Allied Health Professions Australia

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Submission from Allied Health Professions Australia on the IHACPA Work Program and Corporate Plan 2023–24 Draft for public consultation
-March 2023

About Allied Health Professions Australia and the Aged Care Working Group

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. As the national peak body across all disciplines and settings, the collective membership of Allied Health Professions Australia (AHPA) represents around 90% of those professionals.

Many of our 26 member peak organisations provide aged care services via their professional memberships. AHPA primarily engages in aged care policy and advocacy via our Aged Care Working Group which comprises representatives of those member organisations.

AHPA currently sits on a range of national advisory bodies, and is a member of the Independent Health and Aged Care Pricing Authority (IHACPA)'s Clinical Advisory Committee and various hospital pricing working groups. We are also presently represented on the Interim Aged Care Working Group.

Comments on the draft IHACPA Work Program and Corporate Plan 2023–24

The Royal Commission into Aged Care Quality and Safety recommended that aged care include a level of allied health care appropriate to each person's needs (Recommendations 36 and 38). The current state of allied health provision in aged care does not meet this standard. For in-depth discussion of the issues raised in this submission, we refer to the attached aged care brief, *What is needed for quality allied health in Australian aged care?* (Attachment 1) and AHPA's October 2022 submission to the IHACPA on the Aged Care Pricing Framework Consultation Paper (Attachment 2).

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As the Aged Care Pricing Framework Consultation Paper stated, the changes associated with the introduction of the Australian National Aged Care Classification (AN-ACC) are underpinned by a general ethos that pricing and funding should remain closely aligned to the care that is required and provided.

The fundamental problem for allied health pricing and funding is that the care that is currently provided does not align with the care that is required. As a result, the Aged Care Working Group recently met with IHACPA staff to discuss our concerns about the approach to costing allied health aged care being taken by the current Residential Aged Care Costing Study, which simply intends to collect data on care currently provided.

To meet key performance indicators, AHPA is calling for the IHACPA to undertake research and consultation that results in Aged Care Costing Standards and pricing advice which reflect the true cost of allied health.[1] This costing and pricing approach will feed into the Three Year Data Plan and inform Government determination of the value of the National Weighted Activity Unit, and associated AN-ACC weightings.[2] We refer to the attached Royal Commission exhibit as one illustration (Attachment 3).

Costing for future pricing must incorporate research and advice concerning specific assessment of residents' needs, and take into account the present glaring deficiencies in allied health service provision. This approach should be an urgent priority given the Royal Commission recommendations.

The Residential Aged Care Costing (RACC) Pilot Study lacked an advisory committee and a project working group, and none of AHPA and our individual peak profession members were on the list of peak industry bodies in the project's stakeholder communication approach – despite being key members of the National Aged Care Alliance along with many peak bodies who were listed in that approach.

AHPA is calling for the allied health sector to be fully consulted by the IHACPA and engaged in the development of all relevant aged care costing and pricing development.[3]

[1] See IHACPA Work Program and Corporate Plan 2023–24 – Draft for public consultation ('Work Program and Corporate Plan'), pp 20, 33.
[2] Work Program and Corporate Plan, pp 6-7, 18, 22.
[3] See Work Program and Corporate Plan, pp 8, 12-13, 27-28, 30.

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Accordingly, we request that the Committee read the accompanying Policy Brief and give particular consideration to its recommendations.

AHPA is available to expand on our submission.

Regards

Bronwyn Morris-Donovan
Chief Executive Officer

Attachments

No.	Title
1	Allied Health Professions Australia. What is needed for quality allied health in Australian aged care? March 2023
2	Allied Health Professions Australia submission to the IHACPA on the Aged Care Pricing Framework Consultation Paper. October 2022
3	Royal Commission library public document on costing weightings of allied health according to AN-ACC class (Kathy Eagar et al). October 2022

Allied Health Professions Australia

What is needed for quality allied health in Australian aged care?

As the Royal Commission into Aged Care Quality and Safety concluded, allied health is a fundamental element of the aged care system, and is essential for 'reablement'.

Reablement is about rehabilitation and restoring (e.g. after a fall), or at least preserving as much as possible, older people's capacities. The Commissioners said that reablement is critical to older people's wellbeing and should be a central focus of aged care.[1]

The Royal Commission therefore recommended that provision of consistently safe and high quality aged care include delivery of allied health services appropriate to each person's needs.[2]

To achieve this standard of care, the aged care system must address the seven themes and related outcomes below.

1. Mandatory benchmark and associated funding for allied health

Outcomes needed

- A mandatory benchmark for allied health service provision (e.g. average minutes per resident per day), similar to the current approach to personal and nursing care. Subject to monitoring and evaluation, a preliminary benchmark could be 22 minutes, but include variation according to specific AN-ACC classes, as recommended by the Australian Health Services Research Institute.
- Associated additional core funding for care minutes.

Background

AHPA welcomed the recent care minutes reforms in nursing and personal care, but we are extremely concerned about the lack of mechanisms to similarly ensure sufficient allied health – as the third pillar of aged care – in residential aged care.

Research undertaken for the Royal Commission by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong – the same team which developed the Australian National Aged Care Classification (AN-ACC) – found that in 2019, aged care residents received, on average, only 8 minutes per person per day of allied health care.[3]

To meet the allied health needs of residents, the AHSRI recommended an average of 22 minutes' allied health care, and that funding for allied health service provision be built in to the AN-ACC model.[4]

This recommendation has not been implemented, and Australian allied health care still has no minimum required minutes. Identification of allied health needs and related necessary spending is instead left to the discretion of increasingly financially pressured providers, without any designated funding allocation.

The most recent figures are even more concerning than the Royal Commission's 8 minutes. Total allied health per resident per day now ranges, depending on the source, from 2.85 to 6.36 – at best, around a quarter of the 22 minutes recommended.[5]

A recent scoping study commissioned by the Department of Health and Aged Care concludes that the level and breadth of allied health involvement in Australian residential aged care homes is 'limited'.[6]

A survey undertaken by AHPA's Aged Care Working Group, of allied health professionals working in residential aged care, shows there are already serious impacts on both the workforce and residents. These trend include more than one in 8 allied health professionals losing their jobs, and another 30% planning to leave the sector, with professionals reporting particular distress about negative impacts on the quality of care they are able to provide.[7]

As the AN-ACC funding model did not commence until 1 October 2022, data reported by providers does not yet reflect its impact. However, without an allied health benchmark and targeted funding, the AN-ACC will not be sufficient to address the gross under-provision of care identified by the Royal Commission.[8]

2. National care assessment and planning tool

Outcomes needed

- Urgent development and implementation of a nationally consistent, evidence-based, care assessment and planning tool for both residential and in-home care.

