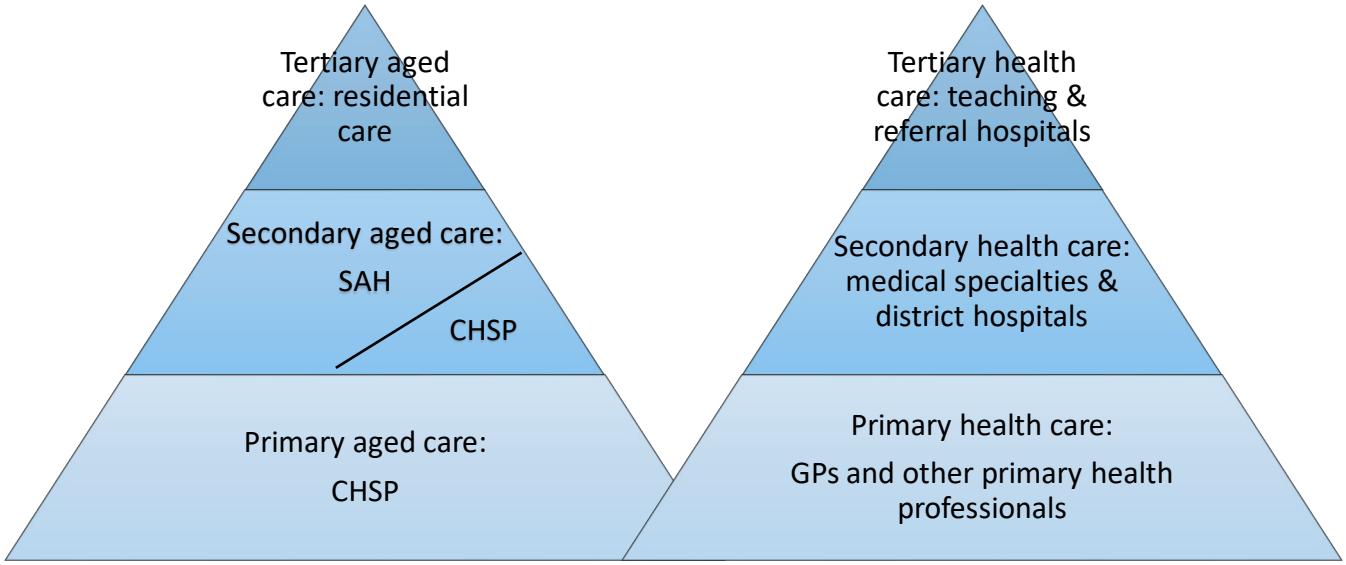
CHSP Alliance Position Statement on 'No Wrong Door' to primary aged care (September 2026)

The Commonwealth Home Support Program (CHSP) Alliance (the Alliance) is an alliance of organisations and individuals committed to advocating for the continuation, expansion and sustainability of CHSP. We argue that the CHSP should be embraced and developed to provide foundational support for older people needing care and operate as the primary tier of the aged care system. As the primary care tier, CHSP has a critical role in enabling older people to age in place, where desirable, relieving pressure from the more complex and expensive tiers of care provided to those with higher levels of need. More information on our policy positions is available in our CHSP Alliance Position Statement on the Future of CHSP (March 2026)[1]

Our vision for how the whole system fits together is set out in this diagram:

Figure 1 Overall schema of the aged and health care systems



This position statement argues that the current aged care assessment system is not working for CHSP and that primary aged care requires a different approach that is streamlined and more efficient. The goal is to benefit both potential service users and taxpayers by significantly reducing waiting lists and times to access preventative and early intervention CHSP services. A significant drop in the numbers of applicants requiring assessment via My Aged Care as we propose in this position statement would also reduce waiting times for more complex and costly services provided through Support at Home (SAH) and Residential Care Services.

[1] https://chspalliance.org.au/357-2/

Background

The national Commonwealth Home Support Program (CHSP) was established in 2015 following the transfer of the (then) Home and Community Care to the sole management of the Commonwealth. At that point, ***My Aged Care (MAC)*** became the single national entry point for new CHSP clients. MAC is an online information and registration system that was established in 2013. MAC also has a telephone contact system for those unable to access it online.

