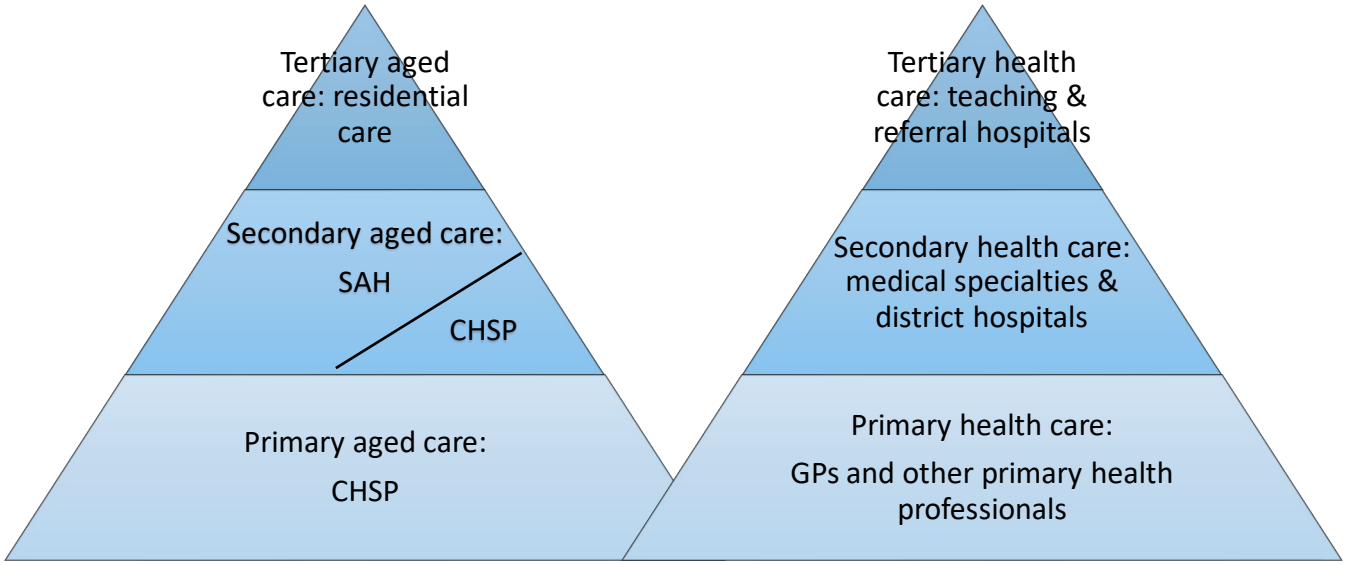
CHSP Alliance Position Statement on how CHSP should be redesigned (November 2026)

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 follows the government announcement to retain the Commonwealth Home Support Program (CHSP) as a separate program. This announcement was in response to successful advocacy by the CHSP Alliance. The Alliance is delighted by this decision. The government intention is that all existing CHSP contracts remain in place until 1 July 2029, allowing time for the government to embark on a redesign of CHSP from 1 July 2029. We stand ready to partner with the government in the redesign process, including the initial consultation.

The CHSP Alliance urges the government to be ambitious in its intentions and not just opt for more of the same. This is the opportunity to create a lasting legacy through establishing a new national primary aged care program that is built on the existing strengths of CHSP. Realising that opportunity depends on a redesign that improves access and coordination while managing risks to funding, service capacity, community delivery and continuity of care.

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

This position statement sets out the CHSP Alliance position on how CHSP should be redesigned. We urge the government to be guided by this document in its redevelopment of CHSP. We further urge the government to commit to establishing a formal, funded transition roadmap over 2027 to 2029 leading to the formal launch of an invigorated national primary aged care program in 2029.

Harness opportunities to redesign CHSP

The decision to retain CHSP as a separate program creates an opportunity to redesign it as a strong primary tier within an integrated aged care system. The priorities below draw together the CHSP Alliance position papers into a practical agenda for co-design by government in partnership with the CHSP Alliance and our members who include older people, providers, other stakeholders and the communities they represent.

Build a revitalised aged care system with CHSP as the foundation of a new Primary Aged Care Program

With CHSP remaining a separate program, the redesign can now give it a clear purpose as the accessible, preventative and early intervention tier, with Support at Home (SAH) as the secondary tier and residential care as the tertiary tier. This should be reflected in program objectives, eligibility, service design and public information. CHSP should be funded and developed to help older people maintain independence, participate in their communities and age in place, while easing avoidable demand on higher intensity care.

