Submission

Inquiry into Aged Care Service Delivery

Senate Standing Community into Community Affairs

Submission by the **Australian Physiotherapy Association**

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Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community.
We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

Submission

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 34,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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1. Executive Summary

The Australian Physiotherapy Association (APA) is pleased to provide feedback to the Senate Standing Committee on Community Affairs Inquiry into Aged Care Service and welcomes the public examination of the impacts the delayed implementation of the Support at Home program and withholding of Home Care Packages (HCP).

In 2021, the Royal Commission into Aged Care Quality and Safety found: "The challenges facing the aged care system are well known - an ageing population, increased demand for services, confusing and fragmented service delivery, waiting lists …substandard care, a lack of transparency about the quality of services."[1]

Sadly, despite four years of significant policy reform intended to re-envisage the aged care system and enable older people to live independently, many of these challenges remain. It is clear that the home aged care system is underperforming, the interfaces between health, community and aged care are disjointed and that clinicians, including physiotherapists, are under intense pressure to provide services to burgeoning number of ageing Australians requiring services.

A Budget 2024-25 commitment to release an additional 24,100 HCPs has not materialised.[2] At 31 March 2025, there were 87,597 people were waiting on the National Priority System (NPS) for a HCP at their approved level.[3] Of those on the NPS, 86,870 (99%) are in a lower level HCP and/or approved for CHSP services, which is already providing entry level services to 816,000 people.[4]

Delays in assessment, approval and assignment of Home Care Packages are having profound impact on older Australians, including:

- lack of access to comprehensive, needs-based physiotherapy care due to demand for services;
- greater dependency on the hospital sector where increased presentation to emergency departments, delayed discharge, bed blocking and use of outpatient services are increasing;
- hospital institutionalisation and hospital acquired complications resulting from more frequent and lengthier stays;
- greater reliance on already stretched short-term community programs;
- deterioration in function and capacity (often leading to reassessment higher level HCPs), and
- early entry into residential aged care, where demand is high and may be subject to wait lists.

Ageing Australians, particularly those with high needs, often face a dearth of available home services or are forced to navigate a disorientating revolving door of disjointed and under-resourced state and community services, long struggling to meet the needs of an ageing population, and under increasing pressure to fill the void of the home care holding pattern.

The state of uncertainty and limbo in home care is further compounded by a narrowing of value that overlooks the true cost and complexity of physiotherapy services. This reflects a broader trend of undervaluation that risks the financial viability of service providers and undermines patient access, outcomes and workforce sustainability.

The introduction of the Support at Home Program is unlikely to be the panacea many hope for with a mounting backlog of assessments and package assignment that will intensify demand for physiotherapy service provision already under threat.

The sustainability of the program can only be achieved by supporting the viability of a strong market of skilled, high-value service providers to ensure equity of access to person-centred, culturally safe, trauma informed and reablement-focused physiotherapy.

However, a pricing framework and Indicative pricing based on flawed methodology and unrepresentative of actual cost of physiotherapy service provision in the home, insufficient funding for key services such as Assistive Technology, flawed registration categorisation and an insufficient linkage to Quality Standards are likely to have dire unintended consequences.

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2. Recommendations

The APA has key recommendations to address the Terms of Reference of the Inquiry:

Recommendation 1	Ensure the Support at Home pricing framework and service list pricing recognise and remunerate all client attributable clinical care time to ensure comprehensive, needs-based care.
Recommendation 2	Advocate for the inclusion of separate billable line items in the Support at Home Pricing Framework to encompass all client-attributable time such a travel and report writing.
Recommendation 3	Release existing market modelling and projections undertaken by IHACPA and the Department of Health, Disability and Ageing, on the impacts of ageing care reform, including pricing, on the home care package and service delivery markets.
Recommendation 4	Conduct examination of the impact on essential allied health service providers, such as physiotherapists, of the devaluation of allied health.
Recommendation 5	Release and further examine data collected to inform Support at Home Indicative Pricing.
Recommendation 6	Examine the impact of home care package provider adjustment of service pricing to align with the non-evidence-based Indicative Pricing and its impact on clinical service delivery provider sustainability.
Recommendation 7	Ensure Support at Home package providers must meet all clinical care Quality Standards, as their residential aged care counterparts are required to do, to ensure the quality and safety of care provided in the home.
Recommendation 8	Advocate for an immediate review of the insufficiently funded and structured Assistive Technology and Home Modifications Scheme to ensure equity of access to essential goods, equipment and assistive technology for older Australians.
Recommendation 9	Advocate for a review of the new Aged Care Registration categories to merge categories 4 (allied health) and 2 (assistive technology and home modifications) to remove the financial disincentive for providers to register in category 2 and to recognise the intrinsic link between the provision of assistive technology and home modifications by allied health professionals such as physiotherapists.
Recommendation 10	Ensure the Commonwealth develops guidance and a uniform approach that can be applied across package providers to reduce the financial and administrative burden on smaller service providers, who are facing inconsistent billing, invoicing and digital readiness requirements.

