SUBMISSION

Pricing Framework for Australian Support at Home Aged Care Services 2026-27

Independent Hospital and Aged Care Pricing Authority

Submission by **Australian Physiotherapy Association (APA)**
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Authorised by:

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Table of Contents

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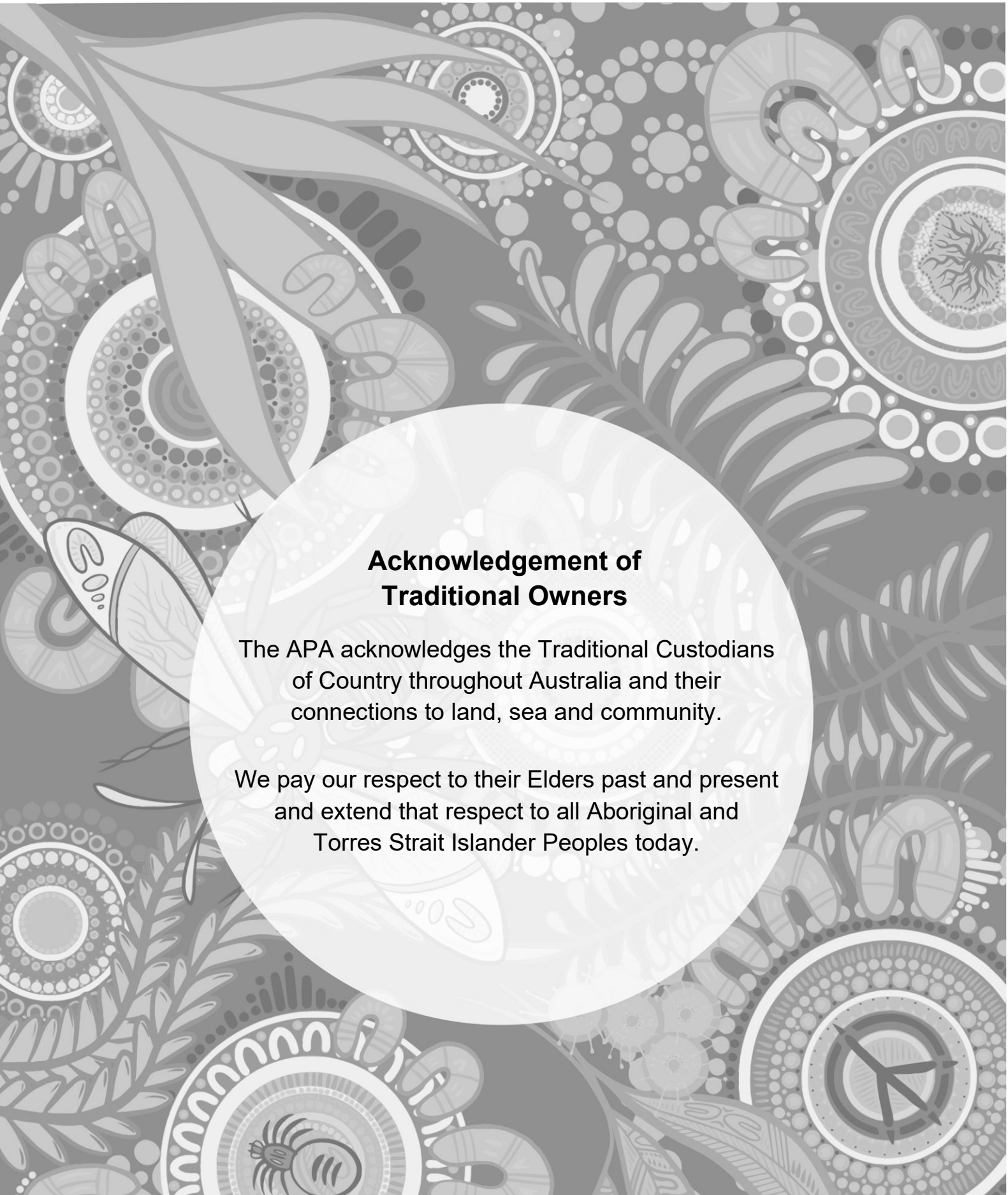

Acknowledgement of Traditional Owners

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 and is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association. Of the potential nine Directors, seven must be financial members of the APA, and up to two may be external, non-physiotherapist Directors.

