SUBMISSION

Residential Aged Care Pricing 2027-28

Independent Hospital and Aged Care Pricing Authority (IHACPA)

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

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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

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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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 36,000 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

This submission on IHACPA's Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026-27 reinforces the Australian Physiotherapy Association's (APA) previous submissions to IHACPA regarding the systemic underestimation of the cost of needs-based physiotherapy in residential aged care.

The next stage of reform is to move allied health pricing from historical utilisation toward assessed need. Nearly four years after the Australian National Aged Care Classification (AN-ACC) came into effect, IHACPA is still seeking to understand "the cost to deliver allied health care and the impact on the development of its pricing advice". That work was important, but it was important in the early implementation of AN-ACC. Four years on, the direction of reform is now clear. The methodology must now better connect assessed physiotherapy need, efficient pricing and actual service delivery.

A needs-based aged care system cannot be priced on the basis of historically constrained care. Physiotherapy has historically been under-supplied in residential aged care. If future prices are based primarily on past delivery, rather than assessed need, the model risks carrying historic under-provision into the next funding cycle. It also risks mistaking low expenditure for efficient expenditure.

IHACPA's commitment to continue investigating allied health residential aged care pricing with the Department of Health, Disability and Ageing signals intent and is welcome. But the reform task can no longer sit in investigation alone. It requires a clear pricing pathway, defined milestones, better allied health data and direct engagement with physiotherapy providers. Without tangible detail and action, ongoing investigation leaves older people in residential aged care at risk of not receiving the care they need.

IHACPA has itself identified important limitations in the evidence and methodology used to cost physiotherapy, including that AN-ACC does not link specific allied health services to funding; that further resident- and service-level data are required to better understand the cost of allied health care; that allied health and indirect care remain areas for refinement within its cost collections; and that the previous 50:50 allocation of direct-care labour between individual and shared care requires a more accurate methodology.

These refinements are necessary, but they do not resolve the more fundamental limitation. Historical utilisation can show what the system has funded. It cannot show whether residents received the physiotherapy they clinically required, or whether the efficient price is sufficient to deliver that care. Where historical service provision has been constrained or inadequate, continuing to use current spending patterns to determine future pricing risks using under-provision to justify underfunding.

The Aged Care Act 2024 fundamentally changes the benchmark against which residential aged care pricing should be assessed and places assessed need at the centre of the system. The funding methodology must now catch up with that statutory shift. A needs-based system requires prices that reflect the real cost of delivering assessed care, including direct treatment, indirect clinical work and resident-attributable care coordination.

AN-ACC recognises physiotherapy as a cost of residential aged care, but there remains no sufficiently transparent mechanism connecting an individual's assessed physiotherapy need with the resources required to meet that need and the services subsequently delivered.

This creates a fundamental tension between a needs-led statutory framework and a substantially utilisation-led pricing methodology.

IHACPA's 2027-28 residential aged care pricing advice should address the core reform test. Is the system pricing the care residents clinically require, or continuing to price the patterns of care the system has historically delivered?

The APA submits that the next stage of pricing reform should improve allied health cost data, replace broad allocation assumptions with profession-specific activity-based costing, recognise resident-attributable clinical administration, link utilisation data to assessed need, and develop a transparent mechanism for funding physiotherapy according to individually assessed clinical need.

2. Recommendations

1	Introduce dedicated, ring-fenced allied health funding within AN-ACC to guarantee that physiotherapy services are directly resourced – underpinned by transparent service rates and minimum payment terms for contracted providers to protect service sustainability.
2	Undertake dedicated allied health costing of respite episodes and establish an episode-based component that recognises the front-loaded clinical and care-management resources associated with admission, assessment and transition.
3	Replace the 50:50 allocation with profession-specific, activity-based costing.
4	Separate clinical administration from corporate overhead and recognise its true cost.
5	Undertake a review of datasets utilised in costings to ensure greater provider transparency and accountability of provider utilisation of funding received for the purposes of delivering care to residents
6	Draw new data points from existing digital sources, and ensure they are linked to assessed need.
7	Undertake detailed costing studies with brokered physiotherapy businesses to inform future evidence, methodology and pricing.
8	Collaborate with the Department of Health, Disability and Ageing to support the implementation of a nationally consistent allied health needs assessment and care planning tool directly linked to AN-ACC funding.
9	Collaborate with the Commonwealth Government to adjust the AN-ACC pricing framework to reflect the true costs of providing allied health services based on individually assessed allied health needs.
10	Undertake data collection and analysis specific to physiotherapy to underpin accuracy in the framework and pricing advice, including: • Nous Group report *Economic Value of Physiotherapy*,[i] which quantified the economic and clinical value of physiotherapy across a range of conditions and settings; • Nous Group report *Hourly rate for the Provision of Physiotherapy Services*[ii], outlining evidence for a sustainable and value-based hourly rate for standard physiotherapy services.

