

Support at home program Inquiry July 2026



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Contents

About Limbs 4 Life	3
Amputee population and impact of amputation	3
Amputation recovery and rehabilitation	4
Consultation process	4
1.The ability for older Australians to access services to live safely and with dignity at home.	4
2. Thin markets including those from geographical remoteness and population size	7
3. The impact of co-payment contributions for independent services and everyday living services on the financial security and wellbeing of older Australians	8
Recommendations:.....	8

About Limbs 4 Life

Limbs 4 Life has been operating in the disability sector for more than 20 years and is the peak body for people with limb loss in Australia. The organisation works to empower amputees through education, knowledge and support. Limbs 4 Life builds community connections among stakeholders ensuring that people and their families do not go through amputation alone; Limbs 4 Life works to ensure that people pre or post amputation have access to the Limbs 4 Life evidence-based best practice peer support program, along with the provision of resources and current health literacy to assist them to transition back to independent living.

Limbs 4 Life's mission is to provide information and support to amputees and their families while promoting an inclusive community. Our philosophy is to empower amputees with knowledge and support to make a real difference, because no one should go through limb loss alone.

Limbs 4 Life provides services to thousands of amputees and their care givers, who rely on its programs and support for assistance prior to, or after amputation. Limbs 4 Life is supported by over 210 trained Peer Support Volunteers, is governed by a voluntary board of management and is operated by staff with a majority representation from those with lived experience of amputation. Since its formation, Limbs 4 Life has greatly extended the supports available to amputees, their families, primary care givers and healthcare staff.

Limbs 4 Life's services include provision of:

- Best practice Amputee Peer Support Programs;
- Evidence-based health literacy resources and wellbeing information;
- Independent support and advocacy to assist people to navigate healthcare and disability systems and pathways;
- Access to social and economic inclusion activities; and,
- Educational workshops to assist people to develop self-confidence, regain self-esteem and learn skills to self-advocate.

Limbs 4 Life advocates for amputees by initiating or participating in research, providing advice and recommendations to government, responding to submissions, and educating the community about amputation and the impact of limb loss.

Amputee population and impact of amputation

Of the 160,395¹ people who have undergone amputation in Australia, it is conservatively estimated that more than 42,000 are living with major limb loss and are potential prosthetic users.

The main causes of amputation include diabetes, vascular disease, cancer, infection, birth deficiencies and traumatic related injuries. Notably, Australia has an appalling record when it comes to diabetic-related amputations increasing by 30 per cent in the past decade and resulting in our country having the second highest rate of preventable diabetic related amputations in the developed world².

¹ KPMG Socio-economic burden of limb loss in Australia 2021

² <https://www.mja.com.au/journal/2018/diabetic-foot-amputations-finally-time-act>
Support at Home Program Inquiry

Scientific literature reports that over the past few decades the amputee community has identified problems with the function and comfort of their prosthetic products³, as well as challenges with patient-prosthetist communication, and that these issues compromise amputee choice and control, limit independence and contribute to prosthetic abandonment for 1 in 5 amputees.⁴

Amputation recovery and rehabilitation

The loss of a limb is considered a major health and disability event which can impact on a person's functionality, mobility, independence and mental health. Following an amputation and acquiring this physical disability, restoring functionality and daily living abilities, reducing dependency on others, increasing mobility and optimising a person's quality of life and satisfaction, are key rehabilitation and disability adjustment goals.

People who undergo amputation spend a period of time in acute hospital settings recovering from the surgery, after which, in most cases, they are transferred to sub-acute rehabilitation facilities to learn to adjust to the loss of a limb/s. Rehabilitation involves a multidisciplinary healthcare team to support amputees build capacity and to learn how to:

- ambulate safely;
- regain functionality, mobility and balance;
- use a wheelchair and/or other mobility aids, and upper limb solutions (assistive technology);
- overcome fears;
- prepare for the fitting of a prosthesis; and,
- plan for re-entry into the community.

With respect to lower limb amputations, it is estimated that recovery post-amputation occurs over a 12 to 18 month period and is inclusive of activity recovery, reintegration into society, and prosthetic training and management. It is also during this period that amputees seek funding supports, particularly the NDIS, to facilitate independence, support needs, community engagement and socioeconomic participation.