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 and are committed to embedding cultural safety within the organisation, policy and education programs.

1. Executive Summary

The Australian Physiotherapy Association (APA) welcomes the opportunity to contribute to the Independent Hospital and Aged Care Pricing Authority (IHACPA) Pricing Framework for Australian Support at Home Aged Care Services 2026-27.

This submission reiterates and builds upon the APA's previous contributions to IHACPA on the Support at Home pricing framework and the APA's Support at Home Pricing Framework Reform Brief (Appendix A).

The absence of IHACPA's 2025 pricing report has limited our ability to provide fully informed, evidence-based feedback on the proposed settings, constraining meaningful assessment of the underlying assumptions and cost modelling.

We acknowledge IHACPA's incorporation of several APA recommendations in the framework, including strengthening the Pricing Principles to better reflect quality care through the inclusion of trauma-informed care within the Quality Care and Services principle, and the recognition of quality considerations within the Efficiency principle.

However, we continue to advocate for the introduction of standalone Viability and Reablement principles, consistent with the intent of the Royal Commission into Aged Care Quality and Safety, to ensure the sustainability of providers and the effective delivery of restorative care.

A central concern for the APA is the viability of associated providers operating within brokerage models, which are critical to delivering reablement-focused physiotherapy in home care settings.

This concern is heightened by broader pricing pressures arising from indicative Support at Home pricing, reductions in care management fee caps, and the removal of package management fees, all of which are contributing to downward pressure on service rates that do not reflect the true cost of care.

These pressures are particularly acute in rural, regional and remote areas, where flat-rate pricing fails to account for the additional costs of travel, workforce scarcity, and service delivery in thin markets.

We are also concerned that the current framework does not adequately reflect the complexity of delivering culturally safe care for Aboriginal and Torres Strait Islander peoples, as envisaged by the Royal Commission, including higher chronic disease burden and the need for culturally responsive models of care.

Given these issues, the APA calls on the Commonwealth Government to defer the implementation of capped Support at Home pricing to allow for the release of the full HACPA evidence base and further consultation with physiotherapists and associated providers.

This is necessary to ensure pricing accurately reflects the real costs of delivering safe, high-quality, and sustainable clinical care.

2. Recommendations

Recommendation 1	Ensure pricing structures and package design support brokered physiotherapy services to maintain access, flexibility and market stability.
Recommendation 2	Publish the IHACPA pricing report immediately to ensure transparency and enable informed input from the sector.
Recommendation 3	Announce a 12-month deferral of caps to 1 July 2027, with a January 2027 readiness checkpoint.
Recommendation 4	Review pricing benchmarks and guidance to account for brokered service arrangements, where providers must recover administrative costs within the service price due to capped care management fees and the removal of package management fees.
Recommendation 6	Introduce dedicated funding for travel, parking, hydrotherapy access, and other essential costs tied to in-home and community-based physiotherapy care.
Recommendation 7	Co-design with Aboriginal and Torres Strait Islander organisations and physiotherapists a funding models that reflect the true costs faced by Aboriginal and Torres Strait Islander aged care providers.
Recommendation 8	Introduce Aboriginal and Torres Strait Islander loadings to recognise the additional intensity, duration, community engagement and coordination required to deliver culturally safe care in these communities.
Recommendation 9	Introduce explicit rural, regional and remote loadings to recognise the additional costs associated with service delivery in thin, non-metropolitan markets.
Recommendation 10	Fund telehealth service delivery for rural, regional and remote Australians to overcome geographic access barriers.
Recommendation 12	Introduce interpreter and communication complexity; cultural safety and engagement loading; and outreach/service access loadings for service delivery in diverse cohorts.

