Submission

Review of Aged Care Rules

Via email to 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.

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 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.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Table of Contents

1. EXECUTIVE SUMMARY 5

2. THE ROLE OF PHYSIOTHERAPY IN AGED CARE 6

3. KEY ISSUES IMPACTING PROVISION AND QUALITY OF HOME CARE PHYSIOTHERAPY SERVICES WITHIN THE AGED CARE RULES 6

4.1 Support at Home Pricing Framework (chapter 4) 6

4.2 Aged Care Quality Standards (section 15) 8

4.3 Worker screening (sections 141, 154 and 379) 9

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

1. Executive Summary

The Australian Physiotherapy Association (APA) welcomes the opportunity to provide feedback to the Senate Standing Committee on Community Affairs Review of the Aged Care Rules (the Rules).

For the purposes of this submission, the APA has not sought to provide commentary on each individual rule or clause. Instead, our response focuses on a set of overarching issues that we consider to be material to the effective design, implementation and operation of aged care reforms.

These issues are:

- Addressing the devaluation of physiotherapy in the current Support at Home Pricing framework
- Inconsistent application of Strengthened Aged Care Standard 3 (Clinical Care) across settings under the Rules; and
- Duplication of worker screening and compliance requirements for Ahpra-registered healthcare professionals, including physiotherapists.

This approach is intended to avoid unnecessary duplication, concentrate on matters of greatest systemic impact, and provide constructive, principle-based feedback that can inform refinement of the rules as a whole.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

2. The role of physiotherapy in aged care

The APA represents more than 35,000 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 are trained and qualified to diagnose deterioration in overall health including arthritis, pain, cardiorespiratory, vestibular and neurological conditions.

3. Key issues impacting provision and quality of home care physiotherapy services within the Aged Care Rules

4.1 Support at Home Pricing Framework (chapter 4)

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 most significant concern regarding pricing is the devaluation of the physiotherapy profession under Indicative Pricing and the rigour and lack of transparency about the methodology to develop the pricing ranges outlined within it that the support at sector is using to guide physiotherapy service fees.

Our concerns are further amplified by the role that Indicative Pricing is expected to play in shaping future price caps. Existing data collection and costing methodologies used by IHACPA provide limited insight into the nature, complexity and cost of allied health services delivered in home settings and are largely driven by available service data rather than clinically assessed need.

As indicative prices are used to inform advice to Government - and potentially form the foundation for capped pricing from mid-2026—there is a risk that early, insufficient pricing assumptions will be embedded over time.

The APA welcomed the introduction of the indirect and indirect fee mechanism introduced under the Support at Home program. However, this reform failed to include a mechanism to transparently and accurately fund practitioner travel costs—a significant omission that is having consequences on access to services 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 Support at Home pricing arrangements do not adequately support the delivery of comprehensive, evidence-based allied health services. Unless addressed, these structural deficiencies risk being

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 the full range of allied health practice realities—including travel requirements, variable service intensity, subcontracting arrangements, workforce and supervision costs, and regulatory and compliance obligations—risks making service delivery financially unsustainable. These pressures are most pronounced for small providers, sole practitioners and regional services, whose withdrawal from the market would reduce access to essential allied health supports, weaken multidisciplinary care, and undermine the delivery of preventive and reablement-focused interventions in the home.

In this context, inadequate pricing poses a direct threat to workforce sustainability, service continuity, and the health, safety and functional independence of older people.

Home aged care pricing has historically been constructed around task-based personal care and domestic assistance, rather than multidisciplinary, preventative, and rehabilitative models of care. Allied health services—such as physiotherapy, occupational therapy, speech pathology, dietetics, and podiatry—are treated as discretionary or episodic add-ons rather than core components of care for people with increasing frailty, multimorbidity, and functional decline.

Current pricing settings provide weak or perverse incentives, favouring short-duration, low-cost services over clinically appropriate care. This undermines best-practice models that rely on:

- comprehensive assessment;
- goal-oriented care planning,
- regular review and progression; and
- collaboration with medical and nursing providers.

Physiotherapy services are cost-intensive due to professional training requirements, regulatory obligations, and the need for travel and non-face-to-face time in home-based care. Current pricing often fails to cover these costs, resulting in:

- limited availability of allied health within packages,
- inequitable access based on geography or provider mix, and
- increasing reliance on reactive rather than preventative care.

This disproportionately affects people with complex needs who would benefit most from allied health intervention.

The introduction of capped pricing, if based on existing cost structures, risks formalising current underinvestment in physiotherapy. Capped prices that do not explicitly account for allied health complexity and value will:

Failure to adequately price physiotherapy in home care has broader system consequences, including:

- increased falls, functional decline, and preventable complications;
- higher demand on hospitals, primary care, and residential aged care; and
- reduced capacity to support ageing in place, contrary to stated policy objectives.
- constrain provider flexibility to deliver clinically appropriate services,
- incentivise service substitution away from allied health, and
- limit innovation in multidisciplinary home care models.

