

# Senate Inquiry into the Transition of Commonwealth Home Support Program into Support at Home

Via email to [community.affairs.sen@aph.gov.au](mailto:community.affairs.sen@aph.gov.au)

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.

## 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 35,000 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.

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## Executive Summary

The Australian Physiotherapy Association (APA) welcomes the opportunity to contribute to the Senate Standing Committee on Community Affairs (the Committee) Inquiry into the proposed Transition of the Commonwealth Home Support Program (CHSP) into the Support at Home (SAH) program.

The APA represents more than 35,000 physiotherapists nationally, many of whom comprise the largest allied health workforce in aged care. Physiotherapists play a critical role in maintaining function, preventing decline, reducing falls, and supporting older Australians to live independently at home. The APA supports aged care reform that delivers high-quality, person-centred, and needs-based care, while ensuring workforce sustainability and a diverse, viable provider market.

The APA's central concern is that the proposed transition of CHSP from 1 July 2027 is premature. SAH remains untested at scale, subject to ongoing pricing and service definition refinement, and constrained by significant assessment and package allocation wait lists. Eliminating CHSP before SAH and its planned multi-provider environment are fully embedded would introduce substantial system risk, reduce access to early intervention and preventative care, and place unsustainable pressure on the allied health workforce.

CHSP currently provides a low-cost, high-value layer of preventative and maintenance care that delays progression to higher-intensity, higher-cost services. Its average cost per client is significantly lower than SAH, reflecting a fundamentally different service purpose and intensity. The removal of CHSP without an effective transitional buffer risks accelerating demand for more expensive care, increasing downstream health system costs, and diminishing outcomes for older Australians. Essentially this reform strips out a proven, low-cost safety net and replaces it with nothing strong enough to stop demand from spilling into far more expensive services.

The APA identifies several unresolved structural and operational issues within SAH that must be addressed prior to any transition:

**Pricing and cost transparency:** Indicative Pricing for allied health, including physiotherapy, does not reflect the true cost of service delivery and risks entrenching underpricing through future capped pricing. The exclusion of travel as a separately funded cost undermines service viability, particularly in outer metropolitan, regional and remote areas.

**Administration and care management:** The removal of explicit administration and care management fees has resulted in margins being applied across service fees to recoup costs, inflating prices, reducing transparency for consumers, and distorting market signals.

**Workforce sustainability and compliance burden:** Ahpra-registered physiotherapists face significant duplication of screening, reporting, training, and portal requirements across multiple registered providers, threatening workforce participation and disproportionately impacting small and regional providers.

**Capacity and wait lists:** Persistent assessment and package allocation delays mean SAH is not currently capable of absorbing CHSP clients without service disruption.

**Reablement and prevention:** The Restorative Care Pathway is constrained by fixed duration and capped funding and is not fit to absorb CHSP recipients with reablement needs. Preventative services - particularly evidence-based falls prevention - risk being deprioritised despite strong clinical and economic evidence of benefit.

The APA strongly supports a genuine multi-provider environment under Support at Home that enables direct access to allied health providers, supports small and discipline-specific practices, and allows physiotherapists to work to their full scope of practice. However, this environment must be operationally embedded and tested before CHSP is transitioned.

The APA urges the Committee to get the sequencing right: stabilise the system, protect the workforce, and safeguard older Australians' access to quality physiotherapy.

## Recommendations

<b>Recommendation 1</b>	Extend CHSP transition until the SAH multi-provider environment is embedded and tested at a minimum to 1 July 2028, and Support at Home wait lists significantly decreased thereby increasing SAH capacity to service CHSP recipients.
<b>Recommendation 2</b>	Urgently expand the CHSP allied health provider network to address allied health service shortages across all MMM zones.
<b>Recommendation 3</b>	Expand CHSP capacity through significant emergency CHSP block funding to increase accessibility.
<b>Recommendation 4</b>	Ensure ongoing access to early intervention and preventative models of care for older people by developing new, nationally funded pathways for evidence-based programs such as falls prevention, delivered as an adjunct to the Restorative Care Pathway and through blended funding models for those ineligible for SAH.
<b>Recommendation 5</b>	Reintroduce administration and care management to enable clear capped and transparent administration and care management fees and reduce inflation of service fees resulting from margins applied to recoup these costs.
<b>Recommendation 6</b>	Reduce compliance burden on Ahpra-registered allied health professionals, such as physiotherapists, working within SAH to support service sustainability.
<b>Recommendation 7</b>	Extend and expand the SAH Restorative Care Pathway by increasing the number of available packages, duration, and budget flexibility to absorb CHSP recipients with reablement needs and prevent loss of early intervention during transition.
<b>Recommendation 8</b>	Develop a National Allied Health Workforce Strategy ensuring it has the strategic depth needed to effectively address geographic and other barriers to service delivery as a matter of urgency to address geographic and other barriers to service delivery.
<b>Recommendation 9</b>	Ensure the APA is consulted on the transition of Specialised Service Supports (SSS) to ensure access to critical allied physiotherapy is optimised.
<b>Recommendation 10</b>	Ensure the APA is consulted by Sector Support Development (SSD) to support service provider transition.