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3. The role of physiotherapy in home care

The APA represents 34,000 physiotherapists nationally, many of whom make up the largest allied health workforce in aged care.

Physiotherapists are highly qualified health professionals who diagnose, manage, treat and review patients living with complex conditions.

They have a broad scope of practice including falls prevention, cardiorespiratory rehabilitation, continence management and maintaining the physical and psychological wellbeing of people living with dementia. As key members of the multidisciplinary care team in residential aged care, physiotherapists work with the medical, nursing and allied health staff, contributing to care planning, maximising client function, prescribing equipment and implementing safe manual handling plans.

Physiotherapists bring additional value, beyond exercise prescription, to the care of older people. They are trained and qualified to diagnose deterioration in overall health including arthritis, pain, cardiorespiratory, vestibular and neurological conditions.

4. Key issues impacting provision and quality of home care physiotherapy services

4.1 Support at Home Pricing Framework

Appropriate Support at Home pricing must support a diverse and high quality service delivery market providing comprehensive needs-based clinical care to enable ageing Australians to live at home independently for as long as possible.

Pricing must also reflect the complexity of need of this vulnerable population, address geographic, cultural and socioeconomic barriers, and recognise the challenges service clinicians face when working with multiple approved package providers and in the home setting.

The APA is concerned about the impacts of the Independent Health and Aged Care Pricing Authority's (IHACPA's) proposal to establish Support at Home single billable hourly rate units on provision of home care. The approach, based on single billing units for service delivery is unfeasible, unsustainable and will diminish quality of care.

While the APA recognises the Authority is an independent body, it is essential the impacts of its decisions on the provision of Support at Home clinical care are understood by this Inquiry.

We object to a framework that is premised on a single, rolled-up hourly rate that cannot conceivably remunerate for the many components of client-attributable time required to deliver high quality person-centred care to a vulnerable ageing population with higher rates of intensive needs and complex co-morbidities.

Initially, IHACPA advised the single billable unit rate would cover face-to-face client time only (including telehealth). It has since revised its approach with single billing units intended to be inclusive of all associated costs or client-attributable time[5].

Client-attributable time includes care planning, travel to client's homes, clinical report writing, multidisciplinary case conferencing, carer support and training, assistive technology assessment, provision and adjustment, administrative requirements and costs associated with aged care reforms.

A single unit price encompassing all client-attributable time would entail projections of how many hours should be billed what might need to be built into the price per visit before it takes place or the establishment of an hourly rate sufficient to factor in these components of care, not actual cost, which is highly variable dependent on individual client need.

Case study 1: Components of physiotherapy client-attributable time

Ms Taylor, aged 72, who lives alone and is fully reliant on her Level 4 home care package, suffered a stroke. She is non ambulant, only able to stand with the assistance of two people and in pain from a shoulder subluxation. She has a resultant facial drop, functional impairment on her left side, aphasia and mild cognitive dysfunction. Ms Taylor requires a physiotherapy functional assessment post-stroke; development of a manual handling plan; ongoing rehabilitation and care team coordination.