Once set, capped prices will be difficult to recalibrate, locking in suboptimal care patterns for years.

Without appropriate price recognition, providers are disincentivised from investing in physiotherapy capability, workforce development, and integrated care models.

As a result, pricing fails to reflect:

- the intensity, duration, and continuity required for clinically effective physiotherapy interventions; and

- the role of physiotherapy in maintaining function, preventing deterioration, and reducing avoidable hospitalisation and residential care entry.

Home aged care pricing must be reoriented to recognise physiotherapy as a core, not optional, component of contemporary aged care. This requires:

- explicit inclusion of physiotherapy cost drivers in pricing models,
- alignment with clinical best practice and preventative care objectives, and
- safeguards within capped pricing to ensure access to comprehensive, multidisciplinary services.

Without reform, current pricing deficiencies will be embedded and amplified under capped pricing, undermining care quality, consumer outcomes, and long-term system efficiency. Addressing physiotherapy pricing is therefore critical to the success of home aged care reform.

4.2 Aged Care Quality Standards (section 15)

Residential aged care consumers benefit from a comprehensive, enforceable set of standards covering dignity, clinical care, governance, workforce capability, and continuous improvement. When home care is subject to a reduced or modified application of these standards, older people receiving equivalent levels of care in their own homes are afforded weaker protections. This results in inequitable treatment based solely on setting rather than need or risk.

Home care now routinely involves complex clinical interventions, including medication management, wound care, continence management, mobility support, and dementia-related care. Applying a lighter regulatory framework fails to reflect this complexity and increases the risk of:

- suboptimal clinical decision-making,
- fragmented care coordination, and
- preventable adverse events.

In effect, regulatory oversight lags behind the clinical reality of contemporary home care.

Residential aged care providers are subject to robust governance, risk management, and quality assurance obligations. Where these are diluted in home care, providers may operate with less explicit accountability for clinical governance, incident management, and escalation pathways. This can obscure responsibility when failures occur and weaken organisational learning and improvement.

The residential sector is more clearly regulated in relation to workforce qualifications, supervision, and competency. In home care, a less stringent application of standards can result in:

- inconsistent training requirements;
- limited clinical supervision; and
- over-reliance on inadequately supported care workers.

Home environments present unique risks, including social isolation, elder abuse, medication errors, and falls. Without the full application of safeguarding, incident reporting, and consumer rights standards, these risks may go unidentified or unmanaged. The absence of equivalent protections undermines the intent of a consumer-centred aged care system.

Differential standards reinforce silos between residential and home care rather than supporting a continuum of care. This complicates transitions, undermines integrated service models, and creates regulatory confusion for providers operating across multiple settings.

The core problem is not that home care is different from residential care, but that the risk to older people is increasingly similar. Applying a lesser set of standards in home care prioritises setting over safety, leading to inconsistent protections, weakened governance, and avoidable harm.

4.3 Worker screening (sections 141, 154 and 379)

AHPRA-registered health practitioners are subject to a nationally consistent, legislated regulatory framework that includes:

- mandatory criminal history checks at registration and renewal;
- mandatory disclosure obligations;
- ongoing monitoring of conduct, performance, and health;
- immediate notification and investigation of complaints; and
- the power to impose conditions, suspend, or cancel registration.

This regime is continuous, risk-based, and enforceable, and exceeds the scope of aged care worker screening, which is largely point-in-time and employment-focused. This is particularly problematic in a dispersed workforce delivering care in isolation.

Applying aged care worker screening in addition to AHPRA requirements would duplicate:

- criminal history checks,
- suitability assessments, and
- fitness-to-practice considerations.

There is no evidence that duplicative screening improves consumer safety where a robust professional regulator already exists. Instead, it increases administrative burden without commensurate risk mitigation.

AHPRA-registered practitioners are individually accountable for their practice, regardless of setting. They are subject to:

- professional codes of conduct;
- mandatory reporting by peers and employers;
- practice audits and investigations; and
- public sanctions.

This level of individual accountability is not present for unregulated workers, which is precisely why aged care worker screening was designed for that cohort.

Good regulatory design requires that obligations be proportionate to risk and coherent across systems. Imposing aged care worker screening on AHPRA-registered professionals:

- blurs the distinction between regulated and unregulated workforces,
- undermines the integrity of the national registration scheme, and
- creates regulatory inconsistency across health and aged care policy frameworks.

AHPRA registration should be recognised as satisfying, not supplementing, worker screening requirements.

Additional screening requirements risk:

- delaying onboarding and service delivery;
- discouraging clinicians from working in aged care, particularly in home and regional settings; and
- exacerbating existing workforce shortages.

These impacts are systemically significant and counter to policy objectives of improving access to skilled clinical care for older people.

Aged care worker screening requirements should not apply to Ahpra-registered health practitioners given Ahpra registration already provides a comprehensive, continuous, and enforceable suitability and conduct framework. Additional screening would be duplicative, disproportionate, and counterproductive, with no demonstrated improvement in consumer safety.