Develop and implement a coherent and effective demand management strategy

A redesigned CHSP can play a significant role in better demand management across the aged care system by matching timely support to people's needs and by preventing avoidable escalation to more expensive levels of care. The aged care system has never before been under such pressure with demand outstripping supply. With the right funding and policy environment, CHSP has the capacity to help by reducing demand for SAH and by reducing preventable hospital attendances. But neither the funding nor the policy environment is allowing this to happen at scale. Likewise, SAH has the capacity to reduce demand for public hospitals and for residential care, but only if SAH has the capacity to deliver sufficient and timely care and support. Effective support for family carers by CHSP will help delay entry to residential aged care, reduce avoidable hospitalisations and sustain the unpaid care workforce on which the aged care system depends. Better demand management is a win:win. It is better for older people and their families and it is better for taxpayers.

Make primary aged care accessible through a genuine no wrong door system

Older people should be able to seek help through the doorway that is familiar and useful to them: a local CHSP service, GP or other health professional, hospital discharge team, community organisation, Aboriginal Medical Service, family member or My Aged Care. These pathways should connect through clear referral and registration arrangements, with access to advocacy support as required. This negates the need for every person seeking a straightforward support service to begin with a single, difficult gateway. Local providers and advocates can help people find the right support and register them in the system. A no wrong door approach must be supported by accurate service directories, appropriate referral matching and clear accountability for resolving system errors, alongside proportionate administrative requirements and accessible provider support.

Replace cumbersome gateway assessment with timely, proportionate support

Access to early intervention and preventative support should not depend on completing a lengthy assessment designed for more complex care. The redesign should enable streamlined eligibility decisions close to the point of service, followed by service-specific assessment and review as needs change. Assessment should be relationship based, recognise strengths and preferences as well as support needs, and avoid unnecessary repetition. Assessment and service arrangements should accommodate progressive and fluctuating conditions, enable timely adjustments as needs change, and support coordinated transitions to higher-intensity care where required, without unnecessary reassessment or disruption. It must be accessible and credible for First Nations people, culturally and linguistically diverse communities, rural and remote residents, people experiencing homelessness and others facing barriers.

Connect aged care and primary health care around the person

A separate CHSP can still be integrated in the ways that matter to people: through practical coordination and information sharing between providers. Develop social prescribing so GPs, relevant clinicians and, over time, other trusted professionals can refer older people to local CHSP supports such as meals, transport, social connection and home assistance. Referral and coordination arrangements should recognise the contribution of specialist community organisations in providing condition-specific information, education and navigation, with appropriate commissioning arrangements to preserve access to this expertise. Support this with shared referral processes, consent-based information exchange and clear responsibilities, so people do not have to coordinate their own care across service boundaries.

Protect continuity and choice as people's needs change

Older people should not have to leave trusted providers or restart their care journey simply because their needs increase, fluctuate or they wait for another service. Set clear pathways between CHSP, SAH and residential care, with eligibility rules understood by clients and referral partners, timely handovers and relevant information following the person with consent. Where a person needs secondary level support, the system should enable a genuine choice of delivery and funding arrangements, including providing the option to continue with their CHSP providers.

Strengthen support for family carers

A strong primary aged care system must better support family carers by recognising them as partners in care while also responding to their own needs and circumstances. The redesign must explicitly recognise and value unpaid carers as a critical component of Australia's aged care system. Assessment, care planning and service delivery should include identification of carers, consideration of their needs and wellbeing, and referral pathways to carer supports where appropriate. Carers may be supporting a parent or partner while raising children, working, managing their health or caring for others. Flexible services such as respite, transport, meals, practical home support and information can help carers sustain their role without compromising their own wellbeing. Respite should be recognised as both a support for older people and an essential intervention to sustain caring relationships, maintain workforce participation and reduce carer burnout. The redesigned program should make it easier for carers to identify support, have their needs and preferences considered, and access timely help as caring responsibilities change.

Make the three tiers work together with clear rules for shared services

Overlap between programs is manageable and should not determine whether CHSP continues as a distinct tier. Establish national rules for services available in more than one tier, services provided by only one tier and access to a service when a person's current tier does not provide it. The rules should address community transport, assistive technology and home modifications, case management, respite, and hoarding and squalor assistance. They should prevent duplicate funding while allowing practical exceptions and consistent decisions, including appropriate access for people in residential care to services they cannot receive there.