3. Pricing framework

Pricing must be recalibrated to reflect the full cost of delivering physiotherapy under Support at Home, ensuring services remain safe, viable, and high quality.

Indicative pricing released by the Australian Government for allied health services under the Support at Home program has been set well below sustainable market rates.

Service delivery units fail to reflect the full scope and complexity of physiotherapy care, placing untenable financial pressure on brokered providers. Independent analysis commissioned by the Australian Physiotherapy Association,[1] supported by sector data from StewartBrown[2] and internal investigations, confirms that the actual cost of physiotherapy service provision significantly exceeds the government's indicative rates. These underpriced signals are already distorting the market and threatening provider viability.

At the same time, administrative arrangements have shifted significantly. Care management fees are now capped at 10 per cent, reduced from 15 per cent under the previous arrangements. Package management fees, which previously funded essential administrative, regulatory and overhead functions, have been removed altogether. With these revenue streams no longer available, registered aged care providers must recover their administrative and non-contact labour costs through other mechanisms. This is resulting in higher direct, indirect and brokered service fees being passed on to clients.

In brokered service arrangements, which dominate physiotherapy delivery, providers are increasingly adding margins to recover lost administration revenue. This places pressure on allied health professionals to lower their fees to remain viable referral partners, further threatening the sustainability of service delivery.

Recent updates to the pricing guidance have confirmed that indirect care costs, including documentation, coordination and service planning, are now billable. This is a critical step forward. However, the broader unit pricing model remains misaligned with service delivery realities.

Physiotherapy services under Support at Home are delivered both in-home and in community settings, often requiring travel time and out-of-pocket expenses such as parking and hydrotherapy pool access. These costs are essential to safe and effective care yet remain unfunded under the current pricing model.

Combined with downward pressure from unsustainable indicative fees and capped administration charges, this omission places significant financial strain on providers and limits access for older Australians, particularly in regional, remote or high-needs settings.

For example, physiotherapy often involves access to hydrotherapy pools, clinical equipment and parking at community venues – none of which are covered under current funding mechanisms. This gap forces providers to absorb costs or pass them on to consumers, creating inequity and reducing access to evidence-based care. Introducing explicit funding mechanisms for travel and ancillary costs is critical to support provider viability and ensure equitable access.

Without this reform, physiotherapy services will continue to be rationed or withdrawn, compromising clinical outcomes and undermining the goals of Support at Home.

Compliance and regulation

The strengthened quality and safety requirements under Support at Home are designed to protect older Australians, but they have also created an unrealistic and increasingly unworkable compliance load for associated providers.

Physiotherapists and other allied health clinicians are repeatedly completing the same onboarding, verification and document checks across multiple brokers and contracting bodies, even when the requirements are identical and add no extra safety value.

This duplication creates heavy administrative overheads, increases operating costs and diverts clinical time away from patient care.

Service demand

The Support at Home Program promotes and champions wellness and reablement via the application of timely and appropriate clinical supports. It presents an opportunity for providers and clients to improve clinical standards and long-term health and wellness outputs.

The APA has received reports from registered providers who estimate their proportionate package usage on clinical care will rise from a current baseline of 3 per cent to between 12-20 per cent under the new model. This significant uptick in demand must be appropriately met by a well, prepared and quality clinical workforce. Pricing must scale at the appropriate pace required to support the industry.

Brokerage model

Protecting the brokerage model is essential to maintain access, flexibility, and consumer choice in physiotherapy under Support at Home. Brokered arrangements currently underpin service delivery, enabling scalable access across diverse settings, particularly for providers not embedded within large organisations.

However, reductions in package and care management fees are increasing administrative burden and financial risk for providers managing multiple service agreements, placing this model under strain.

Without targeted support and structural safeguards, there is a real risk of contraction in brokerage, leading to reduced service availability, longer wait times, and poorer clinical outcomes for older Australians.

