Allied Health Professions Australia

Submission to Independent Health and Aged Care Pricing Authority on Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25

September 2023

This submission has been developed in consultation with AHPA's allied health association members.

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About Allied Health Professions Australia and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing Australia's allied health professions across all disciplines and settings. AHPA's membership collectively represents some 145,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners.

With over 200,000 allied health professionals, including 14,000 working in rural and remote areas, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, including providing diagnostic and first-contact services, and preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses.

Allied health practitioners also support pre- and post-surgical rehabilitation and enable participation and independence for people experiencing temporary or long-term functional limitations. Allied health therefore provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

Working with a wide range of working groups and experts across the individual allied health professions, AHPA advocates to and supports Australian governments in the development of policies and programs relevant to allied health.

Overview

AHPA's submission focuses on the allied health-related issues that we consider should be addressed and included in the Pricing Framework. Current allied health service provision in residential aged care is in a parlous state. This is fundamentally at odds with the ethos that funding should remain closely aligned to the care that is required and provided.[1]

The concept of closely aligning funding in this manner is premised on the assumption that 'care required' is 'care provided'. Yet currently, costing and pricing only address the substandard level of allied health care currently provided – not the allied health care people might be clinically assessed to need.

AHPA appreciates that many of the contributing factors to the present context are outside IHACPA's ambit and mandate. However, in IHACPA's 2022 Consultation on the Aged Care Pricing Framework, it was clear that aged care stakeholders want IHACPA's Five-Year Vision to include a focus on ensuring the pricing system supports the delivery of high quality, person-centred care.[2]

AHPA therefore submits that it is incumbent upon IHACPA to alert Government that system improvements need to be made before IHACPA costing and pricing can fulfil the function desired by stakeholders.

[1] IHACPA, *Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2024–25* ('Consultation Paper'), 13-16.
[2] IHACPA, *Towards an Aged Care Pricing Framework Consultation Report*, May 2023 ('Consultation Report'), 34-36.

IHACPA can and in our view, should, also set out the basis for a more 'aspirational' aged care system in its overarching principles, as these are broadly defined as 'articulat[ing] the policy intent behind the introduction of funding reform for aged care services'.[3]

Also consistent with IHACPA's role and function, there are various considerations that must be incorporated into the Pricing Framework to help to ensure that people in residential aged care receive the type of allied health care they require.

Government determination of the value of the National Weighted Activity Unit (NWAU) and associated Australian National Aged Care Classification (AN-ACC) weightings must reflect the true cost of allied health needs. In adhering to a high quality information gathering process to inform costing and pricing, IHACPA must also make improvements to its own collection of data.

The place of allied health in the aged care system

It is important to contextualise our submission by providing IHACPA with background on the current state of allied health in aged care. Allied health is significantly underprovided and underfunded, and therefore embedding an aged care system that genuinely meets older people's assessed allied health needs will take resources that have not been sufficiently factored into aged care costing and pricing to date.

Royal Commission findings on allied health

In its Final Report, the Royal Commission into Aged Care Quality and Safety concluded that 'reablement' is critical to older people's physical and mental health and wellbeing, and should be a central focus of aged care.[4]

Due to incidents such as falls, or simply because of the ageing process, older people can suffer or be at risk of experiencing a loss of capacity, which can impact on their quality of life. Reablement is about preventing such losses where possible, and rehabilitating and restoring, or at least preserving as much as possible, older people's capacities.

Allied health practitioners provide clinical care with a focus on prevention of functional decline, along with early intervention and treatment to support a person's function and quality of life. As part of multi-disciplinary best practice, allied health professionals play an important role in:

- improving quality of life (for example, addressing pain, psychological and behavioural symptoms, communication, hearing loss and mobility);
- preventing deterioration and serious events (for example, through dietary and swallowing interventions, psychological management and falls prevention); and
- reducing emergency department admissions and preventable hospitalisations (for example, via early assessment and management of chronic conditions, falls risks and dysphagia).

The clinical expertise of allied health professionals is also essential for supervising and upskilling the care workforce to deliver client-centered care, together with ensuring that clinical care standards are met – and thereby mitigating provider risks of non-compliance.

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[3] Consultation Paper, 11.

[4] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101; and Recommendations 35 and 36. See also Exhibit 20-1, Australian Association of Gerontology Position Paper, 'Wellness and Reablement for All Australians', 31 July 2020.