Consultation process

1. The ability for older Australians to access services to live safely and with dignity at home.

The federal government wants older Australians to live independently at home for longer, however many of the systems and supports to enhance this are not meeting their need to do so.

People with major lower limb amputations (below or above the knee) require suitable prosthetics to enable them to ambulate safely in their community and at home, however these devices are not forthcoming, in fact pale in comparison to those lower limb amputees funded by the National Disability Insurance Scheme (NDIS) and/or workplace/transport accident insurance providers.

All Australians over the age of 65 (who are not NDIS eligible) are funded for prosthetics via state/territory-based limb schemes. These schemes in most cases do not reflect the same or even similar levels of funding granted to amputees on the NDIS. The prosthetic componentry is basic to say the least, in fact funding

³ Hagberg and Brånemark 2001, Pezzin, Dillingham et al. 2004

⁴ Laskovy, Long et al. 2023

provided by the state artificial limb schemes rarely increases in line with the consumer price index (CPI). For example: data from the Australian Institute of Health and Welfare (AIHA) shows vascular surgery (most linked to amputations) increased by 14%, compared with 2022-23⁵.

This is in contrast with the 2.37% to 2.5% increase in the VALP budget during the same period, suggesting the funding model is not meeting the basic growth in hospital admissions.

A clinical study used the Australasian Vascular Audit and found that total amputations in Victoria increased by 4.3% during the pandemic period, with a significant 19% increase in major amputations (above-knee and below-knee)⁶.

Older Australians who live with limb loss are amputees do not have access to the vital and complex prosthetic technology which serves to prevent falls, increase confidence, promote physical endurance and prevent mental fatigue.

Standard prosthetic feet (carbon fibre / carbon composite) average at a cost of \$5K. These kinds of prosthetic feet promote energy efficiency and return for the end-user, supporting physical endurance and mental capacity. The current Solid Ankle Cushion Heel (SACH) feet (suitable for Mobility 1 grade ambulators or water/shower prosthetics) have no movable parts, don't support ambulation on uneven terrains, and can negatively impact hips, knees, back and pelvis due to the abnormal walking method required for use.

SACH feet provide no energy return and are exhaustive to use. Energy storing feet are generally preferred as they provide improvements in step length and are designed to replicate human movement. Energy storing and return (ESAR) feet are generally preferred over solid ankle cushioned heel (SACH) feet by people with a lower limb amputation⁷. While ESAR feet have been shown to have only limited effect on gait economy, other functional benefits should account for this preference.

Further, evidence highlights that energy restoring feet supports mobility on uneven terrain and supports whole of body biomechanics when walking on slopes or level ground⁸.

Given the advances in prosthetic technology, it is disappointing that most state artificial limb administrators do not fund access to microprocessor knees (MPK's). MPK's should be added to each state and territory's componentry list, and, given the benefits of these devices, an increase in state/territory budgets should provide access to these knee units.

There are multiple studies and research papers which outline the economic benefits for the provision of microprocessor knees in people with above knee amputations⁹. It is worth noting that there are people 65 years and older who would still like to work; gain meaningful employment and contribute to the economy;

⁵ <https://www.aihw.gov.au/news-media/media-releases/2024/december/number-of-patients-undergoing-elective-surgery-in-australia-s-public-hospitals-highest-on-record>

⁶ <https://www.dovepress.com/article/download/88923>

⁷ Houdijk H, Wezenberg D, Hak L, Cutti AG. Energy storing and return prosthetic feet improve step length symmetry while preserving margins of stability in persons with transtibial amputation. *J Neuroeng Rehabil*. 2018 Sep 5;15(Suppl 1):76. doi: 10.1186/s12984-018-0404-9. PMID: 30255807; PMCID: PMC6157252.

