CHSP Alliance Position Statement on the Future of CHSP

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 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. Consistent with the 2024 Aged Care Act, we are advocating for older people to be offered a genuine choice about the community aged care that will best meet their needs.

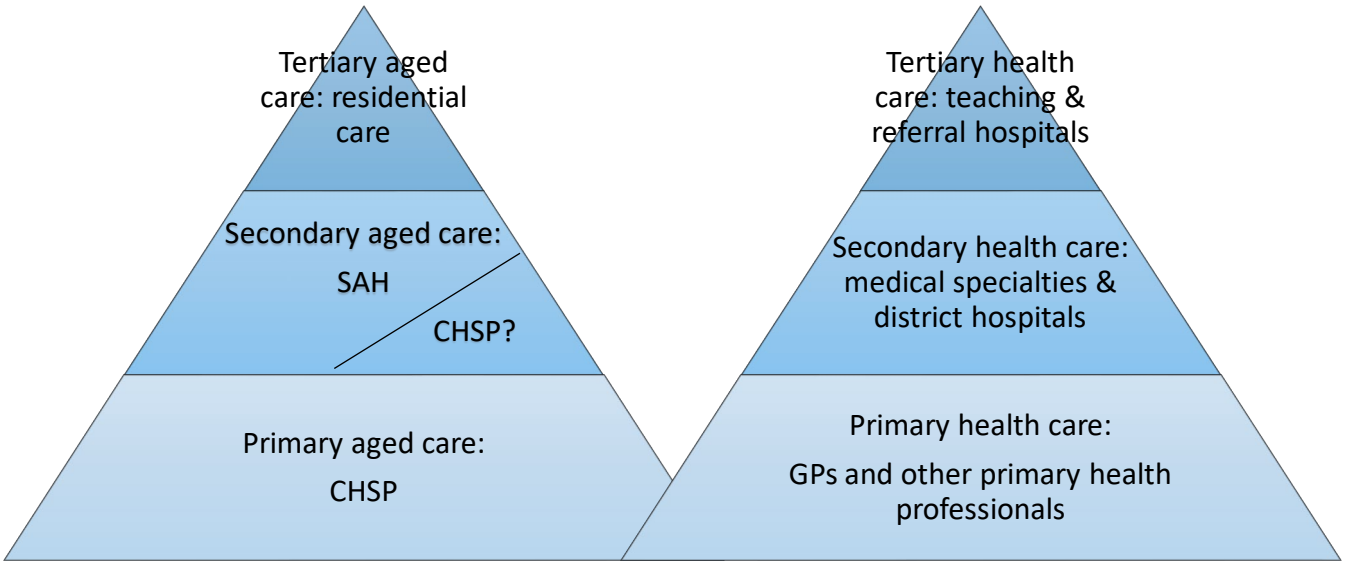
The Alliance has been established to:

1. In the immediate term, advocate for CHSP to remain as a separate program and not get folded into the Support at Home (SAH) program.
2. In the medium and longer term, to work with government to co-design a revamped CHSP program that is fit for the next 20 years +.

The Alliance has one primary goal: the maintenance, funding and further development of CHSP as the primary tier of the aged care system. Our vision is a revamped CHSP that is clearly positioned as the primary tier of an integrated aged care system and that is fit for the next two decades and beyond.

Our secondary goals are:

1. a formal recognition of the secondary tier role of CHSP
2. older people requiring secondary aged care being offered a genuine choice about whether it is delivered via CHSP or Support at Home (SAH)
3. better integration of CHSP and primary health care, including the social prescribing of CHSP by the person's general practitioner and
4. a new funding model that separately funds the fixed and variable costs of delivering CHSP aged care in the community.



The CHSP Alliance has been established by a network of 40 CHSP Alliance Foundation Members. All Foundation Members are committed to our primary goal, namely the maintenance and adequate funding of CHSP as the primary tier of the aged care system. While membership of the Alliance is open to all who commit to our primary goal, support for our secondary goals is not a requirement for membership. That said, the significant majority of Foundation Members support, at least in principle, all four secondary goals.