During the Royal Commission's tenure, there was scant data on the provision of allied health services in Australian residential aged care, let alone on the types and frequency of allied health treatments provided to individual residents. The Commissioners' findings therefore drew on evidence that included research undertaken in 2018 by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong.[5]

The AHSRI research, led by Professor Kathy Eagar, asked staff involved in delivering care to residents to record the amount of time spent undertaking different types of activities during each shift.[6] Results included the finding that aged care residents received an individual average of only eight minutes of allied health care a day.[7] This finding was contrasted by the AHSRI to the allied health care figure in British Columbia, Canada of 22 minutes.[8]

The Royal Commission concluded that allied health service provision is essential for reablement, and that Australia's significant underprovision and undervaluing of allied health care produces morbidity, mortality and negative quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[9]

Accordingly, the Royal Commission also concluded that allied health should be regarded as a fundamental element of the aged care system.[10] The Royal Commission made multiple associated recommendations, including implementation of multidisciplinary care.[11]

The Royal Commission recommended that aged care provided to people at home and in residential facilities include a level of allied health care appropriate to each person's needs.[12] This level of service provision requires needs-based assessment, so the Royal Commission recommendations also emphasise clinically assessing each person, ideally via a multidisciplinary team, against the full range of potentially available allied health services that could help maintain

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[5] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 25. The research was part of the Resource Utilisation and Classification Study (RUCS) which underpins the new Australian National Aged Care Classification model for funding residential aged care (Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N and K Quinsey, *AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019).

[6] Eagar K, McNamee J, Gordon R, Snoek M, Duncan C, Samsa P and C Loggie, *The Australian National Aged Care Classification (AN-ACC). The Resource Utilisation and Classification Study: Report 1*, Australian Health Services Research Institute, University of Wollongong, 2019.

[7] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 25.

[8] Ibid, p24.

[9] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83; and Recommendations 35–37. See also Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.

[10] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.

[11] See eg Recommendations 25, 31, 37-38 and 58.

[12] See eg Recommendations 36 and 38.

their wellbeing and assist reablement. These assessed needs must then be met via ringfenced funding and coordinated care planning.

Provision of allied health in residential aged care

There is no dedicated funding provided for allied health services in residential aged care, and no associated mandatory benchmark equivalent to nursing and personal care minutes. Instead, the Department of Health and Aged Care ('the Department') expects provider payment for allied health services in residential aged care to be drawn from overall federal Government funding to providers under the new AN-ACC model.[13]

Quarterly Financial Reporting ('QFR') is the key public indicator of how much allied health is being provided in residential aged care. AHPA discusses QFR in some detail below, because IHACPA costing relies upon it as one source of data.

The StewartBrown yardstick

Before the three most recent rounds of QFR, the Department assured stakeholders that allied health would be sufficiently funded by referring to a yardstick derived from StewartBrown data.[14] AHPA's previous submission on IHACPA's Aged Care Pricing Framework Consultation Paper (August 2022) discussed the flawed assumptions underpinning this measure. Our calculations based on the yardstick showed that, at worst, residents could end up receiving an average of only 4.6 minutes' allied health care per day.

The October to December 2022 Quarterly Financial Snapshot ('QFS Quarter 2') – the first one to reflect the impact of the AN-ACC model – showed exactly this result of 4.6.[15] The latest QFS (January to March 2023, 'QFS Quarter 3') reports 4.55 minutes.[16] This means that allied health service provision is presently significantly less than the eight minutes criticised by the Royal Commission, let alone the 22 minutes in Canada's aged care system that was commended by the AHSRI.

The last three QFSs have also provided some more detailed data on allied health costs and time spent on residential aged care. QFS Quarter 3 minutes for some individual allied health professions are so low that only four professions are individually represented, ranging from 0.05 minutes for speech pathology to 2.96 minutes for physiotherapy, with occupational therapy, allied health assistants and other allied health categories too low to even feature in the data.[17]

Provider underreporting?

After the July to September 2022 QFS ('QFS Quarter 1') reported 5.6 allied health minutes, the Department indicated that if the next two QFSs showed a decrease in allied health, it might be cause for concern because that data would be expected to reflect a positive impact flowing from

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[13] For more specific discussion of the relationship between AN-ACC and allied health service provision, see 'The Australian National Aged Care Classification' below.