Time needed to deliver services

• Client intake and pre-visit safety screening:	25 minutes
• Initial physiotherapy consultation:	1 hour
• Follow-up consultations:	30-45 minutes
• Development of manual handling plan:	1.5 hours
• Manual handling training x 2 sessions:	2 hours
• Physiotherapy exercise program development:	30 minutes
• Education and training for support workers:	1 hour
• Post-assessment reporting and recommendations:	1 hour
• Travel per visit x 2:	40 minutes
• Follow up with service coordinator:	10 minutes
• Liaising with assistive technology provider:	15 minutes
• Case conferencing:	1 hour

The Support at Home pricing framework and service list pricing must recognise and remunerate all client attributable time to ensure comprehensive, needs-based care.

At a minimum, the APA is calling for the introduction of separate billable line items for client attributable time, including travel and report writing, to reflect the true cost of care, support provider viability and program sustainability, in line with the approach of other funding schemes.

Additional billing line items will support greater transparency and accountability of Support at Home funding spend, and provide more accurate data to inform future costing studies.

Consideration of the impact of ensuring compliance and safety on service delivery cost must be examined and factored in.

The current approach, compounded by the administrative burden of other aged care reforms including a new provider registration model, also favours large service delivery and home care providers who can achieve efficiencies of scale.

The APA has met and formally raised concerns with IHACPA about our concerns about the sustainability of smaller service providers. The APA is calling for the release of existing market modelling and projections undertaken by IHACPA and the Department of Health, Disability and Ageing, on the impacts of ageing care reform, including pricing, on the home care package and service delivery markets. The APA recommends specific examination of the impact on allied health service providers be undertaken.

4.2 Support at Home Indicative Pricing

The APA is concerned the Support at Home Indicative pricing, released by the Department of Health, Disability and Aged Care in March 2025[6], is resulting in downward pressure on service delivery pricing, particularly on physiotherapy rates, effectively pre-empting IHACPA recommendations by influencing pricing that will underpin future costing studies.

Support at Home capped service delivery pricing for allied health, such as physiotherapy, at hourly rates recommended by IHACPA and set by the Commonwealth, was scheduled to come into effect on 1 July 2025 but later revised to 1 July 2026. In the interim, service providers are ostensibly to set their own prices.

The APA is extremely concerned about the methodology and data used to inform the Indicative Pricing list and its consequences. The limited survey undertaken to inform the Indicative Pricing was completed before many of the Support at Home program guidelines were formalised. Its response rate, as the APA understands it, was less than a third of providers.

In addition, it is evident that the data did not consider the margins charged by home care package providers in a predominantly brokered workforce nor did it reflect important considerations of all client-attributable time. It is concerning this data, and not the IHACPA review, was used to inform the Indicative Pricing List.

The published Indicative Pricing service list price ranges do not factor in home care package provider margins, which further dilute the price, with some adding up to 40% to adapt to the reduction in care management and administration fees introduced under the reforms.

Home Care/Support at Home package providers are aligning with the Indicative pricing and seeking to finalise service agreements with physiotherapists well below their current consultation rates.

There is anecdotal evidence that HCP providers have put pressure on physiotherapists to ensure that their prices at the lower end of the indicative price range - which significantly undervalues the profession, and is further compounded by a pricing framework that does not enable clinicians to bill for client attributable time such as travel, report writing and multidisciplinary case conferencing.

An email seen by the APA from a Support at Home provider, based in Melbourne, advised physiotherapists it was reviewing its preferred provider list and updating all third-party provider agreements to reflect the new funding model. It reduced consultation time from one hour to 45 minutes at below market rates.

Lowered pricing rates will have a direct impact on quality of care as providers look for efficiencies in clinical care delivery, putting comprehensive, multidisciplinary needs-based care at risk and impacting service provider viability.

The APA is calling for the full release and further examination of the data collected to inform Indicative Pricing and home care package provider adjustment to align with the Indicative Pricing to examine how this will impact service delivery.

Case study 2: impact on small package provider market

There is evidence that smaller home care package providers are exiting the market due unsustainable pricing and the administrative and financial burden of policy reform. An APA member reported that In Canberra, three small home care packages providers have recently closed, increasing pressure on already stretched home care services and necessitating clients to find alternate package providers.

The demand for care managers is high, resulting in some care managers attending to the needs of Canberra Home Care recipients being based in Wollongong and less familiar with local service providers. This is creating complications and delays for service providers, such as physiotherapists, and impacting continuity of care.