The Alliance membership extends well beyond the aged care system with the Alliance open to any aged care, health care, government or other organisation that commits to our primary goal. The Alliance welcomes as members aged care, health care and other leaders in the care economy including states and territories, not for profit and for profit organisations as well as individuals with lived experience, carers, academics and advocates.

CHSP Alliance Foundation Members

Foundation Organisational Members

Aged Care Industry Association (ACIA)

Allied Health Professions Australia

Anglicare

Australian and New Zealand Society for Geriatric Medicine (ANZSGM)

Australian Association of Gerontology (AAG)

Australian Community Transport Association (ACTA)

Australian Independent Retirees (AIR)

Australian Nurses and Midwives Federation (ANMF)

Brotherhood of St Laurence

Care and Share South Australia

Carers Australia

Community Industry Group

Community Options Australia

Community Transport Organisation (CTO)

Consumers Health Forum

Council of the Ageing (COTA) NSW

Dementia Australia

Federation of Ethnic Communities Councils of Australia (FECCA)

Flexicare

Home Modifications Australia

Meals on Wheels Australia (MOWA)

Meals on Wheels NSW

Meaningful Ageing Australia

National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIASCC)

National Seniors Australia

Occupational Therapy Australia

Older Persons Advocacy Network (OPAN)

Older Women's Network Australia

Older Women's Network NSW

Yaandina Community Services Western Australia

Foundation Individual Members

Professor Kathy Eagar AM (Co-Convenor)

Mr Paul Sadler (Co-Convenor)

Mr Wayne Belcher

Professor Michael Fine

Professor Diane Gibson

Professor Sue Kurrle AO

Mr Adrian Morgan

Mr Mark Sewell

Ms Robyn Vote

Mr Ian Yates AM

Our primary goal: CHSP should be maintained and expanded as the primary preventative and early intervention tier of the aged care system

CHSP is an essential component of the Australian aged care system and is the only part of the aged care system which has consistently performed well over the last four decades. CHSP currently funds 1,265 providers delivering services from 3,652 outlets across all states and territories. In 2025 CHSP funding provided 115 million services to more than 800,000 older people[1].

CHSP is a Labor legacy after being introduced 40 years ago by the Hawke government as the then Commonwealth-State Home and Community Care (HACC) Program. It was transferred to the Commonwealth in 2015 and renamed as the CHSP. Since then, the Commonwealth has had CHSP in little more than a holding pattern without the policy and information developments we have seen in both residential and packaged care and with virtually no population planning or growth funding.

The CHSP largely funds not-for-profit community aged care providers such as Meals on Wheels, community transport, state and local government services such as neighbourhood centres and community nursing and social connection services such as digital skill support and internet access, support for older people in engaging with government agencies and access to food/showers/laundry services for older homeless people.

In addition to direct services, CHSP also funds a network of CHSP sector support and development (SSD) workers who play a critical role in assisting CHSP providers build capacity, support volunteers and improve quality. While SSD funding has not been sufficient to ensure adequate or equitable access to SSD services, SSD is a core component of CHSP that needs to be preserved and strengthened.

The Alliance has a clear vision of the future of CHSP and where it fits into the broader aged and health care systems. At its core, CHSP should be maintained and funded to focus on preventative and early intervention and to be the primary care tier of the aged care system. This includes both the services that CHSP funds and the capacity it builds via the SSD program. Just as the health system would be dysfunctional and much more costly without a strong primary health care tier, so aged care would be without a strong primary aged care tier.

As the primary aged care tier, CHSP should be a support program for people with entry or low level needs. We define this as a program for people who would benefit from prevention and early intervention programs and who require six 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. Instead, CHSP providers would simply register their clients/care recipients with My Aged Care.

Our immediate priority is to ensure that CHSP remains as a distinct program and is not merged into SAH. But simply doing more of the same is not enough. Our goal is that CHSP is progressively reformed to become the primary care tier of an integrated aged care system as shown in the diagram on page 1.