Background

The AN-ACC team recommended the separation of assessment of residents for funding purposes, from the assessment of residents for delivery of appropriate care. The latter requires development and implementation of a nationally consistent, evidence-based, care assessment and planning tool, for both residential and in-home care.[9]

This has not happened. In residential care, the assessor workforce only determines the AN-ACC funding classification level, and 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 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.

Currently, in home care, 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.

Although some work is being done to strengthen the Aged Care Quality Standards, it does not specifically address the need for the tool (see #4). In the foreseeable future then, many aged consumers will not receive the allied services best placed to meet their needs.

3. Multidisciplinary care

Outcomes needed

- Allied health services are an integral aspect of the trial models.
- AHPA and individual discipline peaks are part of collaborative design, implementation and evaluation of the trials.

Background

Many older peoples' needs, especially if complex, are best assessed and addressed via multidisciplinary teams which include various allied health professionals working alongside nurses, GPs and specialists.[10]

As an example of a multidisciplinary aged care model, AHPA originally proposed the Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project.[11] The EMBRACE project would include identification of pathways to the full range of allied service delivery, student placements, and outcome evaluation.

Our longer term vision is for multidisciplinary outreach care to be available for aged care residents, tailored to location so that appropriate services are available wherever older people live.

AHPA has since become aware that work has begun on a joint Commonwealth–States/Territories project, 'Multidisciplinary Outreach Service trials in Residential Aged Care Facilities'. The trials, with a concurrent evaluation, are intended to reduce emergency department attendances and potentially preventable hospitalisations.

AHPA had an initial meeting with the Department of Health and Aged Care in December 2022 concerning the models. We are now seeking further engagement.

4. Regulation of allied health quality and safety

Outcomes needed

- Systemic monitoring of allied health service provision via strengthening the Aged Care Quality and Safety Commission, including through own motion powers similar to those of the NDIS Quality and Safeguarding Commission.
- Quarterly Financial Reporting requirements for allied health service provision by residential aged care facilities include reporting against a recommended best practice minimum ratio of allied health professionals to allied health assistants.
- The Commonwealth works with States and Territories to develop a National Allied Health Assistant Delegation and Supervision Framework that applies across the care and support, and public and private sectors.
- A strong, independent, and well-resourced Inspector-General of Aged Care, with a focus on increasing the accountability of all aspects of Australia's aged care system, legislatively embedded in a consultative structure that requires input from the aged care sector on systemic concerns. One possible mechanism is a stakeholder consultative committee similar to those currently operating for the NDIS Quality and Safeguards Commission.
- An independent unit within the Office of Inspector-General for monitoring implementation and responses to allied health-related Royal Commission recommendations, including those concerning the workforce, funding, and the role of allied health in reablement. The unit is mandated to report on implementation of Royal Commission recommendations at least every 6 months.

Background

As outlined in #1, despite the previous Government's acceptance of Royal Commission Recommendation 36 and in-principle acceptance of Recommendation 38, there is still no accountable standard for allied health service provision.

Equally concerning is what seems to be a trend for aged care providers to substitute 'cheaper' workers from outside allied health, such as lifestyle coordinators, to provide services that considerations of quality and safety require to be delivered by an allied health professional.

Similarly, allied health assistants (AHAs) are sometimes 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, or are simply not suited to the task, which 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.

Currently the Aged Care Quality and Safety Commission (ACQSC) is the only statutory entity tasked with identifying any insufficient or inappropriate aged care provision. But the ACQSC's yardstick is mainly the Aged Care Quality Standards, and even if recently proposed reforms to them are implemented, they will not ensure consistency with the Royal Commission's allied health recommendations.[12] Possible future development of an allied health-related Quality Indicator will also not provide the accountability urgently needed.[13]

In addition, the ACQSC has not yet addressed systemic allied health issues, despite provision of needs-based allied health clearly being a quality and safety issue.[14]

AHPA therefore welcomes the federal Government's proposal to establish an office of Inspector-General of Aged Care.[15] Together with a stronger ACQSC to ensure sufficient allied health provision, the Inspector-General should play a key oversight role in ensuring systemic transparency and accountability of the aged care system, including for allied health.

It is particularly important that the Inspector-General review Commonwealth implementation of responses to the Royal Commission's recommendations, because this process has been especially lacking for most of the allied health-related recommendations. The Review should include examining how Commonwealth measures and actions taken correspond to the recommendations, and an analysis of their effectiveness (Royal Commission Recommendation 148).

5. Allied health data

Outcomes needed

- Allied health services are included in the National Aged Care Data Asset.
- Comprehensive allied health aged care data collection and public reporting, including of allied health service provision delineated by specific professions and AN-ACC class per resident per day.
- Full integration of allied health services into National Minimum Datasets linking health and aged care, to enable identification of whether a person has received aged care services, and the type of those services.

Background

An effective aged care system must be able to ascertain whether people are receiving allied health services according to assessment of their clinical needs, and if care is being appropriately delivered and coordinated. Consumers can use the data to inform their choices about aged care services or facilities, and future improvements can then be based on evidence.

Some data on allied health costs and time spent is now included in the new Quarterly Financial Report for residential aged care (QFR).[16] However, although the next iteration of the QFR will reflect the AN-ACC changes, allied health care provided will not be publicly reported against each of the 13 AN-ACC classes. It will therefore not be possible to know whether, for example, older people with high needs received more allied health services on average than higher functioning residents.

While the QFR means that at least some allied health data by individual profession will now be reported, in-home care data will only include an aggregated allied health figure. It is important that data is collected for each specific type of allied health service across the aged care sector, not only to address older people's particular service needs, but also for workforce planning (see #6).[17]

Currently there is also no way for the public to use the basic allied health data reported to assess whether care is being provided via appropriate allied health needs assessments, care planning, and the involvement of multidisciplinary teams to clinically assess residents and match them with the right types and levels of allied health care (see #3).

6. Workforce planning and support

Outcomes needed

- As a 2-year interim measure, AHPA is funded to work with individual allied health peak bodies to enhance existing workforce data collection.
- The Commonwealth Government invests in the development and implementation of a nationally consistent survey of all allied health professionals.
- The Commonwealth Government funds a national repository for allied health workforce data.
- The aged care sector collaborates with the disability, veterans' care and primary health care sectors to develop a funded National Allied Health Workforce Strategy.

Background

To genuinely enhance the capabilities of the aged care allied health workforce, long-term neglect of the sector must be addressed.

Despite allied health being the second largest health workforce, there is no national allied health workforce strategy and no clear picture of the various settings, sectors and locations in which allied health professionals work.[18] Without these we cannot effectively address areas of particular disadvantage and lack of access, such as where older persons in rural and remote areas cannot obtain particular allied health services.

