THE AUSTRALIAN ORTHOTIC PROSTHETIC ASSOCIATION

14 March 2025

Office of the Inspector-General of Aged Care
Reply Paid 83426
Woden ACT 2606
Email: royalcommission@igac.gov.au

Dear Inspector-General,

RE: Submission to contribute to 2025 progress report on the Australian Government's implementation of the Age Care Royal Commission Recommendations 35 & 36.

The Australian Orthotic Prosthetic Association (AOPA) would like to highlight that the **exclusion of Orthotists and Prosthetists, plus the exclusion of lower limb orthoses from the Support at Home Program** to be introduced on 1 July 2025 will lead to unintended consequences including loss of independence and premature admission to residential aged care facilities for older Australians.

AOPA recommends that:

1. **Orthotists and prosthetists be added in the new Support at Home service list, with Allied health and other therapeutic services.**
2. **The list of lower limb orthoses in the new Assistive Technology and Home Modifications List be more comprehensive to ensure accessibility for older Australians with post-polio syndrome and other disabilities where the trajectory is impacted by ageing.**

Orthotist/prosthetists are university qualified allied health professionals that assess the physical and functional limitations of people resulting from disease, illness, trauma and disability, including limb amputation, and neuromuscular conditions, such as stroke. Orthotic and prosthetic services may involve the provision of orthoses and prostheses to restore function, prevent deterioration, and improve quality of life.

The new Support at Home service list and the new Assistive Technology and Home Modifications List (AT-HM list) released late last year are not aligned. The new AT-HM list includes upper limb orthoses and lower limb orthoses, yet Certified Orthotists are not listed as allied health to deliver services in the new Support at Home service list.

Furthermore, the current Home Care Packages Program Operational Manual clearly states that people with post-polio syndrome will be supported through the scheme. This is not aligned with the new AT-HM list as many relevant lower limb orthoses such as a full-leg Knee Ankle Foot Orthosis (KAFO) often required by older Australians with this condition are excluded.

Additionally, the suggestion that access to lower limb orthoses can be obtained through other schemes such as state-based equipment initiatives is incorrect. Funding through state and territory equipment schemes is minimal leading to substantial out-of-pocket expense for older Australians. We have provided case examples of older Australians who have post-polio syndrome and are likely to end up in high care facilities because access to assistive technology such as a KAFO under the new policy will be prohibitive.

AOPA has requested engagement with government officials to discuss these issues on several occasions but to date have been unsuccessful. The following provides more detail of AOPA's attempt to engage:

- Letter to the Director of Support at Home, Rowena Sierant on 18 December 2024 – no response received
- Accompanying Allied Health Professions Australia to a consultation in 12 February 2025 – AOPA's inclusion was declined
- Letter to the Minister for Aged Care, The Hon. Anika Wells MP, 20 February 2025 – correspondence acknowledge but no further communication.

AOPA would welcome the opportunity to present or provide further information. Please contact our Policy, Advocacy and Research Manager, Judy Powell advocacy@aopa.org.au

Yours sincerely,

Jessica Landers
Chief Executive Officer
Australian Orthotic Prosthetic Association

Case Study One: Frank

Frank is a 73-year-old man who lives with his wife in his house in southeast metropolitan Melbourne.

In 1956 at the age of four whilst living with his migrant parents in Albert Park Melbourne, Frank contracted Polio which resulted in severe paralysis (muscle loss) in his right leg and partial paralysis (muscle loss) in his left leg. The paralysis in his right leg has left him with the inability to keep this leg in the locked position so that he could walk. The Polio has left him with his right leg about 3 inches shorter than his left leg. He also has severe scoliosis of the spine. As part of his initial recovery in 1956 he was assessed as needing a full-leg Knee Ankle Foot Orthosis (KAFO) so that he could walk and has continued to use a KAFO continually up to this day. He was also assessed as requiring a pair of forearm crutches to assist him in his mobility. Frank also suffers Post Polio Syndrome (PPS).

Since being able to access the orthosis and crutches, Frank has been gainfully employed until his retirement and has been able to participate in most normal day to day activities including but not limited to shopping, gardening, swimming, some home maintenance and attending social outings.

The recent changes and exclusion of O & P practitioners from the Support at Home Program means that Frank can no longer be assessed by a professional and access these supports.

