Osteopathy Australia
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Osteopathy Australia's response to IHACPA's draft consultation paper on the pricing framework for Australian Support at Home Aged Care services 2026-27

About Osteopathy and Osteopathy Australia

Osteopaths in Australia are university-qualified allied health practitioners registered with the Australian Health Practitioner Regulation Agency (Ahpra). Osteopaths complete either a dual bachelor's or bachelor's and master's qualification covering functions of anatomy, biomechanics, human movement, the musculoskeletal and neurological systems, as well as clinical intervention approaches, biomedical science including pharmacology which are all underpinned by a biopsychosocial management approach.

Osteopathy Australia is the peak body representing the interests of osteopaths, osteopathy as a profession, and consumer's rights to access osteopathic services. Our core work is liaising with state and federal government and all other statutory agencies, professional bodies, and private industry regarding professional, educational, legislative, and regulatory issues. Most registered osteopaths are members of Osteopathy Australia.

Introduction

Osteopath Australia would like to thank IHACPA's for this opportunity to provide feedback to the Pricing Framework for Australian Support at Home Aged Care Services 2026-27.

We would like to highlight in addition to our response to the survey questions below, that we are still deeply concerned about the classification of osteopathy in the 'therapeutic service for independent living' category in the new Aged Care Act 2024 and the associated Aged Care Rules. Under the New Aged Care Act Rules consultation – Release 1 – Service List, allied health has been defined as "a person who is registered under the National Law in an allied health profession", which would include osteopathy as an Ahpra regulated profession. However, the Support at Home service list classifies osteopathy under the 'therapeutic service for independent living' category rather than the appropriate 'allied health and therapy' service type. This shows a clear lack of understanding of osteopathy's capabilities, scope of practice and position within the allied health sector. We are calling on IHACPA and

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the Department of Health and Aged Care to rectify this blatant omission and re-categorise osteopathy under the appropriate 'allied health and therapy' category.

Feedback to survey questions:

1. **Do the pricing principles provide adequate guidance for IHACPA's development of pricing advice? If not, what changes do you recommend?**

While the current pricing principles provide a solid start, there are key principles that need to be further developed.

Firstly, 'sustainability' should not only be stated in reference to the sustainability of in-home aged care funding provision but also the financial sustainability and viability of allied health practitioners (AHPs) to consistently and continually provide services into the future. Pricing caps and ongoing increases in cost of living and provision of services has already and will continue to limit the financial viability of practitioners to work within the support at home scheme.

Further, we do not believe that the principles of 'access to services' has been taken into full consideration.

The indictive service list currently classifies osteopathy under 'therapeutic services for independent living' rather than the appropriate 'allied health and therapy' service type. This misclassification is concerning as not only does it contradict the definitions of an allied health professional in the new Aged Care Act Rules it will cause significant access issues for older Australians.

By failing to include osteopathy in the allied health category, older Australians will no longer be able to access care that is fully funded by Government. Older Australians will have to significantly contribute to the cost of care they receive by paying for this out of pocket. Most older Australians will not be able to afford to pay for their care out of pocket limiting their access to essential care.

At a time when significant aged care workforce shortages are being identified, it is deeply concerning that a highly skilled and experienced workforce of allied health professionals is omitted from providing older Australians with the essential care they need.

2. **Are there specific service types, locations and population groups that IHACPA should focus on in future cost collections?**

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IHACPA must ensure that cost collections are robust and nuanced enough to capture the range of additional costs that some may incur and the diversity of cost service types to promote representation.

IHACPA should focus on cost collections of isolated outer urban, rural, regional and remote services, Aboriginal and Torres Strait Islander groups, culturally and linguistically diverse groups, older people with complex needs and in any areas that are considered to have 'thin markets'.

3. **How can IHACPA better support providers to participate in its cost collections to continue to improve their representativeness?**

Currently, it is generally only the larger provider who have the capacity and resources to be actively involved in cost collections. As such, making the cost collection process as simple and easy as possible will help encourage providers to participate.

IHACPA should look at implementing resources that can assist providers to participate including, the provision of simplified and automated cost collection templates and dedicated staff who can assist in data reporting as well as implementing streamlined collection methods tailored to small or low-capacity providers.

Also ensuring professions are placed within the correct service type category will encourage providers to participate in cost collections as they will view their data as being correctly represented.

4. **What factors should IHACPA take into account when considering pricing adjustments for services provided in rural and remote areas?**

Services provided in rural and remote areas incur a range of additional costs and often have additional challenges compared to those provided in metropolitan areas and as such IHACPA must take these into consideration and adjust prices accordingly.