Workforce planning needs to be supported by a national minimum dataset (see #5) so that we can accurately predict workforce shortfalls and ensure the right flow of new graduates. Allied health students should also have guaranteed placements so that they can fulfil practical training requirements. Students and clinicians must be provided with access to supervision and mentoring, regardless of where they are based.

7. Digital integration

Outcomes needed

- Adequately funded integration between My Health Record and allied health clinical information systems, with practical support from the Australian Digital Health Agency.
- A modernised My Health Record that enables allied health professionals to contribute critical health information via automated reports.
- Implementation of the Australian Digital Health Agency National Healthcare Interoperability Plan, which identifies ways to overcome interoperability barriers for allied health professionals.
- Funded development of education packages to support allied health professionals to rapidly integrate digital reforms into their practices, and incentives for practices to rapidly adopt digital health and new digital technologies.

Background

Interoperable, accessible digital systems are required to enable the efficient and timely sharing of allied health aged care information (Royal Commission Recommendations 68, 109).

Allied health professionals are essential to aged care multi-disciplinary teams (see #3). The client knowledge they share helps other professionals to improve older people's health outcomes.

Yet allied health remains largely disconnected from digital initiatives aiming to enhance service delivery and collaboration within the broader health and aged care systems, such as My Health Record.

This is not due to allied health lack of interest and unwillingness. It is the result of past Government failure to provide appropriate mechanisms to build system capacity that would facilitate the digital integration of allied health, which in the private sector often consists of small and even sole trader practices.

Endnotes

1 For more detail, see https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/, pp 3-4.

2 See especially Recommendations 36 and 38.

3 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 , 2.

4 Ibid, 33-35; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, ANACC: 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.

5 2.85 from Mirus for January 2023; 4.9 from University of Technology Sydney Ageing Research Collaborative for FY22; 5.07 from StewartBrown for FY22; 5.6 from Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022; 6.36 from StewartBrown for the three months ending 30 September 2022. These figures are averages, except for the Department's which is the median.

6 https://www.health.gov.au/resources/publications/scoping-study-on-multidisciplinary-models-of-care-in-residential-aged-care-homes-summary.

7 https://ahpa.com.au/advocacy/3489-2/.

8 https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/.

9 Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, ANACC: 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.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/. See also Royal Commission Recommendations 25, 28, 31, 37 and 38.

10 See e.g. Royal Commission Recommendations 28, 58.

11 https://ahpa.com.au/advocacy/aged-care-system-needs-emergency-first-aid-say-allied-health-professionals/.

12 https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ , pp 6-11.

13 For example, current Residential Aged Care Quality Indicators contribute a total of 15% weighting to Star Ratings, which inform consumer choice rather than mandating quality.

14 https://ahpa.com.au/advocacy/submission-to-capability-review-of-the-aged-care-quality-and-safety-commission/.

15 https://ahpa.com.au/advocacy/submission-exposure-draft-of-the-inspector-general-of-aged-care-bill-2022/ . See also Royal Commission Recommendation 12.

16 Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022.

17 For more detail see https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ , pp 8-9.

18 https://ahpa.com.au/advocacy/pre-budget-submission-2023/ . See also Royal Commission Recommendation 75.

Allied Health Professions Australia

Submission to Independent Health and Aged Care Pricing Authority on Aged Care Pricing Framework Consultation Paper August 2022

October 2022

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 of this Submission

AHPA's submission focuses on the allied health-related issues that we consider should be addressed and included in the Pricing Framework.

The 'Towards an Aged Care Pricing Framework Consultation Paper' ('Consultation Paper') describes IHACPA's expanded role in providing independent aged care pricing advice to the Commonwealth Government as aiming to ensure that aged care funding, including through the new classification system for residential aged care and respite care, the Australian National Aged Care Classification (AN-ACC), is directly informed by the actual costs of delivering care.[1]

The Royal Commission into Aged Care Quality and Safety ('Royal Commission') concluded in March 2021 that allied health services are underused and undervalued across the aged care system.[2] The Royal Commission concluded that the significant under-provision of allied health care produces morbidity, mortality and quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[3]

The Commissioners called for 'a change in culture in the aged care sector, to view allied health services as valuable rather than a burden on funding',[4] and for allied health to become 'an intrinsic part of residential care'.[5]

The Royal Commission further recommended that the aged care system should focus on wellness, prevention, reablement and rehabilitation, and extend beyond physical health to a

[1] Consultation Paper, p8.
[2] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83.
[3] See eg Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.
[4] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[5] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101.

multidimensional view of wellbeing.[6] Recommendation 38 focused on residential aged care and supported this more holistic approach through requiring the provision of a level of allied health care appropriate to each person's needs.

As the Consultation Paper outlines, the changes associated with the introduction of the AN-ACC are underpinned by a general ethos that pricing and funding should remain closely aligned to the care that is required and provided.[7]

We submit that consistent with IHACPA's role and function, there are various themes 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, and should also be aligned with reporting mechanisms for activity data, benchmarks and standards that inform the allied health components of any costing studies that are undertaken.

AHPA submits that this approach would be consistent with the current principles proposed as an overarching framework for IHACPA's decision making. We also suggest some further principles to ensure that pricing and costing consider needs-based allied health service provision, and to enhance accountability of the pricing framework and its operation.

Response to Consultation Paper Questions

1. What, if any, may be the challenges in using AN-ACC to support ABF in residential aged care?
2. What, if any, concerns do you have about the ability of AN-ACC to support long-term improvement in the delivery of residential aged care in Australia that is efficient, sustainable and safe?
3. What, if any, additional factors should be considered in determining the AN-ACC NWAU weightings for residents?
4. What should be considered in developing future refinements to the AN-ACC assessment and funding model?
19. How should any adjustments for quality and safety issues be considered in the long-term development path of AN-ACC and the associated adjustments?
15. What, if any, additional adjustments may be needed to address higher costs of care related to the resident characteristics?

The current state of allied health provision in residential aged care is fundamentally at odds with the principle that funding should remain closely aligned to the care that is required and provided.

Research was undertaken in 2018 for the Royal Commission by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong – the same team, led by Professor Kathy Eagar, which developed the AN-ACC model.[8] That research found that aged care residents

[6] 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*, 176 and Recommendations 35 and 36.
[7] See eg Consultation Paper, p28.
[8] See eg Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: 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.

receive an individual average of only eight minutes of allied health care a day.[9] Even this figure is probably an over-estimate, and has since decreased to 5.07 minutes.[10]

Lack of funding

The AN-ACC team recommended that funding for allied health service provision be built in to the AN-ACC model,[11] but this has not been implemented by Government.