Brokerage is an essential and important part of Support of Home enabling demand to be met, supporting a wide range of specialists input; clinical supervision of practitioners; professional experience and pathways knowledge; and established support mechanisms to retain and develop staff.

IHACPA 2025 Pricing Report

The IHACPA 2025 pricing report must be released to restore transparency and support market readiness to future reform, and enable accurate and useful input into future costing studies.

Publishing the report would enable informed decision-making, facilitate meaningful engagement with government and IHACPA, and provide a necessary baseline for interpreting findings from the upcoming 2026 Support at Home costing study.

Without access to the underlying analysis, assumptions, and cost modelling, it is not possible to properly assess the basis for indicative pricing settings or to evaluate their alignment with actual service delivery costs under Support at Home. This lack of transparency limits the capacity for meaningful consultation and constrains the sector's ability to contribute constructively to the development of a sustainable and accurate pricing model.

Capped pricing

The introduction of set prices for Support at Home should be deferred to 1 July 2027 to allow time for publication of the full evidence base, completion of a genuine bottom-up costing process, and meaningful consultation with providers. The current framework has been largely adapted from legacy Home Care Package settings and does not yet fully reflect Support at Home design changes, including revised care management arrangements and the evolving role of provider margins in brokered service delivery. Proceeding to implementation in 2026 without this foundation risks structural pricing misalignment and market instability at launch.

Service delivery methods

Clinical services differ from other services in that they can be delivered in multiple ways – in home, in clinic and via telehealth. For this reason, a single fixed rate across these services does not accurately capture the cost of delivery. Further investigation and pricing development is required.

4. Consultation questions

1. What further strategies or measures could IHACPA implement to simplify and help providers contribute to our cost collections?

IHACPA must ensure ground up consultation with Associated Providers to understand their operating, compliance and clinical service delivery costs and ensure accurate data collection and reporting.

Associated Providers should be given a choice about the level of detail of data capture they can absorb in their operations with simplified templates, focus groups, surveys and APA consultation to enable participation.

Given the detailed and time-consuming nature of accurate data provision, Associated Providers should be assisted and guided in how to provide data efficiently. This could be undertaken through individual bookable guidance sessions, live chat and telephone services and seminars.

Closing the loop in this process is paramount to ensure ongoing refinement and improvement in the quality and consistency of data included into the costing collections in the future.

This includes full transparency and timely release of pricing reports, including sources of data, methodology, assumptions and recommendations.

2. How can IHACPA better support participation in our cost collections (particularly from small providers, providers delivering services for people from Aboriginal and Torres Strait Islander communities, Aboriginal and Torres Strait Islander health practitioner and health worker services, providers delivering services for people with diverse backgrounds and life experiences)?

To better qualify the true cost of service delivery, IHACPA must comprehensively include Associated Provider data in future cost collection studies. This particularly important for clinical services, where the majority of supports are provided through a third-party or associate provider organisation. This will ensure the true cost of service delivery, and its components can be appropriately understood and remunerated.

This methodology would allow IHACPA to ensure both Registered Providers and Associate Providers are operating within a customer facing price point which allows both parties to retain a reasonable and sustainable service delivery margin.

3. What cost pressures and supporting data and evidence should IHACPA consider when developing the pricing approach for the transition of the Commonwealth Home Support Program (CHSP) to the Support at Home program?

In developing pricing for the CHSP transition to Support at Home, IHACPA should:

- Recognise structural cost uplifts associated with moving to a more clinical, individualised, and regulated model;
- Incorporate both direct service cost increases and indirect/system-level costs into the efficient price;
- Use transitional adjustments and loadings where costs are temporary but material;
- Ensure pricing reflects true service-level costs in the absence of block funding cross-subsidies; and
- Closely monitor provider viability and market stability, particularly for small and rural providers.