While this system was introduced more than a decade ago, it has not been the only way for an older person to access CHSP. In practice, existing CHSP clients were grandfathered, there was no mandated minimum data set for CHSP (so no standard information on CHSP clients needed to be routinely reported) and compliance was not monitored. Some services continued to accept referrals directly. CHSP services continued to do service-specific assessments and often referred people between each other as required.

In November 2025, the new Support at Home (SAH) program commenced along with a new Aged Care Act and a new aged care Integrated Assessment Tool (IAT). From that date, aged care providers were prohibited from delivering Commonwealth-funded CHSP services to people who had never been registered or assessed through MAC.

Creating one national gateway into home and community aged care was meant to improve efficiency, reduce waiting times and improve access by making it easier for older people to navigate to the care and support they needed.

In practice, the opposite has occurred. Older people and their families consistently report that the system is confusing and stressful to navigate and waiting times and lists are longer than ever. MAC has been the subject of extensive and sustained criticism over the decade, most recently in a review conducted by the Inspector General of Aged Care.

How older people access CHSP now

Since 1 November 2025, the only way that an older person can access CHSP is through a four-step process:

Step One: register online or by phone with MAC

Step Two: complete an in-person needs assessment. The assessment is conducted using the Integrated Assessment Tool (IAT) and takes approximately two hours.

Step Three: the IAT data are fed into a computer algorithm to determine if the person is 'eligible for aged care'. The eligibility requirements built into the eligibility algorithm are set out in the attachment.

Step Four: the same IAT data are fed into a different computer algorithm to determine if the person is to be approved for CHSP or SAH. The assessor cannot override the algorithm decision and the older person gets no say in it.

MAC is now the single entry point even if the person only needs one service such as Meals on Wheels or community transport. Previously these services could accept direct referrals or referrals made by hospitals, GPs and family members acting on behalf of the person. This is no longer the case. Not surprisingly, this has slowed down the referral process and waiting times considerably.

Everyone applying for aged care – whether CHSP, SAH or residential aged care – is channelled through the same "MAC gateway" and priority system that is used to assess who gets assessed and receives services first. In a system unfit for purpose, the MAC gateway has become the MAC bottleneck.

There are currently two very long waiting lists. The first is the wait list to get an assessment. The second is the wait list to get a service once the assessment has been completed. There are now around a quarter of a million older people waiting for support to live safely and well at home. While waiting list and time data are not routinely collected for CHSP, the average waiting time for Support at Home is currently close to a year.

Why the current access and assessment system doesn't work for CHSP and what needs to change

There are numerous problems with the current system. Key ones from a primary aged care (CHSP) perspective include, but are not limited to:

- The system is confusing and hard to access and navigate. It bypasses the usual places and resource people that older people seek help from. This includes bypassing the person's general practitioner, the hospital discharge planner, the local pharmacist, the local community organisations the older person participates in as well as well-known aged care services such as Meals on Wheels or community transport. If, for example, a person requires help with meals or transport, it is easier for them to call Meals on Wheels or a community transport service directly than jump through the MAC hoops. But they are no longer allowed to access services directly.
- Waiting lists and times are too long. No older person needing help to live independently at home and in the community should be waiting for a year. This is the case whether it is for CHSP or for SAH.
- The IAT assessment system is over-engineered with over 450 questions and 220 text boxes. It is based on a 'just in case' philosophy which sees assessment as a one-off event and the only opportunity to identify a person's needs. In practice only 23 items in the IAT are used to determine if a person gets CHSP or SAH. The rest of the assessment is unnecessary at that point.
- People needing access to primary aged care require a nimble and responsive assessment based on a 'just in time' philosophy. Best practice primary aged care sees assessment as an ongoing process in response to an older person's changing needs and preferences over time. This is a long way from the current 'just in case' system.
- Best practice assessment is a system that respects, has expertise in and is credible with, First Nations communities, people who do not speak English, people from culturally and linguistically diverse backgrounds, people who live in regional, rural and remote communities and vulnerable older people including older homeless people. The current system is particularly difficult for these groups.
- Best practice primary aged care assessment is not transaction-based. It is relationship-based. Best practice primary aged care assessment sees the initial assessment only as a starting place. Reassessment over time is more important than the initial assessment.
- Best practice aged care assessment is not focused on deficits. It captures information on the older person's needs, strengths, preferences, appetite for risk and potential to benefit from prevention and restorative care services. It captures what is important for the older person and what they would like to achieve by engaging with primary aged care.
- Literally millions of dollars and hours are being wasted on unnecessary and burdensome assessments for people needing to access CHSP. In many cases, the cost of the assessment and related processes exceeds the cost of the services that the person subsequently receives. Rather than improving access, it has significantly diminished access.