Designated provision of allied health services was omitted from residential aged care costings in the Government Response to the Royal Commission's Final Report,[12] and was absent from both the 2020-21 and 2021-22 federal Budgets. There is no plan to increase access to allied health services as part of core or dedicated funding, and 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]

The Department has derived a yardstick for allied health funding from a recent survey by StewartBrown (2021) which found that residential aged care providers spent 4% of their care funding on allied health.[14] For 2022–23, the Department translates this 4% into approximately $700 million of the care funding allocated by the Government to providers as part of the AN-ACC model.[15]

There are several flaws in this assumption. First, it assumes that such spending will continue, despite recent reports of widespread provider crisis.[16] Second, as outlined in the section below, there is no mandated minimum benchmark for the provision of allied health care.

Lastly, Government has provided no indication of how the '4%/$700 million' might translate into average minutes of allied health care. Minutes are a better measure than aggregate costings because allied health care costs more per minute than, for example, personal care.[17]

AHPA's own calculations and analysis in the separately attached **Appendix 1** demonstrate that even the most sanguine model of provider spending will not produce anything near the recommended 22 minutes a day. In fact, it is not clear that '4%' even translates to $700 million. We therefore relied on an upper and lower measure of spending, and also factored in two

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[9] 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 , 25.
[10] StewartBrown, Aged Care Financial Performance Survey Sector Report (FY22), p16 https://www.stewartbrown.com.au/news-articles/26-aged-care/266-2022-10-stewartbrown-aged-care-financial-performance-survey-sector-report-june-2022 .
[11] 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 , 33-35; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: 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 https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .
[12] Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021.
[13] For more detail see Appendix 1.
[14] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .
[15] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .
[16] StewartBrown, Aged Care Financial Performance Survey Sector Report (FY22) https://www.stewartbrown.com.au/news-articles/26-aged-care/266-2022-10-stewartbrown-aged-care-financial-performance-survey-sector-report-june-2022 ; Rick Morton, 'Exclusive: Nursing homes advised to avoid 'high-needs' residents', Saturday Paper 15 October 2022 https://urldefense.proofpoint.com/v2/url?u=https-3A__www.thesaturdaypaper.com.au_share_14817_2nM17Q1M&d=DwIFAg&c=euGZstcaTDllvimEN8b7jXrwqOf-v5A_CdpgnVfiiMM&r=1YLVEAEPAaN6WcQGpPM9OKWWxtFpusnJGljNyNDHo6Q&m=gKjOQZmSMFVk5C3DzNw01jThHGFCoUxmjXl0OPhoAFg&s=c3ushof-FSN7dTAB6pA0TjXWcSwGhwc37-dsZngqcT0&e= .
[17] AHRSI considered care minutes to be an appropriate proxy for cost per resident per day, given that care staff salaries are the largest contributor to the costs of operating aged care facilities (Eagar K, McNamee J, Gordon R, Snoek M, Duncan C, Samsa P & 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, 34).

approximate costings of allied health services which we described as 'realistic' and 'conservative'. It is also important to note that while we extrapolated to minutes from the two Government spending figures, for the comparison with the Royal Commission finding it was necessary to employ the reverse calculation, from minutes to cost, as costings were not available.

The results are summarised below.

Comparing average allied health service provision figures

Source of estimate	Allied health spending per person per year	Allied health minutes per person per day
Royal Commission	$3489 (conservative[1])–$4900 (realistic[2])	8[3]
Commonwealth Government: $511 million (derived from recent provider spending of 4%)	$2779	4.6 (realistic)–6.4 (conservative)
Commonwealth Government: $700 million	$3807	6.3 (realistic)–8.8 (conservative)

1. Costed at $71.20 per hour 2. Costed at $100 per hour 3. Includes lifestyle spending which is not allied health

Our calculations show that at very best, the Royal Commission's average of 8 minutes per resident per day will only be increased by less than a minute. At worst, residents could end up receiving an average of 4.6 minutes' allied health care per day. In the absence of a benchmark and taking the AN-ACC team's figure of 22 minutes as a proxy measure for meeting residents' needs, Government approach to allied health finding for residential care can be seen to be an abject failure.

Lack of benchmarks

Nursing and personal care minutes are required to be reported against benchmarks, which are reflected in initial AN-ACC prices (Consultation Paper, p28). Despite allied health being emphasised as the third pillar of residential aged care by both the Royal Commission and the architects of the AN-ACC, there is no equivalent standard for allied health, and therefore no reflection in AN-ACC pricing.

This is an especially glaring absence given the recent changes to Part 3 of Schedule 1 of the *Quality of Care Principles 2014* (Care and services for residential care services). These reforms included removal of a distinction between the different Parts of the Schedule so that additional fees are no longer payable by any care recipient for the provision of any of the care and services in Part 3 of Schedule 1.[18] This change means that any allied health service required by the resident is now even more likely to be required to be paid for by the provider from their overall AN-ACC funding.[19]

While AHPA welcomes the recent Government commitment to including allied health costs and time by individual allied health profession in the Quarterly Financial Report for residential aged

[18] *Quality of Care Principles 2014*, Part 2 ss 6 &7 (amended by Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 and Item 25, Aged Care Legislation Amendment (Residential Aged Care Funding) Instrument 2022). For specific allied health provisions, see especially *Quality of Care Principles 2014*, Schedule 1, Part 2, Item 2.8 and Part 3, Item 3.11.
[19] Note that short-term restorative care in a residential setting is still treated differently in that residents may be required to pay fees (*Quality of Care Principles 2014*, Schedule 5).

care,[20] providers will only be required to distinguish the cost and time spent delivering physiotherapy, occupational therapy, speech pathology, podiatry and dietetic care, together with the (undifferentiated) use of allied health assistants. The rest of allied health will be aggregated into 'other'.

Allied health care provided will also not be, at least publicly, reported against each of the 13 AN-ACC classes, so it will not be possible to know whether, for example, older people with high needs received more allied health services on average than high functioning residents. There also appears to be no way under the current model for the public to use even the basic allied health data reported to assess whether allied health care is being provided via appropriate allied health needs assessments, care planning and the involvement of multidisciplinary teams in order to clinically assess residents and match them with the right types and levels of allied health care.

This data gap is because to date, despite recommendations from both the AN-ACC team and the Royal Commission,[21] the aged care reforms do not embed automatic allied health assessment, use of a standardised care planning tool and delivery via multidisciplinary teams, in either residential or home care.

In residential care, the assessor workforce only determines the AN-ACC funding classification level, and it is then up to facility staff to identify any perceived allied health needs. Whether the resident then receives allied health services therefore depends on existing staff skills and breadth of knowledge of different types of allied health, and so may only occur in response to an adverse event.

The onus is then on the provider using their discretion to deliver the right care needs/case mix to meet the person's identified needs, without any designated funding or benchmarks for allied health.

Allied health assessment, care planning and multidisciplinary team coordination entail time and costs, and whether they are employed by providers will not be clear from the data reported, and certainly will not be factored into costings (see further, 'Lack of data for costing and pricing' below).