Failing to account for these factors risks setting prices based on historical CHSP cost structures that are no longer fit for purpose under the Support at Home model, leading to under-provision, reduced participation, and compromised access.

At present, there are significant issues in underspending of allied health through CHSP. One of the key reasons for this is the inability for CHSP providers to outsource services as current price point makes outsourcing non-viable, and presents a situation where CHSP funding goes unspent, despite there being local third-party capacity to support clients.

In transitioning CHSP into Support at Home, we recommend that service rates be aligned to the Support at Home service list and principles, allowing providers to effectively insource or out-source services as per their required needs.

4. Compared to services in metropolitan areas, what cost pressures and supporting data and evidence should IHACPA take into account when considering pricing adjustments for services provided in rural and remote locations?

Physiotherapy service delivery costs are materially higher in regional, remote and very remote areas and require several methods of service delivery to be funded, including telehealth.

Factors that contribute to higher costs include:

- Travel time and cost to provide services (by road, air and sea);
- Freight to remote areas for equipment;
- Accessing allied health assessments;
- Workforce challenges (recruitment, retention, supervision, professional development);
- Workforce scarcity which drives higher wages, incentives, and turnover costs;
- Additional living expenses;
- Smaller client volumes reduce economies of scale; and
- Infrastructure gaps (limited transport, digital connectivity) increase operational overheads.

Travel is a significant cost driver in rural and remote care, with providers having substantial additional expenses associated with fuel, vehicle type required; vehicle maintenance, and non-billable travel time, particularly for staff travelling long distances between clients.

The workforce cost differential between metropolitan and rural/remote settings encompasses the full lifecycle cost of attracting, recruiting, training, and retaining staff in areas where the labour market is structurally constrained, as well as additional wage costs.

The client population itself has higher average acuity, meaning more complex and resource-intensive care is required per person regardless of geographic loading.

Beyond provider-level cost data, system-level evidence exists about the structural underfunding of rural and remote health and aged care. When comparing between Modified Monash Model (MMM) regions, the expenditure gap is largely driven by MMM5-7 regions, with an age-standardised expenditure gap of $4,701 per capita. While increased public hospital and aged care expenditure in MMM 6 and 7 is influenced by the higher cost of service delivery in those regions, spending on aged care is considerably less in remote areas than in MMM2-5 areas.[3]

Higher per-unit costs in remote areas do not fully translate into higher total expenditure. In fact, access and utilisation are sufficiently suppressed that aggregate spending remains lower than in metropolitan areas.

Due to shortages in clinical workforce in regional areas, services can often not be supported face to face in rural or remote communities. The inability to charge additional travel per service in these zones restricts the workforce availability further.

There are 7.3 million people, more than 27 per cent of the total population, living in rural, regional or remote Australia, However, the distribution of the healthcare workforce does

not align with geographical distribution of the population. They face the greatest barriers to physiotherapy and continue to miss out on early intervention to restore function, protect independence and reduce hospitalisation, pharmacological dependence and long-term costs.

The APA Workforce Census 2025 identified that there is a strong intention from physiotherapists to work rurally with 32 per cent stating they would consider moving to a rural location. However, barriers to rural practice include the high costs of moving, lack of professional networks, and lack of professional development and support opportunities. Nearly two-thirds (65 per cent) of respondents said higher remuneration would support them to undertake rural employment, followed by relocation support (52 per cent), and opportunities for skill development and career advancement (31 per cent).

For rural, regional and remote communities, direct physiotherapy access must be backed by stronger, better-targeted workforce incentives. These include expanded rural loadings, relocation support, housing subsidies and structured professional support such as supervision, mentoring and funded continuing professional development to attract, retain and sustain a highly skilled physiotherapy workforce in the places that need it most.

5. Do higher costs or different cost pressures associated with services provided in rural and remote locations apply to all service types, or only to specific services? For example, clinical services in comparison to non-clinical services.

Highly trained and Ahpra-regulated physiotherapists are significantly underrepresented in rural and remote areas compared to the general service workforce, as a result of structural maldistribution.