4.3 Impact on older people in the community

The APA is concerned that delays in Home Care Package allocation and industry efforts to prepare for the implementation of Support at Home are hindering access to critical needs-based physiotherapy care, resulting in unmet need, deterioration in function and capacity of older,

hospitalisations, and early entry into residential aged care and client/carer overwhelm in dealing with an array of entry level community services trying to bridge the gap.

APA members have reported significant impacts on older people as a result of the withholding of Home Care Packages with specific concerns about unmet need.

With 86,000 waiting for assessments, many are left without services due to delays, especially those on lower-level packages (e.g., Level 1 or 2) who are not prioritised for interim solutions while those on higher levels packages are offered entry level services not comprehensive enough to address complex co-morbidities or fund needed equipment such as hoists.

Impacts observed include:

- Reduced or lack of access to comprehensive, needs-based physiotherapy care due to demand for services;
- greater dependency on the hospital sector where increased presentation to emergency departments, delayed discharge, bed blocking and use of outpatient services are increasing;
- hospital institutionalisation and hospital acquired complications resulting from more frequent and lengthier stays;
- greater reliance on already stretched short-term community programs;
- deterioration in function and capacity (often leading to reassessment higher level HCPs),
- early entry into residential aged care, where demand is high and may be subject to wait lists. APA members report seeing an increase in the number of older people entering RACF prematurely due to the unavailability of HCP or electing to move to RACF die to wait time for level 3 or 4 home care packages.
- Carers overwhelmed navigating the various community programs, coordinating care and providing support.
- While the single assessment workforce has a KPI to deliver 10% of those accepted to home care packages to the Restorative Pathway, they estimate about 70% actually need it, and
- Difficulty navigating MyAged Care with barriers including language, hearing or cognitive impairment, lacking comprehension of service providers to contact and trust in service providers.
- Equity of access: co-contributions to services also prohibits many older people from taking up services.

Case study 4: Deterioration while waiting for HCP

Mrs V, 77 year old, lives in a regional area of Western Australia with supportive family close by. Until recently, Mrs V's husband has been supporting all of her care needs, however, she has recently become unwell and requires increased assistance.

Mrs V is assessed by an aged care assessor and given referral codes for occupational therapy and physiotherapy to support with mobility and equipment needs. She is approved for a level 3 HCP. Her goal is to continue to be able to walk however she is at high risk of falling.

Mrs V deteriorates further over the course of the CHSP support. Allied health helps Mrs V access a privately funded hoist and other appropriate equipment, which reduce her falls, the strain on the carer and injury risk to them both.

She received periodic support from her physiotherapist during CHSP while awaiting the HCP, which will likely take many months. By the time the package is available, Mrs V needs will exceed level 3 and she will need to be reassessed for a level 4. When the level 4 comes through however, the client will have to wait to accrue funding to purchase equipment and potentially even for intensive allied health input.

4.4 Impact on community services

Community-based physiotherapists working the Commonwealth Home Support Program (CHSP) and programs such as Rehab at Home, are under tremendous pressure to fill the clinical care void resulting from burgeoning HCP wait lists often extended beyond the scope of those programs while simultaneously adjusting to policy reforms and preparing for Support at Home.

CHSP is intended for entry level, episodic, reablement, non-complex client care however, because of the delay in Support at Home there is an increasing complexity of care needing to be delivered under entry-level allied health services in the community as ageing Australians are waiting longer for packages. Complex care is not the intention of the CHSP however, these clients cannot access care otherwise and will end up being seen in the health system. Complex care may include people:

- Requiring complex manual handling (including bariatric clients) whom allied health support (along with family and care staff) to ensure that their services are able to be carried out safely. This risk increases the likelihood that an ambulance will need to be called, increasing pressure on the health system, which is already at capacity and this is more of a challenge by the client living regionally.
- Who frequently fall;
- Who are palliative and do not have reablement goals; and
- Who have complex mental health conditions and require support in the community.

GEAT (good, equipment and assistive technology) funding does not cover the cost of hoists as the program is not intending to be for prescribing complex aids/lifters.