Osteopaths in rural and remote areas incur additional costs to provide Support at Home services such as increased travel costs. Osteopaths in rural and remote areas will often need to travel long distances between Older Australian's houses to provide services, incurring costs associated with this travel which are often higher in these areas as well as the lost of consultation time spent traveling. Other costs include the higher cost of obtaining

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equipment and supplies due to location and the general increased cost of living seen in rural and remote areas.

Providing services in rural and remote areas also often has higher association client attributed time. Client attributed time, encompasses all other care provision activities that may not fall within face-to-face time such as report writing, check in calls and education to informal and formal care workers. For example, check in calls may occur more frequently to older Australians living in rural and remote areas to assist in care provision between face-to-face consultation that other may have to be limited due to distance. However, under the incoming new pricing model this work is unable to be billed as it is not face-to-face. These changes will result in practitioners be severely under remunerated for their time and care or older Australian going with less care.

We would also like to highlight that while most activity provided by osteopaths to older Australians residing in their homes occurs during standard business hours, there may be occasions where the service is provided outside of business hours such as after hours, on weekends or during public holidays. Osteopaths working in private practice frequently work outside of business hours and on weekends. Out-of-hours work should be appropriately remunerated.

As such, pricing models must be rethought to include cost adjustments for client attributable time and loading payments that take into consideration the range of additional costs incurred by AHPs to practice in these regions.

5. **What factors should IHACPA take into account when considering pricing adjustments for services provided for people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds and other people with special needs?**

IHACPA should consult with peak associations and consumer groups who represent Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse backgrounds and other people with special needs to understand the variety of factors that impact care provision to these groups.

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6. **What provider or participant-related factors should IHACPA take into account when considering data requirements and the pricing approach for the transition of the CHSP to the Support at Home program?**

IHACPA must acknowledge that the CHSP and Support at Home programs are two different programs. One is built on individualised funding and market logic and the other on community support, block funding and preventative care. If merging the programs, the pricing model needs to reflect that complexity.

A shift towards minute-based pricing based on face-to-face time spent with a client ignores that AHPs will undertake a range of activities that are not always carried out face-to-face with a client but greatly assist in providing safe and quality care. This component of care is known as 'client attributable time' and is currently billable across a range of programs in aged care and the National Disability Insurance Scheme (NDIS). While the methodology behind the upcoming pricing changes states that pricing advice is intended to cover all in-scope elements of care it is inappropriate as client attributable time varies greatly form client to client. Many osteopaths and other AHPs will be left to absorb additional costs which will result in more practitioners being unable to service more high needs clients or leave the program altogether.

IHACPA must also take into consideration the repercussions that the significant changes to the categorisation of certain professions, such as osteopathy will have to funding and in the transition of the CHSP to the Support at Home program. The soon to be implemented changes will mean that osteopathy services will no longer be fully funded by the Government as they have been left out of the 'allied health and therapy' service type category. This will result in older Australian's needing to co-contribute to receive osteopathy services or going without their chosen care. These changes will also perpetuate issues in areas with already thin markets.

As such, we strongly recommend that the categorisation of osteopaths is reassessed and moved to the appropriate 'allied health and therapy' service type before the implementation of the new Aged Care Act 2024 on 1 November 2025.

7. **What future priorities should IHACPA consider when developing pricing advice for the Support at Home service list?**

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IHACPA should prioritise the creation of innovative pricing models that reflect the complexity and variety of the aged care sector.

We strongly opposed the benchmarking of the cost-of-service delivery for in-home aged care to other sectors such as the Department of Veterans Affairs (DVA). The DVA scheduled fees are well below market rate across the allied health sector and are not reflective of the actual costs of providing services to patients. DVA fees are prescribed by the Department and do not allow of any gap payments to be charged to the clients. We have seen a shift of practitioners who are no longer able to service DVA clients due to the scheduled fees failing to keep pace with the cost of care provision and thus it is no longer financially viable to do so. This increases barriers to accessing timely care and is most strongly felt in outer urban, rural, regional or remote locations. Benchmarking fees to other sectors risks decreasing pricing to the lowest denominator. Pricing caps and inflexible funding models will impact the schemes' sustainability, and the safety and quality of care older Australian's receive as more practitioners will have to provide less frequent services to lessen the financial strain or must leave the scheme all together. As Australia's population continues to age, these issues will continue to compound, deepening thin markets.

Structure should also be implemented to guarantee that indexation of fees is applied annually to ensure that fees keep pace with the ongoing increases to cost of living and provision of services.

Osteopath Australia would again like to thank IHACPA's for this opportunity to provide feedback to the Pricing Framework for Australian Support at Home Aged Care Services 2026-27. If any further information is required, please contact us on 02 9410 0099 or via clinicalpolicy@osteopathy.org.au.