Implications for accountability

Any effective aged care system must be able to provide measures of public accountability so that it can be ascertained whether people are receiving allied health services according to assessment of their clinical needs, care is appropriately delivered and coordinated, and impacts are documented. In turn, consumers can use that data to inform their choices about aged care services or facilities, and future improvements can be identified and supported by evidence.

In the absence of any Government commitment to allied health provision, the purpose of the new level of allied health reporting is unclear. The Department has simply stated:

[20] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers ; https://health.formsadministration.com.au/dss.nsf/DSSForms.xsp .

[21] 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; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: 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; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ ; Royal Commission Recommendations 28, 31, 37 and 38.

> 'This information is important because it will allow the Department to understand how allied health is delivered in residential aged care facilities. The reporting of allied health care minutes will help the Department to monitor the overall cost of care to aged care facilities.'[22]

The Department insists that allied health will be adequately provided, by citing providers' obligations under the *Aged Care Act 1997* ('the Act') and in particular as defined by the Aged Care Quality Standards in the *Quality of Care Principles 2014* ('the Principles').[23]

Providers' legal responsibilities in relation to the quality of the aged care that they provide include:

> to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;[24]
>
> to comply with the Aged Care Quality Standards;[25] and
>
> such other responsibilities as are specified in the Quality of Care Principles.[26]

When providers' responsibilities under the Act and the Principles are read to together with the Quality Standards most directly applicable to the provision of allied health care to aged care residents,[27] it can be concluded that provision of allied health care and services on a needs basis is mandatory for all residential care recipients. This obligation on providers is strikingly similar to the language of the Royal Commission's Recommendation 38 aimed at addressing the grossly inadequate level of allied health: 'to ensure residential aged care includes a level of allied health care appropriate to each person's needs.'

The Department stated in Evidence to the Senate Community Affairs Legislation Committee Inquiry into Aged Care Amendment (Implementing Care Reform) Bill 2022 that the Aged Care Quality and Safety Commission ('ACQSC') will identify any instances of insufficient allied health provision.[28] We understand that information on the provision of allied health services under AN-ACC will be shared with the ACQSC with the aim of ensuring that providers meet their responsibilities under the Quality Standards.

But it is not clear how, other than via audits and responses to complaints, the ACQSC will actually monitor, let alone enforce, the minutes and cost of allied health provided, against the Quality Standards. Of particular concern is the fact that both the ACQSC and the Quality Standards pre-date the Royal Commission's finding of eight allied health minutes, and associated recommendations.

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[22] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers .
[23] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5 and Schedules 1 and 2. Similarly, the Regulatory Impact Statement for the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 notes 'there is a risk that providers reduce allied care services within residential aged care when the requirement to provide certain treatments to access additional funding is removed. This risk is minimised by the Aged Care Quality Standards requiring the delivery of clinical care in accordance with the consumer's needs, goals and preferences to optimise health and well-being' (p198).
[24] *Aged Care Act 1997*, s 54-1(1)(b).
[25] *Aged Care Act 1997*, s 54-1(1)(d).
[26] *Aged Care Act 1997*, s 54-1(1)(h).
[27] *Quality of Care Principles 2014*, Schedule 2, Standards 1, 2, 3 and 7.
[28] (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 transcript, and ACQSC Compliance and Enforcement Policy (14 July 2021), pp7-9.

Lack of data for costing and pricing

This submission has already referred to the parlous state of allied health data collection in residential aged care, with proposed reforms only going a small way to address this. Costing and pricing decisions concerning allied health must also be based on a benchmark for not only how much but also what types of allied health services are provided, and by whom (see further, our response to Q23).

AHPA therefore strongly supports IHACPA's plan for a series of costing studies to support future classification and pricing refinement (Consultation Paper, p24). We assume that the Residential Aged Care Pilot Costing Study which commenced in November 2021 has not taken allied health costs – at least as measured against any provisional benchmark – into account.

To date, the best source of data on allied health service provision in residential aged care is StewartBrown's apparently one-off, 2020 Allied Health Deep Dive Survey, which disaggregates allied health spending from other aged care contributions, and, to some extent at least, delineates the allied health provided by profession.[29] That data indicates potential underutilisation of occupational therapy and podiatry, at 0.6 minutes each of the daily average total of 7.2 minutes.[30] Other allied health professions, such as counselling, psychology, exercise physiology, osteopathy and music and art therapy, do not even appear as categories, suggesting further unmet needs.[31]

The 2020 Deep Dive Survey costed allied health at a range from $33 per hour for internal allied health assistants to $124 for externally contracted speech pathology.[32] This appears highly conservative when compared to pricing in private practice and the National Disability Insurance Scheme (NDIS), and allied health aged care price increases should also be expected in the future.

Past financial reporting has only provided data on those allied health services funded at provider discretion, rather than for services provided on a clinically assessed needs basis. Under the current reforms, future reporting will continue this approach.

Present AN-ACC funding for allied health is therefore not 'closely aligned to the care that is required and provided' (Consultation Paper, p28). Allied health costing must not only consider potential variation in pricing and costs for individual disciplines. As outlined above ('Lack of benchmarks'), it should also include pricing and costing of multidisciplinary clinical assessment of allied health needs and care planning which enables clinical allied health needs to be met, and which in turn results in compliance with the Quality Standards.

More comprehensive future costing studies must address these issues and include data on allied health care reported against the 13 AN-ACC classes,[33] so that Government determination of NWAU value and associated AN-ACC classification weightings is able to reflect the true cost of allied health needs.

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[29] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 . Data was obtained for the 2019-20 financial year. For more detail see Appendix 1.
[30] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 , 4. In addition, dietician/dietetics and speech pathology minutes were both recorded as '0'. It is unknown whether the proportion was too small to register or if data was not provided.
[31] For the full range of allied health professions see https://ahpa.com.au/what-is-allied-health/ .
[32] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 , 5.
[33] 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), pp 2-3.

5. What, if any, changes do you suggest to the proposed principles to guide the development and operation of the Pricing Framework for Australian Aged Care Services?
6. What, if any, additional principles should be included in the pricing principles for aged care services?
7. What, if any, issues do you see in defining the overarching, process and system design principles?

AHPA supports the proposed overarching principles with the following suggested italicised additions:

> **Access to care –** Funding should support appropriate access to aged care services *provided and coordinated on the basis of assessed clinical 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.
>
> **Quality care –** Care should ~~meet~~ *be regularly assessed against* the Aged Care Quality Standards. *Results of assessment should be publicly reported together with any associated investigation and enforcement mechanisms.* ~~and~~ *Care should* aim to deliver *measurable* outcomes that align with community expectations.