## Key System Challenges Impacting the Transition to Support at Home

### Wait times

CHSP service providers are under increasing pressure to fill the clinical care gap created by substantial SAH assessment and package allocation wait lists. As at 30 September 2025, approximately 121,900 people were waiting for a home care package at their approved level, with wait times of 9-12 months for Levels 1-3 and 12-15 months for Level 4<sup>1</sup>. At the same time, 116,339 older Australians were still waiting to be assessed under the Single Assessment System. Of those receiving packages, 15,998 were receiving a package below their assessed level of need<sup>2</sup>.

Latest Productivity Commission data shows the median time to receive an aged care assessment increased by 22.7% (from 22 to 27 days) in 2024-25. The time between assessment approval and service commencement also increased in 2024-25. The median time to sign a service agreement following a successful assessment was 245 days, up from 118 days in 2023-24.<sup>3</sup>

It is difficult to predict time frames to reduce assessment and allocation wait lists to enable timely access to needs-based care for older Australians under SAH but it is inconceivable that this will occur by 1 July 2027, the earliest the Government has indicated CHSP may transition to SAH.

While there is a lack of data tracking the number of those on SAH waiting lists accessing CHSP services as an interim measure, it is evident that CHSP is at capacity as a result of increased demand and operating beyond its scope in some cases by delivering clinical care to older people with complex needs.

### Accessibility

Despite the policy intent of CHSP to support national consistency in accessibility to entry-level services for older Australians, limitations on the number of allied health service provider tenders opened and funded have resulted in the following service delivery issues across all Modified Monash Model (MMM) zones, including metropolitan areas:

- Inconsistent availability of services across the country, including in metropolitan areas, dependent on the number of approved service providers (tenders);
- Insufficient services to meet demand with approved service providers being forced to close booking portals at times when they reach capacity; and
- A lack of services due to workforce shortages reflecting broader workforce supply issues in regional and remote zones.

The lack of accessibility to allied health across all MMM zones, including metropolitan areas, is often a direct result of the tight controls on the number of allied health service providers under CHSP due to a lack of available tenders and funding.

**The APA urges the Committee to recognise accessibility shortfalls can be addressed through the immediate review of and investment into the expansion of the CHSP allied health service provider network.**

Policy frameworks and funding models such as CHSP and SAH must explicitly accommodate these differential access patterns to ensure equitable allied health support nationwide.

**A National Allied Health Workforce Strategy that addresses barriers to accessing affordable allied health care must be developed as a matter of urgency.**

## Cost

CHSP funding has remained largely flat in real terms over the past decade relative to demographic growth, resulting in effectively stagnant or declining per-capita funding. As a consequence, CHSP service providers, including physiotherapists, are under-resourced to meet growing demand for clinical services. In contrast, SAH funding has expanded significantly, nearly doubling in recent years.

**CHSP capacity must be immediately increased to support accessibility with the investment in significant emergency CHSP block funding.**

CHSP delivers low-intensity, preventative and episodic support to older Australians with emerging or moderate needs. Its average cost per client remains substantially lower than SAH services, indicating a materially different service intensity and cost structure.

In 2023-2024, the average annual cost per recipient under CHSP was approximately \$3,580. By contrast, the average annual cost per Home Care Package (HCP) recipient was approximately \$22,585. Across Home Care Packages, average annualised payment amounts varied by level (e.g., about \$8,100 for Level 1 up to \$46,900 for Level 4).<sup>4</sup>

Government expenditure under SAH increases commensurate with its higher intensity focus, care coordination and administrative/compliance burden.

Removal of registered provider administration and care management fees previously enabled under the Home Care Package program has resulted in the application of approximately 25 per cent+ margins on all service fees, including physiotherapy, in the SAH program to recoup these lost earnings. These margins have the potential to inflate program costs for the government.