- Because of the personal and economic benefits of preventing serious deterioration in the health and resilience of people who will potentially need aged care, assessments of those needing low-cost preventative and early intervention services should be treated as high-priority and undertaken as close to the point of direct service provision as possible. The priority setting process for CHSP needs to be tailored to the goals of primary aged care and is thus quite different to SAH and residential care.

The case for 'no wrong door' to enter primary aged care (CHSP)

We are advocating for significantly better integration between CHSP aged care and primary health care. The aged care system has become progressively more siloed over the last three decades and recent reforms have reinforced the isolation of aged care from health care. This is not in the interests of older people or their families. This division between health and aged care needs is artificial and a barrier that results in delays, duplication and confusion.

Rather than channelling every older person through one MAC gateway, we advocate for access to CHSP to be based on 'no wrong door', a policy approach that supports multiple trusted referral points to make eligibility decisions and referrals and to handle sensitive health information.

If the person is in hospital and preparing for discharge, the hospital discharge planner becomes the front door to the aged care system. If an older person's son walks into Meals on Wheels and asks about meals for his mum, Meals on Wheels becomes his mother's front door to the aged care system. Likewise for all other CHSP funded services. If a First Nations Elder or older person attends their local Aboriginal Medical Service (AMS), the AMS is their front door to aged care. If a person who doesn't speak English attends their local community place of worship, the place of worship becomes the front door. Our vision is a primary aged care system that makes it as easy as possible for the older person to access support through whatever doorway works best for them.

The case for social prescribing

While the need for better integration and communication is always talked about, practical strategies are needed to make it happen on the ground. We see social prescribing of CHSP by GPs, other primary care providers and specialist geriatricians and rehabilitation physicians as one such practical strategy to achieve much better integration of the aged care and the health care that a person living at home needs.

Social prescribing is a means of enabling GPs, primary care and specialist nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellness needs in cost-efficient ways. GPs and other relevant clinical specialists write scripts all the time, but all current scripts are for medicines. Social prescribing recognises that an older person needs much more than a script for a medicine. Social "prescriptions" allow a doctor to write a script for non-medical community-based support. This support typically includes the range of services delivered by CHSP.