[14] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc , as of July 2022.

[15] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23, October to December 2022, 13-14.

[16] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23, January to March 2023, 14-15.

[17] Ibid, 15.

AN-ACC funding.[18] We have now seen QFSs report 4.6 and 4.55 minutes for allied health, showing that there has been a decrease in allied health minutes since AN-ACC commenced.

When the QFS Quarter 2 was published, the Department referred to the fact that the majority of providers did not report any allied health under categories such as occupational therapy, to suggest that the real problem was not underprovision but that providers were underreporting allied health service provision.[19]

Departmental commentary in the QFSs for Quarters 2 and 3 accordingly suggests that providers may still be adjusting their approach to record-keeping for allied health services in order to align with the new QFR requirements.

However, it does not seem commonsense for providers not to report allied services that they are spending funds to provide.

In another recent forum, the Department attributed the decrease in allied health minutes, from 5.6 in QFS Quarter 1 to 4.6 in QFS Quarter 2, to the change from the former Aged Care Funding Instrument (ACFI) to the AN-ACC funding model. This seems at odds with the Department's verbal and written assurances to AHPA, based on the yardstick, that after the introduction of the AN-ACC, at worst, allied health funding would remain the same.[20]

Moreover, the QFS Quarter 3 result of 4.55 minutes is not far removed from the most recent StewartBrown Residential Care Report mean of 5.82 minutes for the nine months ended 31 March 2023.[21] The StewartBrown survey, although based on a smaller sample than QFR, has run for several years – and so it would be expected that at least those participants are familiar with reporting allied health service provision.[22]

And even assuming underreporting by an average of 1.27 minutes, rectification still would mean that, at best, average daily allied health minutes remain just over a quarter of the 22 minutes recommended to the Royal Commission by the AHSRI.

Consistent with its attribution of the low figures to underreporting, the Department has stated that it is actively engaging with the sector to understand and improve provider reporting, and so the data is expected to improve over time. In November 2022, the Department's website published a video presentation providing guidance on reporting allied health care minutes and labour costs in the residential care labour cost and hours reporting section of the QFR.[23]

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[18] Department meeting with Allied Health Professions Australia, 2 March 2023.

[19] See eg Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022, 14; Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23 January to March 2023, 15.

[20] See eg https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc , as of July 2022.

[21] https://www.stewartbrown.com.au/news-articles , 10.

[22] Slightly older data from other sources also produce results broadly consistent with QFR. The QFS Quarter 1 figure of 5.6 sits within the range produced by other aged care provider surveys that have been regularly undertaken for some time: 2.85 (Mirus for January 2023); 4.9 (University of Technology Sydney Ageing Research Collaborative for FY22); 6.36 (StewartBrown for the three months ending 30 September 2022). Note that these figures are averages, whereas the Department's is the median.

[23] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers .

The Department recently suggested that this kind of approach is bearing fruit, because the number of providers that do not report any allied health cost or hours for their services has reduced with each reporting period.

However, this is not evident from a comparison of QFS Quarter 3 with QFS Quarter 2. For Quarter 2, more than 75 per cent of QFR respondents did not report any expenditure for the categories of occupational therapists, allied health assistants and other allied health categories apart from physiotherapy, speech pathology, podiatry and dietetics.[24] For Quarter 3 the equivalent figure was 70 to 80 per cent.[25]

AHPA is not aware of any more recent focused Department engagement with providers to encourage allied health reporting. For example, a 30 June 2023 Department webinar entitled 'Greater transparency about aged care providers and services - new reporting requirements', which was described as aimed at discussing 'reporting mechanisms and the importance of ensuring greater transparency and accountability in aged care', together with providing 'an overview of the requirements and processes for submitting provider operations reporting' and 'valuable insights into sector performance', did not even mention allied health reporting.

There is also no straightforward elucidation of the ostensible problem of provider underreporting of allied health in the Department's 28 August 2023 'Quarterly Financial Report – Data Quality Checks'.[26] This document emphasises that its Data Quality Checks process for QFR 'focuses on the direct care elements that impact the calculation of care minutes used for Star Ratings', while other care categories, including allied health, '*may* also be *considered* as part of the quality checks' (emphasis added).