A risk may be that staff working in CHSP may not have the correct training/exposure to support this client with prescription of complex aids. Furthermore, if the older person/family cannot afford or rent/purchase this, the client is likely to need to go to hospital or enter RACF early.

While HCPs support care coordination, CHSP does not provide a central point of contact and the CHSP referrals often mean different providers, making complex case management and management of GEAT funding time consuming and a challenge.

The increased length of stay on CHSP resulting from package delays means that other clients who are waiting for the CHSP cannot be seen and waitlists grow. These clients deteriorate further while on waitlists for CHSP and by the time they are seen, they are likely to need complex care, which means that if they were not already approved for a package, CHSP providers may need to request an assessment. They may also need to wait for a reassessment for other codes for other services, depending on their initial approvals.

Older people are requiring ongoing CHSP until packages become available. This consists of 12 weeks of physiotherapy and in some areas, the physiotherapy workforce cannot keep up with demand.

APA members working in CHSP estimate that the percentage of their clients requiring a reablement assessment is about 70 per cent.

4.5 Impact on hospitals

Hospital-based physiotherapists and allied health managers report increasing emergency presentations, longer stays and bed blocking among older patients resulting in significant health outcomes and some increasing the number of maintenance beds and keeping seasonal surge beds open yearlong to cope with demand.

Hospitals are under pressure due to increased wait times for home care packages, reducing available home supports, and a lack of available beds in residential aged care to discharge patients to.

In Queensland, the waiting list for level 3 home care packages had grown from 10 months in January 2024 to 12 months in January 2025, and 13 months to 14.5 months for level 4 packages during the same period.

The wait times relate to a) receiving funding approvals and b) waiting for provider availability. There is no ability to escalate patients waiting in hospital for a home care package.

It is expected that the delayed implementation of the new Support at Home funding will add delays to funding timeframes from November while community-based providers understand their obligations under the new scheme.

Delayed discharge of older patients/long stays

An APA member employed at a major tertiary hospital reported that an increase in longer stay aged care pathway patient volume had increased from 98 to 140 patients per quarter between Q4 2025 and Q2 2025.

Without adequate home support, medically stable patients cannot be discharged to their homes, putting them at risk of infection, pressure injuries, muscle loss and declining function and capacity as a result of lack of movement and exercise, institutionalisation, loss of self-worth and dignity,

At the same hospital, the number of patients discharged with supports needed at home were consistently higher from January-June 2025 than the same period the previous year, peaking at 36 patients in March 2025 compared to 14 in March 2024.

Another metropolitan hospital outpatient service reported an increasing number of physiotherapy rehabilitation patients due to a lack of providers or providers with 6-12month waitlists in the community. Trends observed including patients presenting with more complex conditions, and with less family support compared to patients in previous generations.

Other impacts in the hospital setting, often resource intensive, include:

- Increased blocking, occupying a bed that a medically unwell patient requires, results in backing up the whole hospital up to emergency departments;
- Access issues related to rehabilitation and post-acute care result in patients not receiving rehabilitation;
- Cognitive impairment in patients increasing complexity of navigating the aged care system and accessing community services;
- Increased staff time supporting patients access community services and MyAged Care;
- Equity issues resulting in some patients, who cannot afford the co-payments or the transportation to their care centres, not undertaking rehabilitation and maintenance programs resulting in readmission;
- Patient handover/transition disconnects;
- Staff burn out and low morale;
- Pressure from operations centre to get throughput of patients;
- Increased administrative burden of policy reform;

- Wards introducing multiple services – for example in Melbourne, a Transition Care Program (TCP)-moved from bed based to home based care to give the patients as many weeks of support as possible to bridge the gap before an increase to a HCP is available. This is an incredibly high resource use of services.

Case study 5: Hospital impacts

A major regional New South Wales hospital reported increasing beds and services to cope with increasing number of ageing patients unable to access home supports. These included:

- 18 maintenance beds increased to 62 beds in past two years;
- Surge capacity open year-round, no longer seasonal;
- Hospital Acquired Functional Decline is becoming more evident with extended hospital stays;
- More patients requiring transitional care/Geriatric Evaluation and Measurement due to lack of availability of home support;
- Needing to improve functionally entirely in hospital due to lack of community support programs.
- Hospital acquired complications;
- Multiple representations for social issues/carer stress;
- Transitional Aged Care Program (TACP) closing to referrals due to capacity issues as a result on heavy reliance on TACP to get people home safely in absence of viable options for patients to receive services;
- CHSP often closed to referrals or at capacity on a regular basis;
- 4-5 week wait for high priority package level 4 results in delayed discharge for high priority patients; and
- 8-9 months for a single assessment to be conducted receive at home support.