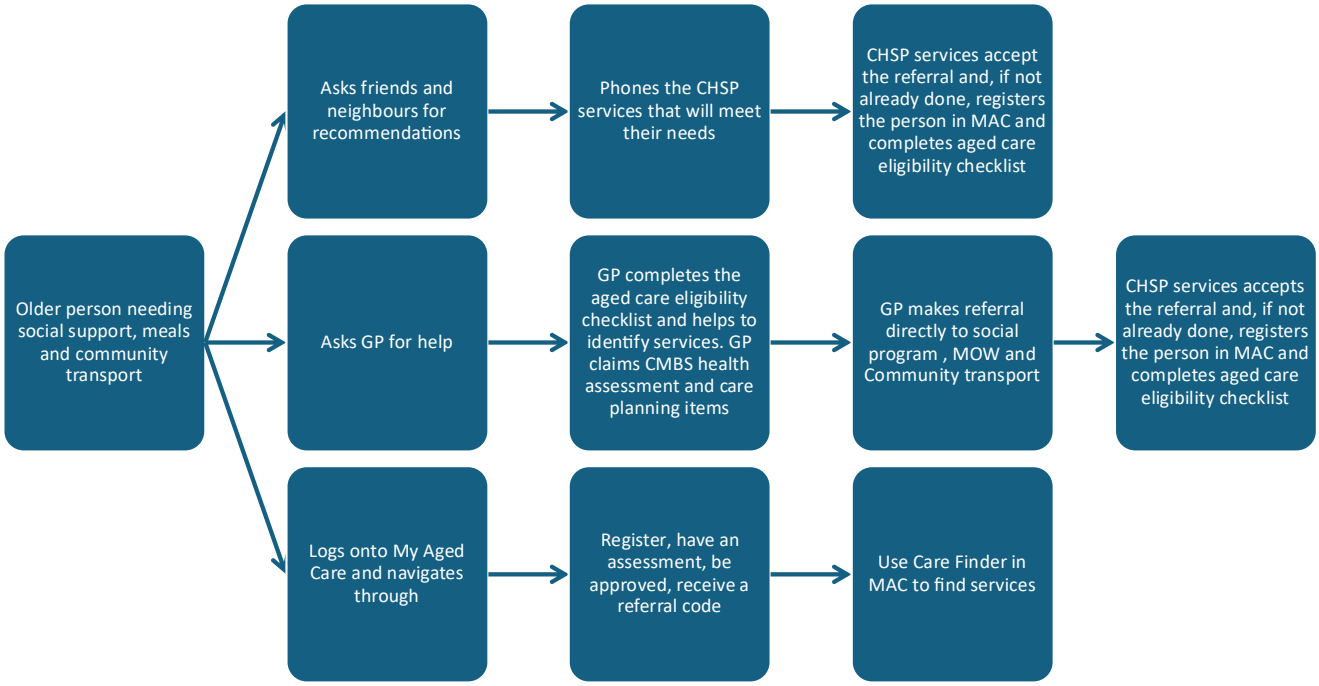
As the primary tier of the health system, the General Practitioner (GP) and other primary care providers are typically the first point of contact for the person and /or their family when they begin to need aged care. By this point, most patients have a GP that they know and trust based on a long-term relationship. Indeed, providing continuity of care to older people is core business for general practice and always has been.

We do not see social prescribing via a doctor as the only pathway into CHSP. Rather, we see this as a fundamentally important strategy to achieve better integration of primary aged and health care, as a practical strategy to improve the accessibility of CHSP and as a practical demonstration that primary aged care has no wrong door to access it. Irrespective of who makes the referral, the relevant service would be

responsible for registering a person as requiring assistance in MAC, and requesting further expert assessment where appropriate.

Development of guidelines and implementation of a new national policy on social prescribing of CHSP is an ambitious goal that the Alliance stands ready to engage in. Our view is that it is best progressed incrementally, starting with those who already have PBS pharmaceutical prescribing rights - GPs, geriatricians and rehabilitation physicians and clinical nurse practitioners. This has the advantage that social prescribing can be funded through existing mechanisms such as items in the Medicare Benefits Schedule. Social prescribing would then be expanded to include primary care nurses and potentially other clinical specialties (including, for example, aboriginal health practitioners) over time.

CHSP Alliance model of pathways to CHSP



The flow chart above illustrates examples of how an older person enters primary aged care CHSP in future. Not all potential pathways are included. There is no wrong door. If the person can navigate the system on their own or with the assistance of their informal supports, they should be able to do so. If a person is engaged with their GP, other primary care provider or medical specialists, the clinician they engage with would write a prescription for the CHSP services they need and would bill for that activity through existing systems such as the Medicare Benefits Schedule (MBS) health assessment and care planning items. Finally, if the person does not know what they need or how to access it, they would enter the aged care system via MAC.

Irrespective of how they enter, the person would be registered in MAC and would undergo an aged care eligibility assessment. Registration and the eligibility assessment would be undertaken by different people depending on the doorway that the person enters.

Further detail will need to be documented during the planning for the new system. This includes the additional requirements on CHSP providers in terms of client registration, establishing eligibility and undertaking service-specific 'just in time' assessments. It also includes the introduction of a meaningful

data collection on waiting lists and waiting times and more formalised systems for referrals between CHSP providers. The CHSP Alliance stands ready to co-design the detail with government and other stakeholders during the design phase.