⁸ Childers, W.L., Takahashi, K.Z. Increasing prosthetic foot energy return affects whole-body mechanics during walking on level ground and slopes. *Sci Rep* 8, 5354 (2018). <https://doi.org/10.1038/s41598-018-23705-8>

⁹ Christine Chen¹, Mark Hanson¹, Ritika Chaturvedi², Soeren Mattke³, Richard Hillestad¹ and Harry H. Liu^{3*} From Second World Congress hosted by the American Orthotic & Prosthetic Association (AOPA) Las Vegas, NV, USA. 06-09 September 2017

and, remain independent at home without being a burden on the government or society¹⁰. However, this is near impossible to do on a mechanical knee. Mechanical knees provide minimal safety and can be a falls risk¹¹. Moreover, mechanical knees are physically and mentally exhausting to use. In addition, evidence outlines that the provision of MPKs reduces the risk of falls, and improves confidence, and in turn reduces the cost of hospital admissions and rehabilitation stays and some home supports. Studies also suggest that MPK's promote greater confidence in the individual which in turn leads to better quality of life-based outcomes^{12 13}.

The Australian Institute of Health and Welfare (AIHW) reports that falls are the leading cause of injury-based hospitalisations and in 2023–24, fall injuries are estimated to have cost the health system over \$5 billion¹⁴. With approximately 400 older Australians hospitalised every day, falls represent the leading cause of injury-related hospital admissions and deaths nationwide, creating a massive economic and personal burden.

Unlike private prosthetic providers who have overheads to run their businesses, public facilities are not burdened with additional costs, as such, microprocessor knees could be funded for a mere 40 – 50K (depending on the device) and that device would be viable for five to six years. The investment in these knee units is minimal when compared to the costs of falls to the health department.

Nationally, falls carry a massive economic and personal toll. Older Australians require about 1.26 million hospital bed days each year due to falls, with an average length of stay of 9.5 days¹⁵.

Peter is 78 years of age, an above knee amputee residing in Queensland. Peter has worked his entire life as a nurse and is extremely active. Peter also cares for his ageing mother.

Peter is increasingly at risk of falls. He lives independently and his risk of falls has increased in the last two years. Peter's prosthetic clinician has made multiple requests (including evidence of trials) for Peter to gain access to a microprocessor knee so that he can continue to safely live alone. Unfortunately, the Queensland Artificial Limb Scheme will not grant Peter approval for the knee which would assist in fall prevention and continue to enable him to live independently.

Given the data and the burden on the National Health system, surely the provision of MPK's would be an investment both economically for each state/territory and for those currently living with above knee

¹⁰ A microprocessor controlled prosthetic knee compared to non-microprocessor controlled knee in individuals over 65 in Sweden: A Cost effectiveness and budget impact analysis. Kuhlmann A,¹ Hagberg K,² Kamrad I,³ Ramstrand N,⁴ Seidinger S,⁵ Berg H⁶ 1Leibniz Universität Hannover, Hannover, Germany, 2Sahlgrenska University Hospital, Gothenburg, Sweden, 3Skåne University Hospital, Malmö, Sweden, 4School of Health and Welfare Jönköping University, Jönköping, Sweden, 5Otto Bock Helathcare Products GmbH, Vienna, 9, Austria, 6Karolinska University Hospital, Stockholm, Sweden Objectives: Growing evidence suggests that individuals with transfemoral who use a microprocessor knee benefit from enhanced safety.

¹¹ Enhancement of a prosthetic knee with a microprocessor-controlled gait phase switch reduces falls and improves balance confidence and gait speed in community ambulators with unilateral transfemoral amputation. Prosthet Orthot Int. 2018 Apr;42(2):228-235. doi: 10.1177/0309364617716207. Epub 2017 Jul 9. PMID: 28691574; PMCID: PMC5888771.

¹² Enhancement of a prosthetic knee with a microprocessor-controlled gait phase switch reduces falls and improves balance confidence and gait speed in community ambulators with unilateral transfemoral amputation. Prosthet Orthot Int. 2018 Apr;42(2):228-235. doi: 10.1177/0309364617716207. Epub 2017 Jul 9. PMID: 28691574; PMCID: PMC5888771.

¹³ Effects of microprocessor-controlled prosthetic knees on self-reported mobility, quality of life, and psychological states in patients with transfemoral amputations. Acta Orthop Traumatol Turc. 2020 Sep;54(5):502-506. doi: 10.5152/j.aott.2020.19269. PMID: 33155559; PMCID: PMC7646606.