4.6 Impact on hospital outpatient services

With increasing pressure on the health system as a result of the shortage of home supports and increasing early rates of early discharge, there is growing demand for outpatient, hospital-in-the home and hospital community care programs and services.

These services include post-acute care, rehabilitation programs and introduction of transition hospital to home services. APA outpatient-based members report growing pressure on clinicians to discharge patients to free up beds, requiring additional outpatient support.

In one case in New South Wales, an elderly lady who had suffered a C3 fracture in the neck, a potentially life-threatening injury. The woman could not raise her arms, feed or toilet herself yet was discharged in a collar with no supports or equipment in place at home.

The hospital community care team rapidly responded to ensure the patient had care, scrambling to make sure the home was safe. She should have gone home with all the equipment and systems and supports in the place.

There was no warm handover in transition from the acute team to the outpatient team, increasing the complexities of providing home based care.

4.7 Impact on the single assessment workforce

Single assessment providers have reported to the APA that they are experiencing significant operational challenges as a result of delay of the Support at Home program and the growing Home Care Package waiting list, impacting business sustainability.

Assessment providers contracted to Support at Home have invested significantly in recruitment and training of clinical staff, many of whom are physiotherapists, in readiness for the release of an extra 24,100 home care packages committed to by the Commonwealth Government in Budget 2024-25.[7]

Delays to contracted numbers of Support at Home assessments and contracted financial incentives to1 November 2025 have forced assessment providers to look for short-term solutions to generate revenue.

To remain viable, some assessment providers have increased assessment caseloads in existing programs while implementing freezes on staff recruitment. With delays simultaneously putting more pressure on community services to make up the funding shortfall, assessors also report spending more time searching for community services, such as CHSP, to refer older people to as they wait for packages to come online.

The APA is concerned about the capacity of both the assessment workforce and care and clinical service providers to meet demand when Support at Home is implementing taking into account the growing backlog.

More critically, all delays risk deterioration in the function and condition of older people waiting for assessment, approval and release of HCP- resulting in a need for reassessment and a change in assessment type from support to clinical assessment, putting additional pressure on the assessment workforce.

Case study 6: Single assessment workforce

An existing non-for-profit assessment provider, employing physiotherapists as clinical assessors and contracted to transition to Support at Home told the APA:

"We are the first point of contact for many people entering the My Aged Care system and contracted to complete thousands of Support at Home assessments per month.

"We employed 15 additional assessors in the two months prior to the delay of Support at Home as part of our consolidation structure. This requires a significant investment of training – 38 hours' training per assessor – and several hours of training were wasted (as there were new changes to the pre-existing training).

"The delay has had numerous effects on the running operations of the organisation. We have stopped recruitment altogether and had to adjust to a shortfall of income of $250,000 expected as an incentive in June. We are currently understaffed by 18 assessors due to the delay and the constraints we have faced.

"In the absence of Support at Home assessments to undertake, we have had to redeploy our assessors to complete Support Plan Reviews in increased numbers. These reviews are not funded, and the new Act also includes increased indirect costs.

"In order to keep our operations sustainable, we have delivered well over the contracted numbers (of ACAT and RAS assessments) every month. The goal posts have shifted and continue to shift, pushing us to over deliver to achieve some sort of return.

"Meanwhile, our assessors are experiencing change and training fatigue, demoralisation due to a lack of community services to refer to, job uncertainty, and burnout die to increased workload."

4.8 Governance and digital transformation

The APA is concerned that service providers, particularly subcontractors, have not been supported for digital readiness to transition to Support at Home.

Substantial effort and cost is required for service providers, particularly those subcontracting to multiple package providers, to adapt their invoicing and systems to align with the requirements of the program and individual package providers, where multiple service agreements will be in place.