Implications for legislation

The CHSP Alliance Position Statement on Required Amendments to the Aged Care Act 2024 (April 2026) sets out the legislative amendments that we believe are necessary. This includes the legislative requirements about access via MAC and standardised assessment. While it is technically possible to develop and strengthen CHSP as a new national primary aged care program without an amendment to existing legislation, our assessment is that implementation of a new national Primary Aged Care Program is best achieved through amendments to the Aged Care Act 2024 and associated rules.

The path forward

We advocate that the Commonwealth government:

1. Not only retain but also expand CHSP (however named) and develop it as a separately funded primary aged care tier.

2. Establish multiple supported referral pathways into and within CHSP.

3. Consistent with our CHSP Alliance Position Statement on Coordination and Integration (April 2026), develop smooth referral pathways between tiers of the aged care system and adopt a population-based approach to CHSP system development and referral systems.

4. Co-design CHSP entry pathways with the CHSP Alliance and consumer representatives.

Status of this position statement

This is Version 1.1 of this position statement of the CHSP Alliance. It has been endorsed by 37 of our 40 Foundation Members. One Foundation Member (ANMF) abstained. Two (OPAN and OTA) did not endorse this policy statement. While they support the overall thrust, they do not endorse some of our specific proposals.

Attachment Aged Care Rules on Eligibility for Aged Care

In addition to being 65 years or older, a person must meet eligibility criteria that are specified in the Aged Care Rules. These sit below the Aged Care Act 2024.

Home support (both CHSP and SAH)

Rule 65-10 of the Aged Care Rules specifies the minimum requirement for a person to be eligible for home support.

A person is eligible for aged care if they meet ANY OF THE FOLLOWING CRITERIA:

(a) the individual has a total score of less than 20 for the questions in the Integrated Assessment Tool with the following headings:

"Climb stairs"	"Transfers"
"Eating"	"Toilet use"
"Dressing"	"Toileting – bladder"
"Take a bath or shower"	"Toileting – bowels"
"Grooming"	"Walk"

These 10 items are from the Barthel Index and all use the same format as illustrated by the following example:

You can climb stairs independently, using handrails, cane or crutches. You can carry these aids as you ascend and descend.

Completely unable (Score 0) With some help (Score 1) Without help (Score 2)

OR

(b) The individual has a total score of less than 14 for the questions in the Integrated Assessment Tool with the following headings:

"Get to places out of walking distance"	"Take medicine"
"Undertake housework (heavy/moderate)"	"Handle money"
"Go shopping (assuming transportation)"	"Use the telephone";
"Prepare meals"	

These items come from the Modified Lawton's IADL scale and are scored as follows:

Unable Score 0 With some help Score 1 Without help Score 2

OR

(c) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed "Cognition" and "Medical and Medications";

Cognition: Does client have a confirmed dementia diagnosis from a geriatrician or neurologist?
Yes score 1 No score 0

OR

A score on a cognitive screening tool (KICA COG, or GPCog or Extended Cognitive) indicating cognitive loss

AND

Medical and Medications: has at least one diagnosis or is having at least one treatment

(d) the individual has a score of greater than zero for the questions in the sections of the Integrated Assessment Tool headed “Psychological”;

A record of any self-reported psychological problems

OR

(e) the individual has a score of greater than zero for the questions in the section of the Integrated Assessment Tool headed “Physical, Personal Health and Frailty”.

Assistive technology and home modifications

Rule 65-15 of the Aged Care Rules specifies the minimum requirement for a person to be eligible for assistive technology and home modifications.

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service groups assistive technology and home modifications for an individual is that the service group home support is approved for the individual (based on the IAT and the algorithm).

Residential care

Rule 65-20 of the Aged Care Rules specifies the minimum requirement for a person to be eligible for residential care.

For the purposes of paragraph 65(3)(b) of the Act, the eligibility requirement for the service group residential care for an individual is that the individual is not able to live in a home or community setting without support.