3. Physiotherapy in residential aged care

Physiotherapy is essential for delivering reablement and maintaining function in residential aged care. The Statement of Rights, a legally binding component of our aged care framework, ensures that all residents are entitled to care free from substandard practices. Crucially, underfunding is a primary driver of such substandard care.

Physiotherapy is integral to achieving this objective. Physiotherapists are highly qualified health professionals who assess, diagnose, manage and review older people with complex and often interacting health conditions. Their expertise extends beyond exercise prescription to the assessment, restoration and maintenance of physical function, including mobility, strength, balance, pain management, cardiorespiratory function, neurological conditions, falls risk and functional deterioration.

In residential aged care, physiotherapists provide both ongoing and episodic clinical care. They prevent and manage falls, support recovery following illness, injury and hospitalisation, manage pain and chronic conditions, prescribe mobility and other equipment, support safe transfers and manual handling, and help maintain the physical and psychological wellbeing of people living with dementia. Through early assessment and targeted intervention, physiotherapy can restore function where possible, prevent or slow avoidable deterioration and enable residents to maintain independence and autonomy for as long as possible.

This is central to reablement, not supplementary to it. The Royal Commission into Aged Care Quality and Safety recognised that reablement and rehabilitation should be a central focus of aged care and that allied health, including physiotherapy, is intrinsic to achieving it. The objective must be to restore and maintain physical and mental health to the highest level for as long as possible.

These objectives are reinforced by the Aged Care Act 2024. The new rights-based framework places safety, health, wellbeing and quality of life at the centre of funded aged care and expressly contemplates supporting older people to maintain or improve their physical capabilities.

The funding architecture should enable providers to deliver against the ambitions of the Aged Care Act but does not reliably do so.

AN-ACC recognises allied health as a cost of residential aged care, but there remains no sufficiently transparent mechanism connecting an individual resident's clinically assessed physiotherapy need with the resources required to meet that need and the services subsequently delivered. Physiotherapy provision is therefore vulnerable to provider allocation decisions within pooled funding, rather than being systematically driven by clinical need.

This disconnect is particularly concerning given historically low levels of allied health provision. Funding based predominantly on observed utilisation risks pricing what is currently delivered rather than what is clinically required, perpetuating under-servicing rather than establishing the true cost of appropriate care.

Residential aged care funding should therefore support comprehensive clinical assessment and targeted physiotherapy funding according to assessed need, including both ongoing and episodic restorative care. A resident experiencing a fall, fracture, hospitalisation or material deterioration in mobility should be able to access the additional physiotherapy required without that care being constrained by historical utilisation assumptions.

The policy objective should be clear: assessed clinical need should determine the care required, and the efficient price should provide the resources necessary to deliver it. Maintaining physical function and preventing avoidable deterioration are not discretionary additions to residential aged care. They are fundamental to delivering the independence, autonomy, health and quality of life that Australia's aged care reforms are intended to achieve.

4. Responses to consultation questions

1. What should we consider when understanding differences in administration and care management costs for respite residents compared to permanent residents?

Respite care has a fundamentally different cost profile from permanent residential care and should be costed as a distinct episode of care, rather than a shorter period of permanent residence.

High resident turnover creates repeated admission, assessment, care planning, clinical coordination, family liaison, documentation, discharge and handover activity. These costs are concentrated around each admission and transition and cannot be accurately attributed through occupied bed days alone.

This is particularly important for physiotherapy, where clinical activity can be heavily front-loaded. A respite resident may require assessment and intervention shortly after admission irrespective of whether the stay is three days or three weeks. Historical expenditure allocated on a per-bed-day basis risks diluting these episode-based costs and understating the true resources required to provide safe and clinically appropriate respite care.

Respite residents may require timely assessment of mobility, transfers, balance, falls risk, pain, functional capacity and manual-handling requirements. Physiotherapists may need to review walking aids, wheelchairs, seating and transfer equipment; establish safe mobility and transfer plans; communicate these requirements to care staff; and identify changes in function.

For residents entering respite following illness or hospitalisation, physiotherapy may also provide rehabilitation and reablement to restore or maintain function and prevent avoidable deterioration.