Other than a passing reference to allied health,[27] the most attention the document pays to potential allied health underreporting is in 'Tips to help with reporting', where it is suggested that aged care providers discuss with the allied health provider that they should supply hours data alongside their fee invoices, so that the total expenditure and hours delivered by each category of allied health worker at a facility level can be seen.[28]

Current regulation of quality does not guarantee sufficient allied health

Inadequate funding of allied health services has flow-on effects to the allied health aged care workforce, including deterioration in the quality of care available to residents. Fewer average minutes mean allied health professionals can often only provide reactive care at best, rather than collaborating in best practice multidisciplinary team approaches. In a recent survey, allied health professionals noted deterioration in the quality of allied health care available to residents.[29]

There is also at least anecdotal evidence that aged care providers are substituting 'cheaper' workers from outside allied health, such as personal care workers and lifestyle staff, to provide services that considerations of quality and safety require to be delivered by an allied health professional.

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[24] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022, 14.
[25] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23 January to March 2023, 15.
[26] Department of Health and Aged Care, Quarterly Financial Report – Data Quality Checks, 28 August 2023, 1.
[27] Ibid, 5.
[28] Ibid, 6.
[29] https://ahpa.com.au/advocacy/3489-2/ .

Similarly, AHPA is aware that allied health assistants ('AHAs') are sometimes being used to carry out essential allied health tasks. Although valuable contributors to the workforce, AHAs are less qualified than allied health professionals. AHAs therefore either require supervision by an allied health professional, or are simply not suited to the task, which then exposes residents to unacceptable risks.

Compromising allied health quality and safety in these ways exacerbates Australia's already considerable health sector burden, via outcomes such as increased hospitalisations and surgeries.

Nevertheless, the Department continues to state that the present regulatory system, centering on the Quality Standards, guarantees a sufficient level of allied health.[30] We disagree. As AHPA has detailed elsewhere,[31] the structure of the current aged care regulatory system fails to ensure quality (including sufficient provision) of allied health services.[32] The process for monitoring compliance with the legislation is weak, and there appears to be no clear and practical translation, nor monitoring, of provider obligations via the Quality Standards and Schedule 1 of the *Quality of Care Principles 2014*.[33]

Principles for activity based funding in aged care

What, if any, changes do you suggest IHACPA consider for the residential aged care pricing principles?

As the Royal Commission recommended, and we outline below under 'The Australian National Aged Care Classification funding model',[34] provision of allied health services and other aged care should be based on clinical assessment of residents' needs. Allied health workforce costing and pricing must ensure that the full breadth of allied health services and associated skillsets are available when needed.

AHPA therefore supports amending the following overarching principles (deletions are as marked, with suggested additions in italics):

> **Access to care**: Funding should support timely and equitable access to appropriate aged care services, ~~for all those who require them.~~ *provided and coordinated on the basis of clinically assessed need, and delivered by suitably trained professionals according to evidence-based best practice. Individuals should have access to care that is not unduly delayed or reduced in quantity or quality by availability, access to assessment, location or other factors.*

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[30] See eg Department of Health and Aged Care, 'Questions and answers: Residential aged care funding reform webinar', 16 May 2023, 14; (Hansard Proof) Evidence to Senate Community Affairs Legislation Committee Inquiry into Aged Care Amendment (Implementing Care Reform) Bill 2022, Parliament of Australia, Canberra, 25 August 2022, 34-35 (Michael Lye and Mark Richardson, Department of Health and Aged Care). See also the Aged Care Quality and Safety Commissioner's response in the same Hansard transcript, and the Aged Care Quality and Safety Commission's Compliance and Enforcement Policy (14 July 2021), 7-9.

[31] https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ ; https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .

[32] See also https://ahpa.com.au/news-events/the-independent-capability-review-of-the-aged-care-quality-and-safety-commission-released/ .

[33] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5, and Schedules 1 and 2.

[34] See also Consultation Report, 17-18.

Quality care: Care should ~~meet~~ *be regularly assessed against* the Aged Care Quality Standards, reflect continuous improvement, support resident wellbeing and deliver *measurable* outcomes that align with community expectations. *Results of needs-based clinical assessment should be publicly reported together with any associated investigation and enforcement outcomes.*

Fairness: Activity based funding (ABF) payments should be fair and equitable, based on *clinically assessed* resident needs, promote the provision of appropriate care to residents with differing needs, and recognise legitimate and unavoidable cost variations associated with this care. Equivalent services should otherwise attract the same price across different provider types.

