inquiry is referred to as the Transition Inquiry, the Commonwealth Home Support Program as CHSP, and the Support at Home Program implemented from late 2025 as S@H, encompassing the former Home Care Package Program (HCP). Packages refers simply to packages as places now within S@H.

The transition strategy proposed is to bring CHSP into S@H as the first of the eight levels of support in a new single program. It aims to rebalance CHSP and former and present Packages and thereby strengthen the foundation of a sustainable community care system. It offers a least change option for existing CHSP clients and providers through streamlining arrangements for providers who already deliver S@H as well as CHSP to begin and optimise opportunities for CHSP only providers to become S@H providers.

My support for the transition of CHSP to the single new program is based on the opportunities for addressing the problems that have compounded in both CHSP and HCPP since 2014 and which have not been fully addressed through reviews since then. Maintaining CHSP as a separate program is not seen as a viable option now and less so in the future.

This Submission follows on from my submission (No. 116) to the Senate Inquiry into Aged Care Service Delivery that reported in October 2025 and my earlier response to the *Discussion Paper: A New Program for In-Home Aged Care*, in late 2022. This submission is particularly informed by the *2025 Progress Report of the Inspector-General of Aged Care* which details the limited progress in implementing the recommendations on community care made by the Aged Care Royal Commission.

### 1.2 Transition of CHSP to Level 1 in S@H

The proposed strategy is based on CHSP already being the *de-facto* provider of Level 1 of S@H. Five indicators of this role were detailed in my submission to the 2025 Inquiry. In summary, Level 1 packages are currently a very small part of S@H and formerly in the HCP Program and do not serve as an entry point which is rather at Level 2. It is instead CHSP that provides support equivalent to Level 1 to some 75% of clients in the combined programs and this scale and diversity of delivery should be recognised.

Transitioning CHSP to Level 1 requires a simplification of assessment arrangements to facilitate prompt access to initial services in accord with the principle of early access preventing further decline in functioning and relieving carer burden. It will also allow for better management of clients waiting for higher levels of packages who currently ‘top-up’ their lower level package with CHSP services with the side-effect of reducing access for

those seeking initial access to any formal care. It offers a means to putting a brake on 'bracket creep' that results in the allocation of an increasing share of resources to smaller shares of clients' higher levels of Packages and encounters diminishing returns to higher and higher expenditure per client.

A phased timetable is set out below. At the end of the first three years, the result will be more than just CHSP grafted on to S@H. This outcome should be marked with a new name, the Aged Care and Support at Home Program (ACSAH) that indicates *who* the program is delivered to, *what* is delivered and *where*.

## 2. A staged timeline

A staged timeline is proposed to start the transition and avoid yet further delays. Instead of aiming for a national changeover at a single time, a four stage process is proposed so that following a trial over the second half of 2026, all providers and service users can be progressively brought into the single program from January 2027.

**Stage 1 – July -December 2026**: The Transition should be trialled in two States rather than waiting a full, one-off national transition. Delaying the start of the transition to mid-2027 will mean a continuing climate of uncertainty for providers and clients and likely growing tensions between CHSP and S@H over funding and other matters.

South Australia and the Northern Territory are proposed for as trial states on the basis of

(a) the roles taken by innovative providers in South Australia in pioneering and scaling up implementing past transformations in community care programs; and

(b) the opportunity for involvement of the range of providers delivering services in rural and remote areas in both states and for cross-state collaboration. Providers delivering the National Aboriginal and Torres Strait Flexible Aged Care (NATSIFAC) Program should also be involved.

**Stage 2 – January – June 2027:** All providers delivering both CHSP and S@H able to opt in to transition to the new single program.

**Stage 3 – July-December 2027**: All remaining providers delivering only CHSP to transition to the new single Program, including through partnering with providers that are already in the single program.

**Stage 4 – January 2028-Deember 2031:** This three year period should be a period of consolidation, with a balance of funding directed to sustaining the new system and priority funding for critical and emerging areas.

## 3. A significant boost to funding

A significant boost to Level 1 in the 2026-27 Budget is required to facilitate the transition. As well as rebalancing the community care system, this boost will expand service provision to maintain the large number of CHSP clients moving to Level 1 and facilitate initial entry to the new program. This measure will enable not only more new entrants but will also enable many existing CHSP service recipients to receive marginal additions to the services they receive without having to be reassessed, wait for and transfer to a higher Level of S@H. It will address the current bottleneck between CHSP and S@H and offer an incentive to providers to adapt to the new, single program.

The Delivery of Aged Care Inquiry saw a small increase in funds for CHSP over a three year period but no immediate boost. Instead, the release of yet more packages, regardless of the backlog in delivery of already released packages, added to mounting unspent funds. The steady growth in unspent funds to that date may abate with the recalibration of the past four levels to more steps in the eight new levels, but savings will still be available to be redirected to Level 1.

Funding for a substantial boost can be secured by progressive reallocating the underspend on Packages in S@H as CHSP providers and clients transition to S@H. This reallocation should be more readily realised as a within-program transfer than between the two programs. The *Quarterly Financial Snapshot for the Aged Care Sector* to Q3 ending March 2025 reported unspent funds amounted to $4bn. That report does not include CHSP but the *unspent* funds exceeded the *total* CHSP budget of $3.3bn detailed in the 2024-25 *Annual Report on the Aged Care Act 1997*.

Funding growth and rebalancing should be maintained through the first full three years of the new S@H, to 2031. Over that time, the number of clients and aggregate funding at each Level should be monitored and a balance set to ensure the effective and equitable operation of the program and to work in conjunction with reassessment to prevent 'bracket creep.'