Physiotherapy also has an important role at transition points. Where a resident is returning home, assessment may identify mobility, equipment or functional issues affecting a safe transition. Where respite becomes permanent residential care, physiotherapy assessment can establish baseline function, identify ongoing clinical need and inform the resident's care plan. These activities generate direct and indirect clinical costs that should not be subsumed into generic administration.

IHACPA should therefore capture respite-specific:

- admission and discharge frequency and length of stay;
- allied health referrals, assessments and interventions;
- direct and resident-attributable indirect clinical time;
- care planning and clinical coordination;
- equipment and assistive-technology assessment;
- discharge and transition activity; and
- conversion from respite to permanent residential care.

Importantly, IHACPA should distinguish administrative activity from clinical care management. Resident-specific assessment, documentation, case conferencing, discharge planning and clinical coordination undertaken by a physiotherapist are components of clinical service delivery, not generic administrative overhead.

Recommendations

› Undertake dedicated allied health costing of respite episodes and establish an episode-based component that recognises the front-loaded clinical and care-management resources associated with admission, assessment and transition. Allied health costs should be separately identifiable by profession and linked to resident need and actual activity, rather than inferred from permanent-resident utilisation or distributed solely across occupied bed days.

2. Which new or existing data sources should we consider to improve provider representation and reduce provider burden in our cost collections?

There is also an important opportunity arising from the Aged Care Rules 2025 to improve data sources to inform costing studies.

Aged Care Rules 2025, Section 166-175(1) requires the quality indicators report to include the:

- number of residents assessed for services delivered by an allied health professional;
- number of allied health and therapy services recommended to be delivered; and
- number of those recommended services that were actually received.

Section 166-175(3) requires the recommended/received data to be reported by allied health profession.

IHACPA should seek to use these routinely collected data rather than require providers to recreate equivalent information for cost collections.

IHACPA should prioritise existing digital sources that capture actual care activity, rather than impose additional manual reporting.

These include:

- electronic health records;
- allied health clinical systems;
- rostering systems;
- payroll;
- referral data;
- incident and falls data;
- AN-ACC assessments;
- QFR/ACFR datasets; and
- mandatory quality indicator data.

For physiotherapy, data should capture not only face-to-face treatment, but assessment, care planning, indirect clinical work, group reablement, equipment prescription and multidisciplinary activity.

Importantly, utilisation data should be linked with assessed need. Current expenditure alone risks embedding historic under-provision into future pricing.

Data integration should therefore support analysis of need, activity, outcomes and cost.

IHACPA's proposed use of health record management system data is a positive development and should be progressed through standardised, interoperable data fields that reduce duplication and provider burden.

Recommendation

〉 Undertake detailed costing studies with brokered physiotherapy businesses to inform future evidence, methodology and pricing.

〉 Draw new data points from existing digital sources, and ensure they are linked to assessed need.

3. What factors should we consider when allocating administrative costs in our residential aged care pricing advice?

IHACPA should establish a clear, nationally consistent distinction between corporate administration, care-related administration and resident-attributable indirect clinical care, and cost each according to the activity that generates it rather than through broad proportional allocation.

For physiotherapy, clinically necessary activity – including documentation, care planning, referrals, case conferencing, falls and incident review, equipment prescription, communication with families and other clinicians, and care coordination – should be recognised as part of the efficient cost of delivering clinical care, not absorbed into generic administration or treated as non-productive time.

Where indirect clinical activity is attributable to an individual resident, it should be linked to that resident's clinical care and resource requirement. IHACPA should also recognise legitimate variation in administrative and indirect clinical costs associated with resident complexity, cognitive impairment, respite and high turnover, specialised care, regulatory requirements and different employment and service delivery models.

Pricing physiotherapy primarily through direct resident-contact time will systematically understate its true cost. IHACPA's methodology must capture the full clinical resources required to deliver safe, high-quality physiotherapy, not simply the time a physiotherapist spends face-to-face with a resident.

Recommendations

- Separate clinical administration from corporate overhead and recognise its true cost.

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4. What factors should we consider when refining how we allocate care costs between individual and shared components?

According to the Australian Bureau of Statistics (ABS), approximately 60 per cent of current residential aged care recipients are now over 85 years of age - a marked increase from the 45 per cent observed two decades ago. This demographic shift highlights that the residential aged care population is significantly more complex, carrying a higher acuity of care needs.