With respect to the amended 'Quality care' principle above, our response under 'Developing aged care pricing advice' below demonstrates that the present Quality Standards, including the draft 'strengthened' Standards, are inadequate to the task of ensuring high quality allied health provision. However, we recognise that it is not IHACPA's role to reform the regulatory process.

At this stage we support both the proposed process principles and the proposed system design principles, particularly the person-centred approach that focuses on meeting individual need.

The Australian National Aged Care Classification funding model

What, if any, factors should IHACPA consider in future reviews of the AN-ACC classes? Are there any other legitimate or unavoidable costs associated with a permanent resident's stage of care? For example, entry into or departure from a service.

Although the AN-ACC is important, it is essential that this is not the sole focus of costing and pricing analyses. The AN-ACC is a funding tool which is not designed for allied health funding needs, and does not itself assess or prescribe the amount or types of allied health care to be provided. The AHSRI emphasised that the current version of the AN-ACC is only the first step in a necessary development process,[35] and that adequately building allied health into the AN-ACC would take several years.[36]

However, the distinction between AN-ACC funding and overall care funding has been somewhat elided by the recent introduction of mandatory minutes for personal and nursing care. Care minutes have, in effect, set benchmarks via which providers have begun to allocate portions of their overall AN-ACC funding for direct care spending. But there is no comparable benchmark for allied health care provision, and consequently no ringfenced funding and spending.

AHPA was therefore pleased to learn that IHACPA's current Residential Aged Care Costing Study will improve upon QFR data. QFR does not report the amount or cost of allied health care provided

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[35] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019, https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 33.

[36] Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-10. See also Professor Kathy Eagar and Dr Conrad Kobel, Australian Health Services Research Institute, 'Letter to Beth Midgley, Director Policy', Royal Commission into Aged Care Quality and Safety, October 2020, 3; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .

to residents against each of the 13 AN-ACC classes. It is therefore not possible to ascertain from QFR whether, for example, older people with high or complex needs receive more allied health services on average than higher functioning residents.

IHACPA's costing approach will show the amount of care provided to each individual resident, thereby also enabling analysis of the amount of care provided by AN-ACC class. It is important that costing and pricing be informed by data on allied health care reported against AN-ACC classes, so that Government determination of NWAU value and associated AN-ACC classification weightings is able to reflect the true cost of allied health needs.[37]

Nevertheless, current IHACPA costing remains limited by the fact that it only counts what allied health care is currently provided, and not what is actually needed by each individual resident. IHACPA costing also does not distinguish the provision of allied health by individual discipline or on the basis of whether the allied health provider is an employee of the aged care provider or a contractor. This data is important, because pricing often varies according to what types of allied health services are provided, and by whom.[38]

Aligning IHACPA costing of allied health and the ensuing AN-ACC funding with actual assessed clinical needs also requires costing other mechanisms that are not yet in place, despite Royal Commission recommendations. These include clinical assessment and planning of allied health needs, and multidisciplinary team delivery of services to meet those needs.

See also our response concerning other legitimate or unavoidable costs, below.

Assessment of allied health needs

Neither IHACPA's methodology nor QFR facilitates mapping of whether residents actually receive the amount and types of services that they are clinically assessed as needing. The AN-ACC assessment tool is not designed for the provision of clinical care assessment and planning. The AHSRI recommended the separation of assessment of residents for funding purposes, from the assessment of residents for delivery of appropriate care.[39]

The first type of assessment is now undertaken under the AN-ACC model, but the second type requires nationally consistent assessment of allied health needs, as recommended by the Royal Commission.[40] This has not been implemented.

In residential aged care, once the assessor workforce determines the AN-ACC funding classification level, it is then up to facility staff to identify any perceived allied health needs. Whether the resident ends up receiving allied health services depends on existing staff skills and

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[37] See eg Professor Kathy Eagar and Dr Conrad Kobel, Australian Health Services Research Institute, 'Letter to Beth Midgley, Director Policy', Royal Commission into Aged Care Quality and Safety, October 2020, 2-3.
[38] QFR data also remains insufficiently granular. Although reporting now includes some data on staffing minutes for individual allied health professions in residential care, only physiotherapy, occupational therapy, speech pathology, podiatry and dietetic care, and the (undifferentiated) use of allied health assistants are distinguished. Provision of any other types of allied health services is reported under 'other'. See further 'Provision of allied health in residential aged care', above.
[39] Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N and K Quinsey, *AN-ACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-11; https://www.australian-ageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .
[40] Royal Commission Recommendations 25, 37 and 38.

breadth of knowledge of different types of allied health, and so may only occur in response to an adverse event, and may vary by provider facility and even among individual staff.