Over this period, additional packages at each level of S@H should only be released when indicated by close monitoring of outcomes of reassessment and progression of service users, and monitoring of the geographic distribution of client numbers at each level and funding in an Equity of Access Monitoring Framework.

The timeline to 2031 coincides with the marked increase in the share of the population over 70 that is over 80 projected to the early 2030s. Immediate attention to expanding community care is urgently needed in the face of the slow growth of residential care in recent years and the longer lead time to make good this lag compared to the relatively shorter lead times to expand community care.

The great majority of CHSP clients receive funding below the limit to Level 1 of the 8 levels in S@H. CHSP currently serves around 800,000 clients, most of whom receive relatively low amounts of funding. It is neither necessary nor practicable to implement individualised funding for these clients, many of whom receive shared services such as centre-based social support and transport. Level 1 should instead be funded through a three part arrangement that covers service delivery on the basis of activity, administration as a set proportion of total funding (instead of the case management part of Packages), and a variable capital component related to provider type and timing of capital expenditure.

## 4. Impacts

### 4.1 Waiting times and access

The transition of CHSP to Level 1 avoids a substantial load of assessment as existing clients would not be added to the National Priority System (NPS) and reassessment would only become necessary when the cost of a client's support exceeded the limit to Level 1. This approach is consistent with almost all those waiting for a Package being eligible for CHSP and in fact accessing it.

Further attention to the NPS is required to differentiate a number of streams instead of only high and moderate priority and to rename the arrangements as the National Access Register or similar. Access to services would then be managed according to different priorities and at a

regional level to address geographic variations in client loads and inequities in access. The four streams proposed are:

1) Waiting in Hospital, highest priority, including those waiting for access to residential care.
2) Waiting at home for initial access to any community services, noting that assessment is an important service in itself and that gaining initial services has greater benefits than increments of further services due to likely diminishing returns.
3) Already on CHSP and needing more services, to be automatically classified as Level 1, and reassessed as and when care needs change and costs exceeds Level 1 limit.
4) On a Package at Level 2 or higher, possibly topping up with CHSP, while waiting for a higher Level S@H. Making CHSP into Level 1 would remove this topping up.

Setting targets for waiting times is of little use unless measurement of waiting times is improved to distinguish (a) the time waited until access is gained by those who take up services from (b) the time that others continue to wait. Both measures should be reported by regions to show where people are waiting and for what.

### 4.2 Service Caps

Both the Lifetime Cap of $15,000 on home modifications and the time limit on the Palliative Care Pathway should be maintained, with provision for extension on the basis of clinical assessment, until the further Inquiry into the Home Support Program is completed to avoid short term changes and disruption.

## 5. Thin markets - and 'thick' markets

Thin markets in outer regional and remote areas have been raised in many inquiries and a number of initiatives have been taken over decades to address the problems of these areas. Many of the issues continue to be presented in very general terms. It is timely to commission AIHW and a research centre specialising in rural and remote Australia to prepare a detailed report to give a clearer understanding of the diversity of these regions, service providers and delivery arrangements including workforce management, and outcomes. Experience over the last decade, since the inception of CHSP and the growth of Packages from 2014, should by now offer a number of tested and varied models for successful service delivery and innovation so that positive outcomes need to be documented and promoted.

While thin markets may incur high unit costs, the total volume of service provision is limited compared to what can be termed 'thick markets.' These 'thick markets' are typically found in outer metropolitan suburbs with large, growing, and diverse aged populations, but they do not stand out as areas of conspicuous ageing as high overall growth means the proportion aged in the total population may not be markedly above the national average. The extent to which these areas are currently underserved, and likely to face more pressures with burgeoning older populations, has not been sufficiently recognised yet imposes may constraints on access to services. Past service development has been constrained by limited provider infrastructure and capacity, lower socio-economic status, and competition for services from other groups in local communities.

In comparison to thin markets, underserved markets in metropolitan areas have not been recognised and have received scant little attention. One barrier is the single category for major metropolitan areas in the Modified Monash Model. A refined MMM is needed to provide for adequate monitoring of intra-metropolitan differences and to inform service development. Relying on provider initiatives for service development will not be adequate to

realise provision where there is a lack of provider interest or capacity and these areas will be locked in a cycle of under-provision.

The 2026 Census will provide sound baseline population data for the transition and for monitoring progress in an Equity of Access Framework.

## 6. Other matters

Other matters will be taken up in a submission to the Inquiry into the Support at Home Program and in the light of the report of the present Inquiry. They will include:

1. Workforce development responses to expressed worker demand for additional hours and permanent part-time employment instead of alternative employment arrangements or overseas recruitment.
2. The interface with the NDIS, especially for those aged 65-70.
3. Fees and charges, especially the inequity of those with higher levels of dependency and so needing more services having to make larger payments.
4. The roles of the Carer Allowance and Carer Payment, and consideration of increasing the Carer Allowance in the face of continuing cost of living pressures and noting that neither of these payments are intended to pay fees for services but are compensation to carers for their efforts.

**Anna Howe PhD** has been involved in aged care research and policy development since the mid-1970s. She had major roles in the reforms of the 1980s and from 1989 to 1993 was the Director of the Commonwealth Office for the Aged. Over her career she has held academic research position in Australia and worked with local and State governments and for-profit and not-for-profit aged care providers. She has carried out international consultancies for AusAid, the WHO, OECD, and World Bank. Now retired, she maintains an active role in the field through her positions as an Honorary Professor in the Department of Sociology, Macquarie University, and a Presidential Life Member of the Australian Association of Gerontology. She has made influential submissions to government inquiries including the 2011 Productivity Commission inquiry and the recent Royal Commission on Aged Care Quality and Safety.