We support the proposed process principles, and we note that a key purpose of Activity Based Funding (ABF) described in the Consultation Paper is 'to better align the price of care to underlying costs and optimise efficiency over time' (p33). AHPA submits that the solutions we have proposed for overcoming the identified barriers to needs-based allied health provision are consistent with this purpose. For example, there is a strong relationship between allied health services and reablement. The emphasis of many allied health services on prevention and early intervention helps to avoid costly and unnecessary hospitalisations and surgery.[34]

AHPA supports the proposed system design principles, particularly the person-centred approach that focuses on meeting individual need. However, while we appreciate the logic of ABF pre-eminence, we would prefer to see some incorporation into the principle itself of an acknowledgment that circumstances may exist where it is not practicable to fund a service through an ABF model. This could be along the lines of:

> **ABF ~~pre-eminence~~ *with flexible funding* –** ABF should be used for funding aged care services wherever practicable and compatible with delivering value in both outcomes and cost. *However, some services in some situations will be more compatible with alternative models such as fixed and block funding. Use of such models should be transparent and evidence-based.*

8. What, if any, concerns do you have about this definition of a residential aged care price?

If funding is to be closely aligned to the care that is required and provided, Government determination of NWAU value and associated AN-ACC classification weightings must reflect the true cost of allied health needs and be aligned with reporting mechanisms, benchmarks and standards that inform all of the allied health components of pricing and costings.

[34] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 68; National Aged Care Alliance, 'Position Statement – Meeting the Allied Health needs of older people in residential aged care' (March 2022) https://naca.asn.au/wp-content/uploads/2022/04/National-Aged-Care-Alliance-Position-Statement-Allied-Health-1.pdf .

At least some of the costs of multidisciplinary allied health assessment, care planning and delivery (eg team coordination) may be better met through block funding combined with an ABF approach (see also our response to Qs 5–7 above).

9. What, if any, additional aspects should be covered by the residential aged care price? 10. What, if any, concerns do you have about the proposed pricing approach and level of the residential aged care price?

We strongly support IHACPA's view that there are a number of reasons why the recommended residential aged care price will need to account for additional factors beyond the average cost, at least in the short- to medium-term (Consultation Paper, p37). This submission has outlined a number of these factors relevant to allied health needs-based service provision. For further detail, see our separately attached **Appendix 2**.

AHPA is therefore concerned that the Consultation Paper refers to the recommended residential aged care price being intended to *predominantly* cover the cost of care (our emphasis), and the further statement that elements of care in-scope for the price are specified under Part 2 of the Schedule of Specified Care and Services [in the *Quality of Care Principles 2014*] (p37). Our interpretation is that Part 3 of the Schedule is also in-scope (see 'Lack of benchmarks' above).

11. How should 'cost-based' and 'best practice' pricing approaches be balanced in the short-term and longer-term development path of IHACPA's residential aged care pricing advice?

We find the discussion of best-practice and cost-based pricing confusing (Consultation Paper, p38). Our interpretation of the proposed combination of the two approaches is that while required care standards fundamentally shape pricing, market-based competition also refines the final prices, with flow on effects to funding.

The difficulty from an allied health perspective is that the current aged care system, even once proposed reforms have been enacted, does not properly ensure the provision of allied health to a needs-based quality standard, and provides no real accountability. As evident from the findings of the Royal Commission, a pricing approach that has to date relied heavily on market forces has resulted in provider competition that frequently produces poor and even life-threatening quality of care.

There may be some useful parallels with the NDIS, which still largely relies on price-setting by the National Disability Insurance Agency due to a generally accepted view that markets are not mature enough to settle on an appropriate price. As with the NDIS, there are also unresolved challenges for the aged care sector in terms of adequate provision of services in rural and remote regions, or other 'thin markets' (see our response to Q23).

In this context, and in the short- to medium- term, a best practice approach should be taken. In the longer term, if any cost-based approach is to be built in, providers and Government must be able to publicly demonstrate that any lower pricing will not result in contravention of the Quality Standards.

If pricing through the best practice approach on its own raises fiscal sustainability issues, we note that various strategies to meet the increasing cost of aged care were discussed by the Royal Commission and continue to be mooted, including an aged care levy.[35] It is AHPA's firm view that if Government is genuinely committed to the concept of reablement, the fundamental issue is

[35] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3B The new system*, 628-637.

whether the resident needs the service, not the need to reduce federal Budget expenditure or support providers to make a profit.

23. How might workforce challenges present in the implementation and refinement of AN-ACC for the aged care system?

Realistic pricing for the allied health component of residential aged care must be based on costing the effective delivery of needs-based allied health care. This in turn will require not just increasing the total amount of allied health care provided, but also ensuring that the full breadth of allied health services and associated skillsets are available as required. These requirements have workforce implications.

Reports from the National Aged Care Workforce Census and Survey show that by 2012, of a total allied health FTE proportion of 5.3%, allied health professionals contributed 1.7% and allied health assistants 3.6%.[36] By 2016, the proportion of allied health professionals had dropped to 1.1% with the remaining 2.9% being allied health assistants.[37] The 2020 Aged Care Workforce Census Report indicates that allied health professionals were 3.2% of aged care FTE, with an overall allied health staff proportion of 4.5%.[38]

The Census data seems unlikely to signal any significant upward trend unless there are new funding commitments. Certainly AHPA is aware that since the introduction of the AN-ACC and the associated NWAU value, some allied health professionals have left the aged care sector, and some large providers are disbanding their in-house allied health professional teams, due to the uncertainties around funding for their services.[39] In addition, as outlined above ('Lack of data for costing and pricing'), the data that exists suggests that provision of specific allied health services is particularly inadequate.

Equally concerning is the significant and apparently growing proportion of allied health workers who are allied health assistants. Although valuable contributors to the workforce, assistants are less qualified than allied health professionals, and therefore either require supervision or are simply not suited, nor lawfully permitted, to carry out some essential allied health tasks in aged care.

Another trend is for providers to substitute, again for cost reasons, workers from outside allied health such as lifestyle coordinators, diversion therapy staff and personal care workers to provide services that are much more appropriately undertaken within the scope of practice of an allied health professional. Under-costing and under-pricing, leading to underfunding, risks further such substitution at the expense of allied health professionals and, ultimately, aged care residents.

Nevertheless, given the lack of benchmarks in aged care, together with the ongoing absence of allied health needs-based assessment and care planning, we simply cannot know in any depth how many and what kinds of allied health professionals will be required by the new residential and home care systems.