Home care, at least at present, is also variable in terms of allied health needs assessment. An assessor determines the range of total service needs, including potential allied health services, for each person. It is up to the assessor to decide if the person should be referred on to an appropriate allied health professional for a detailed clinical assessment, which will then recommend the services they should receive. Whether the older person proceeds on this pathway again depends upon whether the assessor has the training and knowledge to decide on referral to an appropriate allied health professional.

The aged care system therefore needs a nationally consistent, evidence-based, assessment and care planning tool, to be used consistently to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care. This reform is not only necessary to ensure high quality care (see below) – it is essential for true costing and pricing of allied health service provision in a high quality aged care system, with associated implications for funding.

Multidisciplinary team care

The provision of care via multidisciplinary teams was viewed by the Royal Commission as the most appropriate and effective way to meet the needs of individual aged care consumers, especially if those needs are complex. As a cornerstone of the system, and crucial in reablement, allied health providers must be key members of those teams, working alongside nurses, GPs and other specialists.

At a minimum, provision should be made for the delivery of care by the suite of allied health professions listed in Royal Commission Recommendation 38(b): oral health practitioners, mental health practitioners, podiatrists, physiotherapists, occupational therapists, pharmacists, speech pathologists, dietitians, exercise physiologists, music therapists, art therapists, optometrists and audiologists.

Costing, pricing and funding must incorporate more than simply adding together individual professional time spent. For example, team coordination and support must be provided.[41]

Developing aged care pricing advice

As the Consultation Paper states:

> 'the recommended residential aged care price is intended to cover the cost of care. Elements of care in-scope for the price are specified under Parts 2 and 3 of the Schedule of Specified Care and Services [Schedule 1].'[42]

AHPA has sought to understand from the Department the minimum obligations on providers to provide allied health care and services, flowing from Parts 2 and 3 of Schedule 1. We have also been trying to clarify the extent to which, under the Quality Principles, providers are required to

[41] As an example of a multidisciplinary aged care model, in August 2022 AHPA proposed the Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project https://ahpa.com.au/advocacy/aged-care-system-needs-emergency-first-aid-say-allied-health-professionals/, especially 7.
[42] Consultation Paper, 19.

pay for these services, rather than simply providing access to them via, for example, transporting the resident to an appointment.

The Department responded to us on 5 July 2023 that various Items in Schedule 1 may pertain to particular allied health services, depending on the circumstances, and that whether providers are required to pay for the actual delivery of an allied health service and/or associated costs also varies.

On 11 July 2023 AHPA therefore asked further questions of the Department (where relevant, numbered below), for which we have not yet received a response.

However, we have been able to obtain some relevant information from the Department in another context, and which is indicated in italics below.

1. Given the lack of detail in some of the Items, how is the precise meaning of Schedule 1 authoritatively interpreted, including where different types of allied health sit in relation to the different Items?
2. How do providers decide which Item is relevant to a particular potential instance of allied health service provision, and thereby understand the nature and extent of their obligations?
    - ***Item 2.6 (Rehabilitation Support)*** *- aged care homes must ensure residents have an appropriate therapy program developed for them which is designed to maintain or restore physical functioning so they can undertake daily activities as independently as possible. The aged care home is required to organise for development of the program, including organising and paying for the initial assessment appointment/s, booking any necessary transport. The resident cannot be charged for cost of designing and developing this program.*
    - ***Item 3.11 (Therapy Services)*** *- once a rehabilitation support program has been designed and developed for a resident under Item 2.6, the delivery of the program itself falls under Item 3.11. This item will generally include physiotherapy, podiatry and/or occupational therapy, but can include other therapies as needed to address the assessed therapy need. In line with this, the aged care home is responsible for delivery of the treatment/services, including appointment costs and any transport.*
    - ***Item 2.7 (Health practitioner services) -*** *aged care homes must provide access to general health services (such as GPs, dentists, and hearing tests) which meet the resident's particular care needs. Whilst the home is responsible for any arrangements, the actual appointment fee, and any transport/escort costs, can be passed to the resident. Usual Medicare Benefits Schedule (MBS) arrangements apply for those services covered by Medicare, with the resident expected to cover any co-payments.*
    - ***Item 2.8 (Specialised therapy services) -*** *aged care homes must provide access to the health practitioner services resident's need, including allied health services (such as physiotherapy or occupational therapy). Whilst the home is responsible for any arrangements, the actual appointment fee, and any transport/escort costs, can be passed to the resident. This item is for services that are outside of a tailored therapy program (Item 3.11). In these instances, if residents require supports, they may be eligible for Medicare benefits of up to 5 individual allied health services each calendar year.*
    - ***Item 2.9 (Support for cognitive impairment) –*** *aged care home must ensure the delivery of therapy services/activities and programs which are specifically tailored to residents with a cognitive impairment and are aimed at enhancing their quality of*