Essential features of primary care (including CHSP) that distinguish it from other tiers and that ensure it functions as the platform for the rest of the health and aged care systems are:

- Primary care is **first point of contact**
- Primary care is **accessible**: there is no wrong door to access it

[1] https://www.gen-agedcaredata.gov.au/resources/access-data/2025/october/aged-care-data-snapshot-2025

- Primary care Is **affordabl**e with no financial barriers to stop people accessing the prevention and early Intervention services they need to live well at home
- Primary care offers **comprehensive** services (prevention, early intervention, home care support and continuity of care over time including capacity to surge in times of extra need)
- Primary care builds **continuity** through long-term relationships and **case management** where required
- Primary care refers to and **coordinates** with secondary and tertiary care as required
- Primary care is **person-centred,** empowering individuals and communities and incorporating principles including community engagement, volunteering and engagement with carers and neighbourhoods.

Translating those features into practice cannot just be left to the market. It requires a ***community***, and not just an individual, focus that includes:

- **Planning** and **commissioning** the mix of services required in each region to meet the changing needs of older people,
- Ensuring services are geographically, financially and culturally **safe** and **accessible,**
- Investing in **capacity building**, helping older people build on their strengths and achieve their goals and engaging **volunteers** and **local communities**.

Assisting people with daily living is essential but it is not enough. Our goal is that CHSP is a primary aged care system that enriches the lives of older people.

Our secondary goals

The Alliance has a set of four secondary goals. While all members of the CHSP Alliance are committed to our primary goal, not all members necessarily support all of our secondary goals. However, each of our secondary goals is supported (at least in principle) by 90% or more of our Foundation Members.

Formal recognition of the secondary tier role of CHSP

In addition to its primary tier role, CHSP should also be recognised and resourced to be:

- A support program for people with higher level needs and who are waiting to access SAH. CHSP is already being asked to fill this role without any formal recognition and without the additional resources that are necessary.
- A program with the capacity to deliver secondary aged care for people with higher needs who elect to receive services via CHSP and not via SAH (see below).

Older people requiring secondary aged care choose whether it is delivered via CHSP or SAH

With formal recognition of the secondary tier role of CHSP, CHSP will become both the primary care tier of aged care and a program with the capacity to deliver secondary care if that best meets the needs of the older person. This is designed to ensure that the older person has the right to make a real choice.

Giving older people a real choice between CHSP and SAH is consistent with the 2024 Aged Care Act with its emphasis on independence, autonomy, empowerment and freedom of choice. [2]

It is also designed to ensure continuity of care for older people who begin to access services when they have low level needs and whose needs progressively increase as well as people whose needs fluctuate from time to time. These cohorts should be able to age in place with the support of their CHSP providers and should not be required to change providers when their needs change.

Not every person needing care at home wants individualised funding or to receive services through the SAH program either when they first apply for aged care or later when their needs increase. Individuals should have the right to choose to:

- receive individualised funding (SAH) or
- receive the same level and range of services via a grant to not-for-profit CHSP provider/s of their choice.

This requires two fundamental changes to government policy on CHSP:

1. CHSP being no longer defined as being a low need / entry level program
2. CHSP being able to again offer case management.

The range and quantum of services would be the same in the two program options; the only difference is in how each option is managed and funded. This is real consumer choice.

[2] https://www.agedcarequality.gov.au/workers/statement-rights

Better integration of CHSP and primary health care, including the social prescribing of CHSP by the person's general practitioner

This secondary goal is perhaps our most ambitious. 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.

From the perspective of the older person and their family, the division between health and aged care needs is artificial and a barrier that results in delays, duplication and confusion.

The international evidence supports this. People do not need aged care just because they are old. People need aged care when they develop health conditions that result in loss of strength, agility and mobility movement and that lead to increasing frailty and/or cognitive loss and/or behaviour issues. In turn, these reduce the person's ability to manage daily activities of daily living (ADLs).