IHACPA should move away from a uniform allocation assumption and develop a profession-specific methodology that reflects how physiotherapy is actually delivered in residential aged care. The previous 50:50 allocation of allied health labour between individual and shared care is unlikely to reflect the clinical activities, resource requirements or models of physiotherapy practice.

The objective should be to establish where physiotherapy resources are actually consumed and why, rather than imposing an administratively convenient ratio that does not reflect clinical practice.

For physiotherapy, the distinction should be based on the purpose and beneficiary of the clinical activity, not simply whether the physiotherapist is physically with an individual resident.

Individual resident-attributable physiotherapy should include all activity undertaken to assess, treat or manage an identified resident's clinical needs. This includes mobility, strength, balance and functional assessment; falls-risk assessment and post-fall review; individual treatment and rehabilitation; pain management; transfer and mobility assessment; prescription and review of walking aids, wheelchairs, seating and other equipment; post-hospital rehabilitation; and development and review of individual exercise and mobility programs.

Importantly, indirect clinical activity attributable to an individual resident should remain an individual care cost. Physiotherapy does not begin and end with face-to-face treatment. Reviewing clinical records, documenting assessment and treatment, developing care plans, communicating with families and other clinicians, equipment prescription, referral and discharge planning, and resident-specific case conferencing are necessary components of clinical care. Classifying this activity as generic shared care or administration would understate the true resource requirement associated with individual clinical need.

Shared physiotherapy activity should be separately identified and should include activities genuinely benefiting a group of residents or the service as a whole. This may include appropriately designed group exercise programs, falls prevention interventions, facility-wide mobility programs, workforce education, general manual-handling training and broader clinical governance activities.

Physiotherapists play an important role in training care staff, aides and assistants. Thorough well-developed physiotherapy programs often include the use of aides and assistants, which contributes to mitigating costs while meeting Aged Care Quality Standards.

Critically, multidisciplinary activity should not automatically be classified as shared care. A multidisciplinary meeting discussing the falls, mobility or rehabilitation needs of a specific resident is resident-attributable individual clinical care. Only activity genuinely supporting multiple residents or the facility generally should be allocated to shared care.

IHACPA should therefore collect physiotherapy activity at a sufficiently granular level to identify:

- direct individual clinical care;
- resident-attributable indirect clinical care;
- group clinical intervention;
- facility-level/shared clinical activity; and
- non-clinical administration.

Allocation should also recognise differences in resident complexity, AN-ACC class, episodic rehabilitation needs, service model and directly employed versus contracted physiotherapy provision.

This distinction has material pricing consequences. Individual care primarily informs AN-ACC class funding, while shared care informs the Base Care Tariff. Misclassifying resident-specific physiotherapy as shared care risks shifting costs away from the resident's assessed needs and obscuring the relationship between clinical need, physiotherapy resource utilisation and AN-ACC funding.

Recommendation

〉 Replace the 50:50 allocation with profession-specific, activity-based costing.

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5. What changes in service delivery costs associated with the implementation of the Aged Care Act 2024 should we consider in developing our pricing advice?

Pricing should reflect the cost of delivering the higher standard of rights-based, person-centred care required under the Aged Care Act 2024, rather than relying solely on historic expenditure patterns.

The Aged Care Act 2024 changes not only the regulatory requirements of residential aged care but the standard of care that the pricing framework must resource. IHACPA appropriately states that its pricing advice is based on services meeting Australian Government policy and legislative requirements, including the strengthened Aged Care Quality Standards.

The implementation cost should therefore not be treated narrowly as transitional compliance expenditure. IHACPA should identify the ongoing clinical and operational resources required to deliver the rights-based, person-centred model of care established by the Act, including assessment, care planning, reablement, maintenance of function, clinical governance, documentation and coordination. For physiotherapy, these costs differ materially according to the service delivery model.

Directly employed physiotherapy

The true cost of an employed physiotherapy workforce extends beyond salary and direct resident-contact time. It includes superannuation, leave, recruitment, professional development, clinical supervision, registration and credentialing, workers compensation, payroll tax, professional indemnity insurance, clinical governance, equipment and systems, as well as non-resident-facing clinical time.

Importantly, clinically necessary indirect activity, including assessment review, documentation, falls and incident review, care planning, case conferencing, equipment prescription, multidisciplinary coordination and communication with residents, families and other health professionals, must be recognised as part of the efficient cost of delivering physiotherapy, rather than treated as unproductive time or generic administration.

Contracted and brokered physiotherapy

A different cost structure applies where residential aged care providers purchase physiotherapy from external practices or contractors. Pricing must reflect the real-world cost of securing a sustainable clinical service, rather than assuming that contracted care can be costed by reference to an employed clinician's wage.