There has never been a national allied health workforce strategy, let alone one that would help to inform allied workforce planning in aged care. In its absence, current aged care policy generally

[36] Aged Care Financing Authority, *Annual Report on the Funding and Financing of the Aged Care Sector – 2021*, Appendix D. Results for earlier years did not distinguish between allied health professionals and allied health assistants.
[37] Ibid.
[38] Department of Health, *2020 Aged Care Workforce Census Report*, 9-11.
[39] See also (Hansard Proof) Evidence to Senate Community Affairs Legislation Committee, Parliament of Australia, Canberra, 25 August 2022, 20-21 (Scott Willis, National President, Australian Physiotherapy Association).

fails to acknowledge that workforce issues for allied health are significantly different to those for personal care workers, and so simply canvasses and applies the same 'solutions'.[40]

Further contributing to the lack of allied health aged care workforce planning is the fact that there is no minimum allied health dataset of any type to assist that process. Allied health workforce data is, at best, only collected in aggregated and partial form. This makes it impossible to obtain a snapshot of the allied health workforce at a single point in time, let alone inform workforce planning with identified trends, including in relation to workforce supply, activity, distribution, movement of the allied health workforce in and out of the sector, and demand.[41].

Allied health also remains largely disconnected from digital initiatives aiming to enhance service delivery and collaboration, such as My Health Record. This is not due to allied health lack of interest and unwillingness, but rather is the result of past Government failure to provide appropriate mechanisms to build system capacity that would facilitate the digital integration of allied health – which in the private sector often consists of small and even sole trader practices – into the broader health system.

Government aged care sector policy also presents practical obstacles to meeting allied health workforce requirements. As an illustration, a longstanding issue for training the future allied health workforce is that students on practical placements are not able to provide hands-on treatment to patients if the latter are being treated under Australian Government funding schemes (eg Medical Benefits Scheme, Department of Veterans' Affairs) or via private health insurance (eg Medibank, HCF).

These restrictions make it difficult for students to find placements and fulfil practicum requirements. This problem is exacerbated in most private allied health practices because patients under Government-funded or private insurance arrangements are a significant proportion of their casemix, meaning that any potential hands-on experience in private practice for students is limited to those fewer private paying patients. Private practice placements in lower socio-economic areas are accordingly even more limited.

A related long-term problem is the scarcity of senior clinicians able to provide supervision, especially in rural and remote areas. This is also a particular problem for students in newer and emerging allied health professions, who have limited access to supervision in the public system, such as for hospital-based placements.

To truly enhance and make the most of the capabilities of the aged care allied health workforce, long-term neglect of this component of the sector must be addressed. To do otherwise risks turning the whole aged care sector into a 'thin market' for allied health that compromises safety and quality.

25. What would be considered markers of success in IHACPA's aged care costing and pricing work?

Allied health care has no benchmarked minutes, no standardised care planning, no minimum standard and no ringfenced funding for provision of care via coordinated multidisciplinary teams.

[40] For example, the agenda for the Aged Care Workforce: Pre-Jobs and Skills Summit Roundtable https://www.health.gov.au/ministers/the-hon-anika-wells-mp/media/aged-care-roundtable-advances-practical-solutions . In contrast, see Appendix 2.
[41] Department of Health, Allied Health Workforce Data Gap Analysis Issues Paper, 10 June 2022 at https://www.health.gov.au/resources/publications/allied-health-workforce-data-gap-analysis-issues-paper .

As outlined above, if not addressed and appropriately reported, these system weaknesses will then have flow-on effects for the quality of aged care.

If funding is to be closely aligned to the provision of care that is needed, Government determination of the NWAU value and associated AN-ACC classification weightings must reflect the true cost of allied health needs assessed via nationally consistent mechanisms, and be aligned with reporting mechanisms, benchmarks and standards that inform the allied health components of pricing and costings. Allied health workforce costing must be based on a principle of ensuring that the full breadth of allied health services and associated skillsets are available when needed.

The allied health sector must be fully consulted and engaged in the development of all relevant aged care reform, including in pricing development. We note IHACPA's commitment to the establishment of advisory sub-committees and a new statutory Aged Care Advisory Committee (Consultation Paper, p14) and we look forward to engagement via those mechanisms.

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October 2020

Beth Midgley
Director, Policy
Royal Commission into Aged Care Quality and Safety

Re: Methodological advice on casemix-adjusted staffing ratios and related matters

Dear Ms Midgley

We refer to your request for expert advice from the Australian Health Services Research Institute on the methodology that should be used to casemix-adjust staffing ratios using the Australian National Aged Care Classification (AN-ACC). You also sought advice on the split of costs between care staffing and other care-related operating expenses.

In relation to the question about how casemix-adjust staffing ratios should be determined, we draw on the Resource Utilisation and Classification Study (RUCS) that we undertook for the Department of Health and further research we have since undertaken for the Royal Commission into Aged Care Quality and Safety (the Royal Commission).[1,2] In Study One of the RUCS we captured the actual time residents received individual care by different staff classifications. These records were used in the development of the AN-ACC and the methodology is set out in detail in the peer-reviewed journal article that we have subsequently published.[3] This information is also used to determine the average individual care needs for each of the 13 AN-ACC classes.

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[1] The Resource Utilisation and Classification Study (RUCS) Reports are available at https://www.health.gov.au/resources/publications/resource-utilisation-and-classification-study-rucs-reports

[2] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) *How Australian residential aged care staffing levels compare with international and national benchmarks.* Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

[3] Eagar K, Gordon R, Snoek MF, Loggie C, Westera A, Samsa PD and Kobel C (2020) *The Australian National Aged Care Classification (AN-ACC): a new casemix classification for residential aged care.* Med. J. Aust., 213: 359-363. doi:10.5694/mja2.50703 and included as an attachment.

The AN-ACC funding model has two main components:

- An individual component based on 13 AN-ACC classes and
- A base care tariff component to cover shared time that every resident benefits from.

For casemix-adjust staffing ratios purposes, total staff time needs to take into account both individual time and shared time. The RUCS did not report on how shared time is distributed between the classes. Accordingly, it is necessary to apply expert judgement in apportioning shared time between the classes for the purposes of determining staff ratio requirements and this is what we have done.

We first tested the two extremes: at the one end, shared time is distributed equally among classes, i.e. residents in class 1 get the same amount of shared time as residents in class 2, or any other class. At the other end, shared time is distributed in proportion to individual time. Neither extreme is clinically plausible and neither aligns with the funding model.

We thus developed a mixed model and tested this with a small group of aged care service experts. The details of the recommended approach are:

- The resident's individual time is determined as per their AN-ACC class.
- The shared time is calculated in two components. 50% of shared time is split equally between the classes. The other 50% is split in proportion to individual time. In other words, 75% of total time for mandated staffing purposes is based on individual time as per the resident's AN-ACC class and 25% is based on shared time.

This is clinically defensible and is a sensible middle course. The values in the table below represent the total time (i.e. individual and shared time) for this compromise.

This table shows relative staff time for the AN-ACC classes and the values for each staff type are calibrated separately so that the average across the classes is 1 (or 100%). These values can be used to determine the casemix-adjusted staffing ratios specific to the respective staff type or total care staff. Total care staff includes registered nurses, enrolled nurses, personal care workers and other care staff but not allied health.