For the older person, who does not have transparency of baseline service provider fees, the significant increase in fees (due to cost recovery margins) deducted from their SAH package budgets, may act as a disincentive to accessing services with potentially negative impacts on health and quality of life.

SAH is designed to deliver coordinated, ongoing, and higher-intensity care, targeting people with multiple, progressive or complex needs and is built around individual budgets, pricing caps, and care coordination. CHSP operates through grant-based, block funding and minimal administration.

While a physiotherapist may receive the same hourly rate to deliver services in CHSP and SAH, there is a significant disparity in the cost to the taxpayer between the programs.

**Distinct administration and care management fees within Support at Home must be reintroduced to support transparency, data collection, service mapping and informed consumer decision-making.**

## SAH pricing framework

**A key issue for reform is the adequacy of the current unit pricing model and its ability to reflect the realities of contemporary care delivery.**

Appropriate SAH 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, address geographic, cultural and socioeconomic barriers, and recognise the challenges clinicians face when working across multiple registered providers and in home-based environments.

The transition of the CHSP is intended to complete the shift to a single, streamlined model. SAH is intended to deliver flexible, personalised aged care aligned with the principles of safety, dignity and consumer choice. Yet current pricing framework undermines this ambition.

Physiotherapists are being asked to deliver services at fee levels that do not reflect real-world costs. This disconnect threatens the right to access high-quality, sustainable care.

The most significant concern is the devaluation of the physiotherapy profession under the Government's Indicative Pricing. The methodology lacks transparency and rigour, yet the rates are already shaping market expectations.

Independent analysis commissioned by the APA, supported by StewartBrown data and internal investigations, confirms that actual service delivery costs significantly exceed the indicative rates. These underpriced signals distort the market and threaten provider viability.

These concerns are amplified by the role that Indicative Pricing is expected to play in shaping future price caps. There has been no transparent methodology or meaningful engagement with the sector to inform these pricing decisions.

The Independent Health and Aged Care Pricing Authority's current costing methods provide limited insight into the nature, complexity and cost of allied health services delivered in home. They are driven largely by available service data rather than clinically assessed need.

If early assumptions are embedded into capped pricing from mid-2026, the consequences will be long-lasting

**A key structural reform to explicitly fund practitioner travel and ancillary costs to support sustainable, equitable home-based service delivery is critical.**

This omission is already affecting access across all MMM zones. There has also been significant divergence in the sector as to how indirect costs are billed (rolled up in the hourly service delivery rate or as a separate charge) and therefore captured in reporting.

Current SAH pricing arrangements do not adequately support the delivery of comprehensive, evidence-based allied health services. Unless addressed, these deficiencies will become entrenched under the proposed capped pricing framework, with adverse consequences for consumer outcomes, system sustainability, and downstream health costs.

Pricing that fails to account for travel, variable service intensity, subcontracting, workforce and supervision costs, and regulatory and compliance obligations risks making service delivery financially unsustainable.

The burden falls disproportionately on small providers, sole practitioners and regional services, whose exit from the market would erode access to essential allied health supports, weaken multidisciplinary care, and compromise preventive and reablement-focused interventions in the home.

**A key structural reform to ensure that physiotherapy is appropriately valued and priced within SAH must be undertaken if SAH is to have capacity to absorb CHSP recipients.**

The introduction of capped pricing, if based on existing cost structures, risks formalising current underinvestment in physiotherapy.

## Compliance and operational duplication

There is considerable duplication and administrative burden placed on Ahpra-registered physiotherapists in the SAH program resulting from new compliance activities under the Aged Care Rules including worker screening and record keeping.

Associate providers are currently required to adapt to multiple registered provider portals and repeatedly submit screening documentation and other compliance documentation, undertake training for each register provider they are contracted to and adjust to the variance in reporting and invoicing requirements among registered providers.

This repetition impacts workforce sustainability due to the significant operational burden.

**CHSP transition planning must include addressing the considerable duplication and administrative burden on Ahpra-regulated physiotherapists to repeatedly meet worker screening, personal information and record keeping requirements before CHSP service providers transition to SAH or risk smaller providers exiting the program.**

## Multi-provider environment

The APA supports a multi-provider SAH environment that enables:

- Older people to access directly contracted allied health providers, rather than receiving allied health through a lead provider that subcontracts services;
- Small practices and sole traders, regional and rural providers, discipline-specific services, culturally and linguistically diverse providers and Aboriginal Community Controlled Health Services
- Physiotherapists to operate within their full scope of practice, supporting clinical autonomy and professional standards.