There is significantly lower per-capita supply of physiotherapists in rural and remote areas compared to metropolitan areas. In contrast, Everyday Living supports such as cleaning and gardening are more likely to be embedded in local economies therefore scaling more evenly with population distribution.

For rural, regional and remote communities, direct physiotherapy access must be backed by stronger, better-targeted workforce incentives. This includes expanded rural loadings, relocation support, housing subsidies and structured professional support such as supervision, mentoring and funded continuing professional development to attract, retain and sustain a highly skilled physiotherapy workforce in the places that need it most.

6. What cost pressures and supporting data and evidence should IHACPA take into account when considering pricing adjustments for services provided for people from Aboriginal and Torres Strait Islander communities?

The Royal Commission into Aged Care Quality and Safety made seven specific recommendations relating to aged care for Aboriginal and Torres Strait Islander people,

including Prioritising Aboriginal and Torres Strait Islander organisations as aged care providers (recommendation 50); enshrining cultural safety (recommendation 48) and funding (recommendation 52).[4]

The Royal Commission specifically recommended block funding for Aboriginal Community Controlled Organisations (ACCOs) be retained given the entirely different nature of service delivery and policy approach required (recommendation 52(1)) .

The Inspector-General of Aged Care's 2025 Progress Report found that the Royal Commission recommendations had not been adopted and highlighted that nearly 40 per cent of ACCOs delivering aged care are at risk of financial instability under current funding structures. [5]

The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) warned that shifting to mainstream funding models without adjustments could force some providers to close, reducing access to culturally safe care in remote and regional communities.[6]

ACCOs commonly identify factors that make it challenging for them to expand into aged care services. These include pricing models not reflective of the true costs of delivering culturally safe care; a lack of incentives and ongoing funding for capability development; and challenges recruiting a sufficiently qualified workforce.

Pricing under Australia's Support at Home program cannot be culturally neutral if it is to work in Aboriginal and Torres Strait Islander contexts. A standard activity-based or time-based pricing model will systematically understate the real cost of culturally safe, effective service delivery, which is complex and multifactorial.

Pricing structures must factor in, as ongoing and not one-off, costs such as:

- Geographical locations;
- Cultural safety and workforce capability;
- Recruitment and retention of Aboriginal and Torres Strait Islander workforce;
- Cultural competency training for non-Indigenous staff;
- Time for reflective practice, supervision, and community engagement;
- Use of interpreters or cultural brokers where needed;
- Relationship-based care (non-transactional time); and
- Missed or rescheduled visits due to cultural obligations or community events.

7. What cost pressures and supporting data and evidence should IHACPA take into account when considering pricing adjustments for services provided for people with diverse backgrounds and life experiences?

The Royal Commission into Aged Care Quality and Safety found that aged care must embrace and accommodate the diversity, difference and complexity of individuals and that diversity should be core business in aged care.[7]

However, the Inspector General of Aged Care Progress Report 2025 concluded that urgent, system-wide action is still needed to move from a "one-size-fits-all" approach to one that truly embraces cultural diversity and is inclusive.

Support at Home pricing is built on incorrect systemic assumptions that there is a common level of understanding and engagement with the system and healthcare practitioners among diverse cohorts.

Communication and language barriers; lower levels of health and system literacy, care coordination complexity, culturally aligned care planning; and workforce training and capability are among many factors contributing to increased cost of delivery of in-home clinical care to culturally and linguistically diverse communities.

These factors necessitate:

- Effective care that often depends on trust and continuity:
- Longer consultation times;
- Greater flexibility in scheduling to support cultural practices;
- Higher intensity clinical care;
- Increased coordination of care;
- More intensive care planning and review processes; and
- Higher administrative burden.
- Longer visit times to build rapport and avoid “clinical churn”;
- Multiple visits before service uptake or compliance;
- Time spent engaging with family and support people;
- Need for flexible service bundling rather than discrete line items; and
- Engaging interpreter services, bilingual workforce, and using translated materials.