His orthoses require continuous maintenance and will need to be replaced in the not-too-distant future. He was planning to use his Support at Home Program funding this year for this purpose. In the past he has applied to other schemes such as the State-wide Equipment Program (SWEP) for funding for his orthoses; however, SWEP will only contribute about $2,000 whereas a new KFO will cost around $8,000. Without his orthoses Frank will be **unable to walk** which would mean **significant** additional need for personal care services for household activities and mobility issues. As a result, he would require the use of a wheelchair to carry out even the most basic daily functions which in turn would require his house to be substantially modified and if those necessary modifications are unaffordable or are structurally inappropriate then Frank would most likely end up in a nursing home.

This case demonstrates that the change to the current Support at Home Program will result in much higher costs to the government than simply providing funding for assessment and replacement of a KAFO.

Case Study Two: John

John is an 83-year-old man who lives independently in his unit in the eastern suburbs of Melbourne.

Due to Poliomyelitis as an infant and Post-Polio Syndrome (PPS) later in life, he was assessed for orthoses. He required a full-leg Knee Ankle Foot Orthosis (KAFO) on the Right, and originally a half-leg Ankle Foot Orthosis (AFO) on the Left. Due to the progressive nature of PPS, John required increased support and now wears a full length KAFO on the Left to reduce pain, decrease the need for ongoing therapy, improve mobility and enhance his quality of life.

Since being able to access the orthoses, John has returned to work and to be active in his community. Socially, he participates in three choirs and square dance (wheelchair) each week, engages as a part time actor and is on the committee of a community music club. John drives himself and neighbours to medical appointments as required and for 4 months of the year (Jul-Oct inclusive) he is employed full time as a taxation consultant. He not only uses his skills and knowledge for gainful employment but contributes as a community representative on the ‘North East Link Project’. The orthoses provided allow John to get to his place of work and other activities.

The proposed changes and exclusion of O & P practitioners and Lower Limb Orthotic Devices from the Support at Home Program means that John can no longer be assessed by a professional and access these supports. The state-based subsidy scheme only provides approximately 15% of the cost of a KAFO, and he is only able to access this subsidy if he agrees to pay out of pocket costs of approximately $14000.

His Right KAFO needs to be replaced, and he was planning to use his Support at Home Program funding this year for this purpose. In the past he has applied to other schemes such as SWEP and provided private funds to pay for his orthosis, but he is now reliant on the full pension and hoping to use the Home Care Package Funding. Without his orthosis John will have additional need for personal care services for household activities and his need for therapy is likely to increase due to pain and mobility issues.

Case Study Three: Gwen

Gwen has post-polio syndrome. Her condition associated with this diagnosis is impacted by ageing. This has left Gwen with great difficulty in mobilising independently. She relies on her knee ankle foot orthosis (KAFO) to safely move around her house and in the community. Without this KAFO, Gwen would live a sedentary life and rely heavily on care supports.

It is most appropriate that Gwen has access to her orthosis and wrap-around clinical services from her home care package. Although Gwen must save her funds up before she has enough to engage an orthotist, she is still able to do so without out-of-pocket expenses. This year Gwen had enough money to replace her decade-old KAFO. She saw certified orthotist/prosthetist Paul, who assessed her changing mobility and functional needs, took a cast of her leg, manufactured the KAFO, provided the orthosis to Gwen and ensured it was comfortable and fit for purpose over several appointments. Gwen now has a brand new KAFO that is lighter than her previous one, making ambulation and mobility easier.

Gwen can no longer afford her orthosis and wrap-around clinical services. This is because Gwen's only option is to engage with her state equipment program. She lives in Victoria which has one of the more comprehensive state equipment schemes – she would have to pay for her assessment out of pocket, but part of her KAFO would be subsidised (approximately 15% of the cost of the actual device, meaning Gwen now must source approximately $15 000 for the remainder of her KAFO cost). One fitting and one review appointment would also be covered by her state equipment scheme, but Gwen would be forced to pay for ongoing orthotic services out of pocket. Gwen cannot afford this. As a result, she would have to go without her KAFO, forcing her into a sedentary lifestyle with higher care and support needs. These needs would be more costly than her KAFO and orthotic services and would be funded by the Australian Government.