Plan and commission services around community needs

Primary aged care cannot rely on market supply alone. Use population needs analysis and regional planning to identify gaps, plan the mix of services and respond to demographic change, disadvantage and local conditions. Commissioning should recognise geographic, cultural and financial access, and involve older people, carers, local providers, health services, community organisations and volunteers. Existing regional capacity, including Primary Health Networks and CHSP Sector Support and Development, could support planning and coordination if properly resourced.

Fund local capacity sustainably and respond to changing demand

Redesign grant funding so it responds to demand and does not leave providers carrying the cost of maintaining local service capacity. Fund fixed infrastructure and readiness costs separately from the variable costs of services delivered to individuals. Provide predictable funding at the start of the year for workforce, facilities, transport, volunteer support and local availability, then link activity funding to service

volume and need, with adjustment for actual delivery. Introduce the model progressively and account for differences in scale, location and service role.

Keep primary aged care affordable and remove barriers to early support

CHSP's co-payment policy should reflect its preventative purpose, service model and cost structure. Avoid mechanically matching SAH fees: higher charges can deter people from seeking early help, while means testing and fee collection at CHSP scale could add substantial administrative costs for government and providers. Preserve provider ability to waive or adjust fees in response to individual circumstances and ensure that charges do not become a financial barrier to essential support or create inequitable access.

Modernise legislation, information and accountability for primary aged care

The Aged Care Act and associated rules should clearly enable prevention, early intervention, reablement, coordination and population-based primary aged care, including grants and commissioning arrangements for suitable community organisations under proportionate safeguards.

Create new streamlined and proportionate systems to collect consistent information on access, waiting times, service availability, outcomes and unmet need so government and communities can monitor equity, plan services and improve the program over time. Data collection and outcomes measurement should include indicators relating to carer wellbeing, sustainability of caring relationships and access to support.

Manage and avoid risks in the redesign of CHSP

Act now on 2026/27 priorities

Increase fund to match population need and delivery costs

The most immediate risk is that CHSP continues without meaningful additional funding while demand, costs and population needs rise. The CHSP Alliance estimates that the program is currently $1.4 billion below an equitable level of funding. The Alliance has made a submission seeking an additional $700 million per annum through the December 2026 Mid-Year Economic and Fiscal Outlook (MYEFO), with the goal of increasing funding from $3.1 billion to $5.5–6.0 billion over three years. The Alliance has identified increased service capacity, shorter waits, a sustainable workforce and improved access in regional, rural, remote and other underserved communities as priorities. Funding should reflect population growth, service demand and the real cost of delivery, rather than relying principally on historical grants and indexation.

Replace the assessment system and algorithm for primary aged care

The current My Aged Care gateway, lengthy assessment and algorithmic allocation cannot remain the default for people seeking CHSP, as the current pathway is a major barrier to early support. The current system is delaying prevention, increasing pressure on higher tiers and excluding people who find the system difficult to navigate. People seeking an early intervention or single support service do not need, and should not have to wait for, a comprehensive assessment and they should have greater opportunity to choose or challenge the pathway assigned to them. Reform should make the access pathway proportionate to need, allow trusted local referral pathways, achieve cost savings and retain appropriate safeguards and review.

Integrate CHSP redesign with the wider aged care and health systems

Redesigning CHSP as a stand-alone program, without planning its links to SAH, residential care and primary health care, risks shifting problems rather than solving them. CHSP already absorbs pressure when people wait for more intensive services or when other parts of the system cannot respond. If this backstop role is neither acknowledged nor resourced, providers may be overwhelmed and people may experience gaps, repeated assessments and poor handovers. The redesign should set out how the tiers and health services will work together, and how CHSP will be supported when demand rises because of pressures elsewhere.

Make CHSP activity, costs and unmet need visible

Without consistent information on services delivered, waiting lists and times, provider costs, service availability and unmet need, government and communities cannot see where access is failing or whether reform is working. A lack of data also weakens the case for growth funding and makes it harder to plan fairly across regions and population groups. The redesign should establish a practical, proportionate data framework from the outset, with clear definitions, routine reporting and public accountability, while avoiding reporting requirements that consume resources needed for service delivery.