*life. Aged care homes **cannot** charge a resident for the development and delivery of these programs.*

The Department has also responded that the legislative references in the Schedule itself communicate the obligations of aged care homes, which are supported by guidance material that is available on the Department of Health and Aged Care website.

3. What level of data from Schedule 1 is collected, and is it capable of informing QFR?
   Aged care homes are not required under the Schedule to specifically record what had been delivered and the source of payment.

4. Were any of the 4.60 allied health minutes per resident per day in the Quarterly Financial Snapshot for Quarter 2 funded from outside AN-ACC?
   All care related costs, including the provision of allied health services to residents, are covered by the AN-ACC funding model.

It is therefore evident that if an item of allied health care is deemed to fall under Item 2.8, the aged care provider is not required to pay for delivery of that service, nor for any transport/escort costs.

We do not know the quantity and types of allied health services to which Item 2.8 currently pertains. QFR does not separately record allied health services provided under Item 2.8, and it is still not clear from the response to our Question 4 whether and to what extent the allied health minutes from Item 2.8 contribute to the overall QFR average minutes. AHPA understands that IHACPA's Residential Aged Care Costing Study methodology also does not distinguish allied health services according to their Schedule 1 Item number.

It is nonetheless evident that some allied health in aged care is being paid for by means other than AN-ACC funding. AHPA is aware that at present some healthcare, including some allied health, is simply paid for privately by aged care consumers. Other services are provided through Medicare, Veterans' Care, private insurance, and State and Territory health services.

Spending via these 'outside' channels is highly unlikely to come close to meeting allied health care needs, in part because of limited access to the various avenues, and also due to restrictions on the amount and type of care that can be obtained. Many consumers are also increasingly out-of-pocket due to gap fees and limited rebates, and so may simply not pursue treatment.

It is a matter for Government, rather than IHACPA, to convene public debate about whether there is any place in a fair and sustainable aged care system for the use of channels outside the aged care system to fund care provided to aged care consumers. For example, the impact on other health consumers of the use of external pathways such as the annual limit of five MBS allied health items per year to, in effect, subsidise aged care providers, must be investigated.

Deliberations must also take into account Government acceptance of Royal Commission Recommendation 69, which proposes that allied health care for people receiving aged care be generally provided by aged care providers.

The immediate implication for IHACPA is that given that the breakdown of funding of service provision under Item 2.8 is not currently visible in QFR, these pathways need to be mapped for accurate costing.

Adjustments to the recommended price

What, if any, additional cost variations are associated with the provision of care to residents who require specialised services? What evidence is there to support this?

What, if any, evidence or considerations will support IHACPA's longer-term development path for safety and quality of AN-ACC and its associated adjustments?

As this submission has outlined, allied health care has no benchmarked minutes, no standardised assessment and care planning, and no ringfenced funding for provision of care via coordinated multidisciplinary teams. These system weaknesses compromise the quality of aged care, and at present have a flow-on effect to costing and pricing.

Government determination of the value of the NWAU and associated AN-ACC weightings is informed by IHACPA analysis and advice. If allied health funding is to be closely aligned to the provision of care that is needed, IHACPA advice to Government must address the current gaps in allied health costing and pricing discussed in this submission. IHACPA should also draw Government's attention to the true cost of providing needs-based allied health care to a reablement standard.

The allied health sector must be fully consulted and engaged in the development of all relevant aged care reform, including in costing and pricing development. We look forward to ongoing collaborative engagement with IHACPA, including via its Advisory Committee and Working Group mechanisms.