The APA recommends the Commonwealth develop guidance and a uniform approach that can be applied across package providers to reduce the financial and administrative burden on smaller service providers.

4.9 Assistive Technology and Home Modifications Scheme

The APA has significant concerns about the design and funding sufficiency of the Support at Home Assistive Technology and Home Modifications Scheme and we are calling for significant revision and consultation to ensure this meets the needs of ageing Australians.

Physiotherapists have a central role in functional assessment and prescribing goods, equipment and assistive technology, such as mobility aids, to enable independence and safety at home for older people.

Lifetime funding cap is too low

The $15,000 lifetime cap on home modifications is grossly inadequate. Major modifications - such as level-access bathrooms or ramps - can cost well over $50,000, rendering the cap unrealistic for many households. This cap will force older Australians into residential care prematurely, increase hospitalisations due to falls, and create financial stress, particularly for those unable to self-fund the gap

No Accrued funding mechanism

Under previous systems such as Home Care Packages, participants could save up their funds over time for larger modifications. The new scheme removes this flexibility, disallowing fund accrual and undermining the ability to plan for higher-cost needs

The APA is concern that, fearing future needs, participants may decline clinically-recommended smaller modifications in order to preserve the limited funding, leading to avoidable falls or disability progression.

Insufficient funding tiers for assistive technology

The funding tiers are woefully insufficient with the lowest at just $500 is woefully insufficient, especially for even basic assistive items like \smart watches (about $300). The places the older person at risk of early residential care placements and/or hospitalisation/death if an older person cannot access the assistive technology and home modifications they need and as a result has a fall. Furthermore, if a home cannot be modified or the necessary assistive technology cannot be put in place due to insufficient funding, providers will not provide a service such as personal care if it is deemed unsafe for the client and/or staff.

Equity and access barriers

Studies highlight wide disparities in public funding for assistive technology and home modifications across schemes - notably, a 50-fold difference in annual per-person funding between aged care ($51) and the NDIS ($2,500)[8].

Equity of the scheme is another issue. Assistive technology sits under the Independence category of Support at Home services, incurring a consumer co-contribution, which may discourage disadvantaged and vulnerable cohorts from accessing aids, such as walkers, they require to stay mobile and prevent falls.

Implementation, guidance and support gaps

There is a need for clear guidelines on what is included/excluded, defined roles for prescribers, and a structured process for reviews and reassessments

We are concerned about access barriers in rural and remote areas, with limited availability of allied health professionals and equipment suppliers, and a need for telehealth, mobile services, and installation support

The APA is calling for meaningful engagement, especially with under-represented groups, and caution that communication devices and other disability-specific supports may not be adequately addressed

Consultation transparency and last-minute changes

The $15,000 cap was introduced late in the development process, without prior discussion during consultations. This has undermined trust and left stakeholders feeling blindsided.

Insufficient wrap-around services

Even when assistive technology is funded, we are concerned about the lack of investment in follow-up support, training, maintenance, and organisational costs. Without these, the benefits of equipment may not be fully realised.

New aged care registration scheme

The Aged Care Quality and Safety Commission's new aged care provider cost-recovery/registration model further constrains access to assistive technology for older Australians.

Assistive technology and home modifications are critical to supporting older people undertake their daily tasks and remain safely in their homes. To access them under Commonwealth funding, the assistive technology and home modifications must be prescribed by physiotherapists and other allied health professionals following functional and home assessments.

Under the new aged care registration model, Allied Health (Category 4) and Assistive Technology-Home Modification services (Category 2) are delineated and package providers must register for both categories, at additional cost, to be able to provide assistive technology and home modifications. Further, the cost of assistive technology and home modifications must be initially paid upfront by the provider, who is reimbursed by the Commonwealth, creating another disincentive to provide these vital aids.

The additional category and audit costs is already resulting in package providers not registering under Category 2, which may force clients to switch change providers, disrupting continuity of care.

There is also ambiguity about how clinical governance applies across these categories, risking misalignment in standards and oversight.

5. References

[1] Royal Commission into Aged Care Quality and Safety, Final Report*: Care, Dignity and Respect*, page 24

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