When older people need care and support, they increasingly need holistic care that includes coordinated attention to their health needs, their functional needs, their psychosocial needs and eventually their end-of-life needs. Neither the aged care system nor the health system can meet their needs in isolation of the other.

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 as a practical strategy to achieve much better integration of the aged care and the health care that a person living at home needs.

As the primary tier of the health system, the General Practitioner (GP) is most often 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.

The idea of social prescribing by GPs recognises that an older person needs much more than a script for a medicine. Social "prescriptions' allow a GP to write a script for non-medical community-based support. This support typically includes the range of services delivered by CHSP.

The idea is best illustrated by example.

> *Jo's GP gently breaks the news to Jo that she is no longer fit to drive. The GP explains that the GP is required by law to take away her driver's license. Jo's first reaction is panic – how will they get to GP appointments and to the shops? Under the new social prescribing system, Jo's GP can immediately approve her for community transport. The GP practice phones the local community transport service, does the introductions over the phone and forwards the GP prescription for CHSP funded community transport. The CHSP service registers Jo with My Aged Care and books a time for someone to visit her at home.*

Achieving a new national policy on social prescribing of CHSP by GPs is an ambitious secondary goal of our Alliance. We do not see the GP 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. The GP is an important and well-known pathway but should not be the only one.

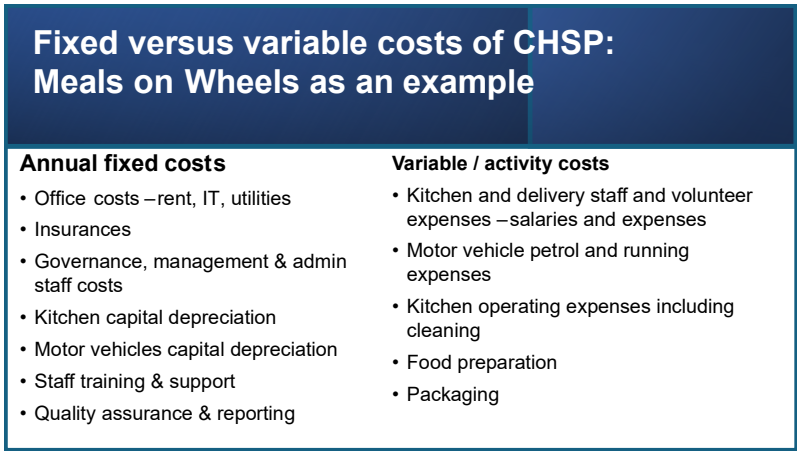
New funding model that separately funds the fixed and variable costs of delivering CHSP aged care in the community and

While block funding has served CHSP well until now, it is not a suitable funding model for the future. The history of CHSP demonstrates too clearly that block funded services quickly become 'set and forget' in the minds of policy and funding bodies. Also, block funding models are not nimble enough to respond to changing population need and demand.

We have a clear view of the new funding model that is required for CHSP. It draws on the residential aged care funding model (the Australian National Aged Care Classification) in recognising that, like residential aged care, CHSP has two separate sets of costs:

- **Fixed infrastructure costs** necessary to establish a service and give it the capacity to deliver its services. Fixed infrastructure costs vary by size, location and role. These costs can be calculated up front and should be funded at the beginning of each year. This gives the organisation the cash flow to begin and plan each year.
- **Variable activity costs** which relate directly to delivering a service to an older person. Once separate account is taken of fixed costs, activity costs are based only on the needs of the person and the nature of the service they receive. Activity costs do not vary considerably by location or the size of the service delivering the service. These costs can be funded prospectively (based on anticipated activity) or retrospectively (based on actual services delivered). Our preferred approach is that activity is funded prospectively with a retrospective adjustment at the end of the year based on the volume of service actually delivered.

The figure below illustrates the idea using Meals on Wheels as an example.



A new funding model for CHSP based on the AN-ACC is one of our secondary goals. It could be achieved progressively as service capacity develops and would not need to be implemented in one go.