To ensure these drivers are captured, IHACPA should:

- Enable granular reporting of direct and indirect time, including non-face-to-face activities (coordination, liaison, cultural engagement);
- Collect service duration data at a level that allows stratification by client characteristics;
- Capture interpreter use and associated costs explicitly;

- Allow for flexible cost allocation methodologies where standard service-level attribution is not feasible (e.g. bundled or time-based approaches); and
- Stratify data by relevant client cohorts, including cultural and linguistic diversity and other markers of complexity.

IHACPA should recognise indirect care costs; reflect these cost drivers in pricing advice through a combination of classification and price weights that incorporate service intensity; recognise longer average service duration and higher indirect cost ratios in the efficient price and apply loadings and adjustors for additional costs such as:

- Interpreter and communication complexity loading;
- Cultural safety and engagement loading; and
- Outreach/service access loading.

The APA recognises that LGBTQIA+ people experience disproportionate barriers to accessing care, including stigma, discrimination, and poorer health outcomes in some domains.

Physiotherapists develop capability in LGBTQIA+ inclusive practice, including appropriate language, understanding diverse identities, and creating welcoming clinical environments.

The APA encourages practitioners and employers to embed inclusion in policies, training, and service design, including:

- Use of inclusive intake forms and documentation (e.g. pronouns, gender identity separate from sex assigned at birth);
- Ensuring privacy and dignity in clinical interactions;
- Avoiding assumptions about anatomy, relationships, or health needs; and
- Building trust and continuity, particularly for clients with prior negative healthcare experiences.

These service delivery inclusions must be factored into appropriate costing of inclusive, person-centred care.

8. Do higher costs or different cost pressures associated with services provided for people from Aboriginal and Torres Strait Islander communities, or people with diverse backgrounds and life experiences, apply to all service types, or only to specific services? For example, clinical services in comparison to non-clinical services.

The significantly higher chronic disease and disability burdens among Aboriginal and Torres Strait Islander people compared to non-Indigenous people[8], language and health literacy barriers, compounding social determinants (access to food,

housing, transport) and cultural practices (eg end-of-life observation and relationship building) significantly increase the cost of clinical care delivery.

These factors necessitate:

- Effective care often depends on trust and continuity:
- Longer consultation times;
- Greater flexibility in scheduling to support cultural practices;
- Higher intensity clinical care;
- Increased coordination of care;
- More intensive care planning and review processes;
- Higher administrative burden
- Longer visit times to build rapport and avoid “clinical churn”;
- Multiple visits before service uptake or compliance;
- Time spent engaging with family, Elders, and community decision-makers;
- Flexible and outreach service models (mobile services, fly-in/fly-out, hub-and-spoke); and
- Need for flexible service bundling rather than discrete line items.

The additional complexity of care and ensuring cultural safety requires extensive training, supervision and mentoring of practitioners, resources (e.g. two clinicians), specialist equipment and more experienced and, hence more highly remunerated, practitioners.

At a structural level, robust pricing must ensure these factors are remunerated. The additional flexibility, skill, administration and coordination required to provide in-home aged care to Aboriginal and Torres Strait Islander communities must not penalise the healthcare practitioners, such as physiotherapists, delivering these critical services.

6. References

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[3] National Rural Health Alliance – "The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia" (2025 update)

[4] Royal Commission into Aged Care Quality and Safety (2021). Final report: Care, dignity and respect, recommendations 47-52

[5] 2025 Progress Report from the Inspector-General of Aged Care

[6] Media Release: NATSIAACC welcomes Inspector-General of Aged Care's 2025 Progress Report, Calls for Stronger Action to Support Aboriginal and Torres Strait Islander Elders, Older People and Providers, 05/09/2025

[7] Royal Commission into Aged Care Quality and Safety, Final Report, Care, Dignity and Respect (March 2021)

[8] Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Performance Framework - Summary report 2025