**CHSP operates under a multi-provider environment with uncapped pricing flexibility that supports a diverse provider market. It is critical that a transition of CHSP to SAH occurs once a multi-provider environment has been embedded and tested in SAH to ensure an operationally smooth transition.**

## Prevention

In policy terms, CHSP is framed as a “maintenance and prevention” program, sitting between informal/community supports, and more structured, higher-cost in-home aged care programs.

CHSP offers a high-value, low-cost intervention layer that supports ageing in place and delays progression to more resource-intensive care.

In this context, physiotherapists deliver interventions that:

- Maintain mobility, strength, balance and endurance;
- Reduce falls risk and prevent deconditioning; and
- Support joint health, pain management and continence.

International and domestic evidence consistently shows that removing preventative tiers increases downstream costs.

**The APA is concerned the transition of CHSP to SAH will remove a critical layer in the aged care continuum that provides early intervention, preventative care in individual and group settings, accelerating demand for higher-cost care.**

We urge the Committee to ensure cost-saving, person-centred reablement and early intervention is not lost in the transition.

One key example of the efficacy of early intervention is in falls prevention. Despite the clinical and cost effectiveness of physiotherapy-led exercise in preventing falls long established through high certainty evidence, and supported by the Australian Commission for Safety and Quality in Health Care Falls Prevention Guidelines<sup>5</sup> falls prevention has not been prioritised in recent reforms.

**There is an urgent need for system-led investment in falls prevention through timely access to physiotherapy interventions. The APA recommends establishing a nationally funded falls prevention pathway across health and aged care.**

Evidence-based 12-week physiotherapy-led falls prevention must be funded in addition to existing Restorative Care Pathway funding within SAH. Further, group community programs delivered by physiotherapists via Primary Health Networks (PHNs) via a nationally consistent model is critical for those who are unable to access to SAH.

## Restorative Care Pathway

Despite solid policy intentions, the Restorative Care Pathway (RCP) is constrained by fixed duration, capped funding, and poor continuity, resulting in a program that delivers time-limited activity rather than needs-based reablement.

Reablement is rationed by program rules rather than individual capacity to benefit. Funding is not aligned to reablement intensity and eligibility is administratively constrained.

**The SAH Restorative Care Pathway must be extended and expanded by increasing eligibility, budgets, duration and the number of available packages to enable genuine needs-based reablement and SAH capacity to absorb CHSP recipients during transition.**

## Other elements of the CHSP transition

### Specialised service supports (SSS)

Specialised service supports, including continence and dementia advisory services, have been extended until 30 June 2026 and are required to map their services to allied health, where possible. We understand some specialised support services may be grant funded and therefore unable to conduct mapping to allied health services. We call for a better understanding of how these vital services link to physiotherapy care provision – and that they are better supported to do so.

SSS is not currently integrated into the new in-home aged care service list under the Aged Care Act 2024, so it is temporarily extended while the Department consults with providers on how those services can be remapped or otherwise funded beyond 2026.

**The Australian Physiotherapy Association must be consulted on the transition of SSS to ensure understanding of how SSS supports access to critical allied physiotherapy and identify improvements.**

### Sector Support Development (SSD)

An extension to 30 June 2026 has also been granted to transitioning SSD. Sector Support and Development under the CHSP refers to non-service delivery activities that help strengthen the capability, capacity and performance of service providers and the broader CHSP sector. It is being used to support providers through these reform processes, including service mapping, data reporting changes and future

system design work. This activity is also extended for 12 months to allow for consultation and development of a proposed new in-home sector support system.<sup>6</sup>

**We call for the APA to be consulted throughout this process to ensure current associate providers and physiotherapy service providers entering the future multi-provider environment are supported.**

## References

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- <sup>1</sup> HOME CARE PACKAGES PROGRAM Data Report 1st Quarter 2025-26
- <sup>2</sup> Department of Health, Disability and Ageing given in evidence to the Senate Community Affairs Legislation Committee on 7 October 2025
- <sup>3</sup> Productivity Commission, 2026 Report on Government Services (RoGS)
- <sup>4</sup> Report on Government Services 2025 Community services (part F), Steering Committee for Review of Government Services
- <sup>5</sup> Australian Commission on Safety and Quality in Health Care. Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Community Care in Australia. Sydney; ACSQHC, 2025
- <sup>6</sup> <https://www.health.gov.au/resources/webinars/commonwealth-home-support-programme-2025-27-extension-and-reforms-update-webinar>