External providers and contractors face a broad spectrum of expenses beyond direct labour, including training and compliance, recruitment and retention, rostering and contingency planning, practice overheads, and clinical governance. Furthermore, operational costs - such as administration, non-client clinical time, and general sustainability expenses - are critical considerations. Supporting this, an independent analysis by the Nous Group, commissioned by the APA, underscores that pricing models must reflect the full cost of sustainable service delivery, rather than focusing solely on salary.

The fiscal frameworks governing brokered services differ structurally from those based on direct employment. It is imperative that pricing assumptions acknowledge these variances; otherwise, they risk fundamentally understating the genuine costs associated with sustainable service delivery. IHACPA should therefore undertake bottom-up costing across both employed and contracted models, capturing direct clinical time, indirect clinical time, governance and compliance, workforce costs, equipment, overheads and the additional costs of delivering services in thin, regional and rural markets.

This distinction is supported by the Nous Group report *Hourly rate for the provision of physiotherapy services*. Its independent analysis found that sustainable physiotherapy pricing needs to support competitive salaries and sustainable business models, and identified $261 per hour as a sustainable and value-based standard physiotherapy rate, with higher rates and loadings for experience, qualifications and rural/remote practice. Nous also specifically says non-client time such as reporting should be valued appropriately.

Residential pricing is intended to fund the cost of care, and its methodology is designed to reflect services meeting the strengthened Quality Standards. If providers genuinely need to use external physiotherapy services to meet residents' assessed clinical needs - particularly in thin labour markets - the efficient price needs to recognise the efficient cost of obtaining that care, not assume a lower theoretical employed cost that the provider cannot actually access.

Recommendation

› Undertake bottom-up costing across different service delivery models, capturing direct clinical time, indirect clinical time, governance and compliance, workforce costs, equipment, overheads and the additional costs of delivering services in thin, regional and rural markets.

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6. What factors should we consider when assessing the potential inclusion of the Specialist Dementia Care Program in our pricing advice?

The APA contends that IHACPA should not incorporate the Specialist Dementia Care Program into mainstream AN-ACC pricing unless it can demonstrate that existing classifications accurately identify and fund the substantially higher clinical and multidisciplinary resource requirements of residents with severe behavioural and psychological symptoms of dementia.

The stream should be expanded to fund physiotherapy, use AN-ACC funding for these services that include: mobility and falls management, pain assessment, safe transfers, environmental modification and reducing reliance on restrictive practices, as well as the additional time required for specialised communication, care planning, case conferencing, staff education and resident-attributable indirect clinical care.

Specialist funding should follow demonstrated clinical need and remain transparent and identifiable. It should not be averaged across the broader resident population or absorbed into pooled funding where this risks diluting resources or reducing access to required allied health care.

Where existing AN-ACC classifications cannot reliably predict these additional resource requirements, IHACPA should retain a dedicated needs-based funding mechanism rather than trade funding transparency for administrative simplicity.

Recommendation

› Protect needs-based funding for specialist dementia care.

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7. What factors should we consider when assessing the potential inclusion of the oxygen and enteral feeding supplements in our pricing advice?

IHACPA should first establish whether these costs are sufficiently predictable and consistently associated with identifiable resident characteristics to be safely incorporated into AN-ACC pricing. Both oxygen therapy and enteral feeding can generate additional nursing, allied health, monitoring, equipment, consumable and care coordination costs. From a physiotherapy perspective, residents requiring oxygen may have complex respiratory, mobility and exercise-tolerance needs, while enteral feeding may coexist with frailty, neurological impairment and high physical assistance requirements. Incorporation should not obscure these associated multidisciplinary costs or create an assumption that the supplement represents the full cost of care.

IHACPA should model variation by resident complexity, geography, workforce availability and equipment cost, and assess the risk of underfunding high-cost individuals. Where costs are highly variable or clinically specific, retaining transparent supplements may be preferable to averaging them across the broader AN-ACC model.

Recommendation

- IHACPA should only incorporate existing clinical supplements into AN-ACC where resident-level evidence demonstrates that the classification system can reliably identify and fully price the additional resource requirements. Where this cannot be demonstrated, transparent needs-linked supplementary funding should be retained.

5. References

[i] Nous Group. (2020). Value of Physiotherapy in Australia. Australian Physiotherapy Association.
[ii] Nous Group. (2025) Hourly rate for the provision of physiotherapy services, Australian Physiotherapy Association