Build primary aged care pathways for people with complex needs

A redesign focused only on low needs could leave people with complex or changing needs without a workable primary aged care pathway. CHSP's preventative role should remain clear, while the system also recognises that some people benefit from continuity with CHSP providers as their needs increase, or need timely support while waiting for SAH. Creating a pathway for older people who choose to remain with CHSP for their secondary tier level services is a solution supported by the Alliance. The program should define appropriate pathways for higher needs, including optional case management where needed, clear transition and referral arrangements, and adequate resources for any expanded role. This does not remove the need for SAH or residential care when those tiers are appropriate.

Keep CHSP fees affordable and distinct from SAH fees

Increasing CHSP fees to match SAH would risk making preventative support unaffordable and discouraging people from seeking help early. The programs have different purposes, funding arrangements, cost structures and administrative systems, so equal fees do not necessarily produce fair treatment. Means testing and fee collection across the much larger CHSP population could also impose substantial costs on government and providers. CHSP should retain a co-payment policy suited to primary aged care, including provider discretion to waive or adjust fees where a person cannot afford to pay.

Priorities for 2027/28 and beyond

Protect CHSP's service range and role as the primary tier

A separate CHSP could lose its substance if services or capabilities are progressively shifted into SAH without a clear account of the effect on local access and prevention. Many service types appropriately operate across more than one tier, while others have a distinctive role in CHSP. Decisions about service boundaries should be based on older people's needs and the function of each tier, not on a goal of making programs look uniform. Any proposed transfer should be assessed for its effect on continuity, provider viability, geographic coverage, consumer choice and the capacity of CHSP to function as the primary tier.

Preserve CHSP's not for profit and community-based culture

CHSP's community roots, local relationships, volunteers and not for profit providers are central to its reach and responsiveness. A redesign that prioritises standardisation, large scale contracting or narrow service outputs could weaken those strengths and displace smaller organisations that understand local needs. A future CHSP should support community-based and intergenerational group programs alongside individualised services tailored to the individual and their family. Program settings should value community participation, reinvestment of resources, local partnerships and the contribution of volunteers, while maintaining sound governance and accountability. Funding and contracting arrangements need to be accessible to diverse community providers.

Amend the Act to establish a sound basis for implementation

If the redesigned program is implemented without a clear legislative basis, uncertainty may remain about the scope of primary aged care, the role of community organisations, commissioning and grant funding, flexible access and proportionate oversight. This could constrain delivery or lead to inconsistent rules and repeated ad hoc fixes. Amendments to the Aged Care Act 2024 and associated rules should establish primary aged care as a recognised function, enable appropriate funding and commissioning models, and provide a fit for purpose framework for eligible community providers.

Keep regulation proportionate to service risks and provider capacity

New requirements intended to support quality and accountability could become regulatory creep if they are copied from higher intensity care without regard to CHSP's service and client mix, risk profile and provider diversity. Disproportionate registration, reporting, audit or information technology obligations may divert resources from care and make small community organisations unable to participate. Regulation should be matched to the nature and risk of each service, protect older people and public funds, and be co-designed with providers so compliance is clear and workable.

Re-engage local, state and territory governments

CHSP depends on services, infrastructure and partnerships shaped by local and state and territory responsibilities. Failure to engage these governments in redesign and implementation risks losing local knowledge, duplicating existing services and weakening coordination across transport, health, housing, community services and emergency response. Establish structured intergovernmental engagement early, clarify roles and funding responsibilities, and provide a continuing way for governments and local partners to shape regional planning and resolve implementation issues.

Create a clear path from grant funding to population needs-based funding

If block funding continues to be based mainly on historical allocations, services have no reliable way to expand when demand increases or communities change. Providers are left carrying the costs of maintaining infrastructure and readiness, while areas with limited historic services remain underserved. CHSP requires grant funding based on transparent allocation principles, population and cost adjustments, a regular review of service capacity and a defined mechanism for growth funding. Over time, separating fixed capacity costs from variable service activity will make funding more predictable and responsive.

Strengthen CHSP's capacity to attract and retain staff and volunteers

Without sustained investment in wages, training, supervision, safe workloads and volunteer support, CHSP may be unable to deliver the capacity envisaged in the redesign. Workforce shortages can reduce service availability, lengthen waits and place extra pressure on carers and remaining staff. The program should include a workforce plan that reflects regional and remote recruitment challenges, supports skill development and career pathways, and recognises the time and infrastructure required to recruit, train and retain volunteers. Funding assumptions should include the real cost of a stable workforce.

Status of this position statement

This is Version 1.1 of this position statement of the CHSP Alliance. It has been endorsed by 38 of our 40 Foundation Members. Two Foundation Members (OPAN and Dementia Australia) abstained.