¹⁴ Australian Institute of Health and Welfare 25 November 2025, <https://www.aihw.gov.au/reports/injury/falls>

¹⁵ <https://www.ovid.com/journals/ajag/abstract/10.1111/ajag.13157~the-rising-cost-of-falls-health-researchers-are-calling-for?redirectionsource=fulltextview>

amputations. In addition, it would resolve the huge disparity of funding between people supported by the National Disability Insurance Scheme and those, who are discriminated against due to their age. The Productivity Commission when reviewing viability and fairness, highlighted that funding for people with disabilities was a postcode lottery, based on haves and have nots. The current system which is supposed to support older Australians does not even meet a below benchmark standard.

Similarly, people with upper limb loss (arms – above/below the elbow) are burdened with basic body powered prosthetics or myo-basic prosthetic arms. Myo-basic arms are often very heavy and contribute very little to functionality. Long term use impact, neck, shoulder and back strain. Upper limb prosthetic technology has advanced significantly in recent years and access to light weight technology would result in greater functional outcomes.

It is evident that people over 65 years of age are not having their inalienable human rights realised. Article 20 on the United National Convention on the Rights of People with Disability Personal Mobility:¹⁶:

*State Parties shall take effective measures to ensure personal mobility **with the greatest possible independence** for persons with disabilities, including by:*

a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;

*b) Facilitating access by persons with disabilities **to quality mobility aids**, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;*

c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;

2. Thin markets including those from geographical remoteness and population size

With the exception of amputees who reside in Queensland and New South Wales, amputees in other states and territories cannot select a provider of their choice. People who are over 65 and live outside of those states are bound by their state health departments as to which providers they have access to.

This impacts many older people in various ways:

- a) They cannot see the clinician they wish to see.
- b) Some people are required to travel for hours for an appointment even when there is a prosthetic clinician 10 minutes from their home
- c) They have little or no say in regard to their choice of prosthetic device as significant funding restrictions apply.

Carol, a 74 year old below knee amputee has resided in Shepparton for most of her life. Each time Carol needs a modification to her prosthesis Carol must travel to Bendigo (121 kms – approximately 1.30 hours, one way) from Shepparton to access prosthetic services. Carol has a prosthetic clinic 12 minutes from her home; however if Carol choses to see the local provider she needs to pay all costs out of pocket.

As Carol ages the impact of these trips becomes tiresome and hazardous. Carol can often be away from home for up to five hours on the days that she needs to travel to Bendigo.

¹⁶ <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-20-personal-mobility.html>

Creating an open market model would reduce wait times in the public system and ease the burden on people who are required to travel to see a clinician. In addition, these people are not only discriminated against due to their age, they are also burdened with costs associated with travel, fuel or otherwise.

3. The impact of co-payment contributions for independent services and everyday living services on the financial security and wellbeing of older Australians

When participants are funded by schemes such as the NDIS without any out-of-pocket costs, why should older people be burdened by co-payment contributions. Often older people are unable to work, therefore their ability to attain an income is very difficult. As such, why should older Australians need to contribute to co-payments when other disabled members of the community do not.

People who are disabled and funded by schemes including the NDIS do not incur out-of-pocket costs for the equipment and support that they need. Why should older people who are disabled and ineligible for fair and equitable funding be burdened with co-payment contributions? Older people are often unable to attain an income, making them even more vulnerable and inequity more pronounced.

Recommendations:

1. Create an open market whereby older Australian's living with amputations (limb loss) can see the provider of their choice. Remove state/territory limitations.
2. Disband the state-based prosthetic funding models and create one national scheme for the supply, fit and manufacture for prosthetic limbs in Australia for people over 65. A national scheme would significantly reduce administration costs which could further support an increase in the standard of prosthetic devices being fitted to older amputee Australian's.
3. Provide access to energy restoring feet, microprocessor knee units and advanced myo-electric upper limb prostheses by way of standard prescription, in line with devices which are accessible to National Disability Insurance Scheme participants.
4. Publish state and territory financials and data relating to the artificial limb scheme. Public funding should be transparent.
5. Remove the restrictions placed on placed on home care packages whereby unspent funds (on a quarterly basis) are retained by government. Older people should have the opportunity to utilise those funds on additional assistive technology as required regardless of whether they are co-contributing to the package or not.