Staff time	Total	Registered Nurse	Allied Health
Class1	1.721	1.509	0.789
Class2	0.521	0.715	1.119
Class3	0.703	0.780	0.796
Class4	0.552	0.648	1.017
Class5	0.796	0.982	1.119
Class6	0.763	0.832	1.338
Class7	0.958	0.903	1.018
Class8	1.038	0.938	1.215
Class9	1.052	1.179	0.621
Class10	1.529	1.480	1.165
Class11	1.484	1.032	0.568
Class12	1.448	1.074	0.854
Class13	1.721	1.509	0.789
All	**1.000**	**1.000**	**1.000**

We recommend that the Royal Commission uses the table above to determine casemix-adjusted staffing requirements using the Australian National Aged Care Classification (AN-ACC) based on the USA Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare system. As Professor Eagar outlined in her evidence in October 2019, the CMS system makes provision for two elements: total staff and registered nurse staff time. Allied health time is excluded from the CMS model but we recommend it be included in any Australian refinement.

The casemix-adjusted total staffing requirement is determined by multiplying the desired number of minutes (e.g. 215 minutes) with the 'total' values for each class, e.g. for class 2 on average 112 minutes (= 215 minutes x 0.521) of total staff time are required. The casemix-adjusted registered nurse staffing requirement can be determined by multiplying the desired number of minutes (e.g. 44 minutes) with the 'registered nurse' values , e.g. for class 1 on average 66 minutes (= 44 minutes x 1.509) of registered nurse time are required.

We have shown allied health relativities separately as these are not included in the CMS model.

In relation to the question about how to split of costs between care staffing and other care-related operating expenses we draw on results from Study Two of RUCS where we investigated total care cost.[1] We found that the vast majority of direct care-related costs are salaries for care staff. Based on this evidence, we recommend that any regulation of staffing and the requirement that care funding is spent on care provision includes a minimum of 85% of care funding be spent on care staffing with up to 15% on consumables and overheads.

We also recommend that, in the longer term, an empirical study should be undertaken to update this shared time distribution along with updated cost and utilisation data.

Please contact us if you require any further information.

[redacted]

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The Australian National Aged Care Classification (AN-ACC): a new casemix classification for residential aged care

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The known: The profile of Australian aged care residents has changed markedly in recent years. Residents are older and frailer, with an annual mortality rate of around 32%.

The new: Residential aged care needs and cost predictors are captured in the Australian National Aged Care Classification by measures of frailty, mobility impairment, functional decline, cognitive loss, behavioural disturbance and technical nursing needs.

The implications: The Australian National Aged Care Classification is a new casemix system for classifying aged care residents, and for determining funding and staffing requirements. It can be used in routine evaluation of aged care facility outcomes, taking into account the mix of residents in each facility.

Abstract

Objective: To develop a casemix classification to underpin a new funding model for residential aged care in Australia.

Design, setting: Cross-sectional study of resident characteristics in thirty non-government residential aged care facilities in Melbourne, the Hunter region of New South Wales, and northern Queensland, March 2018 – June 2018.

Participants: 1877 aged care residents and 1600 residential aged care staff.

Main outcome measures: The Australian National Aged Care Classification (AN-ACC), a casemix classification for residential aged care based on the attributes of aged care residents that best predict their need for care: frailty, mobility, motor function, cognition, behaviour, and technical nursing needs.

Results: The AN-ACC comprises 13 aged care resident classes reflecting differences in resource use. Apart from the class that included palliative care patients, the primary branches were defined by the capacity for mobility; further classification is based on physical capacity, cognitive function, mental health problems, and behaviour. The statistical performance of the AN-ACC was good, as measured by the reduction in variation statistic (RIV; 0.52) and class-specific coefficients of variation. The statistical performance and clinical acceptability of AN-ACC compare favourably with overseas casemix models, and it is better than the current Australian aged care funding model, the Aged Care Funding Instrument (64 classes; RIV, 0.20).

Conclusions: The care burden associated with frailty, mobility, function, cognition, behaviour and technical nursing needs drives residential aged care resource use. The AN-ACC is sufficiently robust for estimating the funding and staffing requirements of residential aged care facilities in Australia.

As in all developed nations, the Australian population is ageing and the need to provide care for older people who cannot live independently is increasing. In 2017–18, total government expenditure for aged care services was $18.4 billion, including $12.4 billion (67%) for residential aged care.[1] Expenditure will inevitably increase as the number of older people grows, and must also increase to mitigate the quality and safety problems care identified by the Royal Commission into Aged Care Quality and Safety.[2,3]

Since the introduction in 2008 of the current aged care funding model, the Aged Care Funding Instrument (ACFI), the profile of people entering residential care has changed substantially, partly because of the success of programs that enable people to stay at home longer. Residents are now typically older and frailer on entry (about half are over 84 years old), and their annual mortality rate is around 32%. Consequently, about half of those who enter residential care will live there for two years or less.[4,5]

The 2017 review of the ACFI found that it does not sufficiently discriminate between the care needs of residents, that it is administratively inefficient, and that it provides perverse incentives; for example, if a resident's functioning improves, ACFI funding can be reduced. It concluded that the ACFI is "no longer fit for purpose".[6]

The 2017 review investigated overseas funding models and found that none were suitable for Australia. The only well developed system for classifying people in long term care is the Resource Utilization Groups (RUG) system, a casemix system developed through a series of research studies and designed to explain and predict resource use. The original version, developed in the United States in 1994, comprised 44 classes and explained 55.5% of variance in daily costs; the most recent version, RUG-IV, includes 66 classes. The statistical performance of the RUG system has varied in overseas studies, reported reduction in variation statistics ranging between 0.12 and 0.56.[7] Designed for use in both nursing homes and skilled nursing facilities in the US, it has a hierarchic patient category structure — rehabilitation, extensive services, special care, clinically complex, impaired cognition, behaviour problems, and reduced physical function — not directly relevant to the Australian aged care system.

The 2017 ACFI review proposed developing a new funding model for Australian residential aged care.[6] In this article, we describe the development of a new classification system to underpin this funding model.[8]

Methods

Sampling

The population of interest comprised residents in non-government aged care facilities in Australia. As it was impractical to include all of Australia, three regions — Melbourne, the Hunter region of New South Wales, and northern Queensland — were purposively selected to respectively represent major cities, regional areas, and remote areas. Within each region, homes were stratified by type (not for profit, for profit) and size

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(large, medium, small) to ensure that these characteristics were adequately represented in our sample. The number of facilities selected from each stratum was proportional to its size. Facilities were then randomly selected from each stratum, and all residents in each selected facility invited to participate.

Our sample size calculation took into account the mean and variance in cost for each stratum, based on Department of Health data on the location, type, size and government funding received for each residential aged care facility in Australia. The required sample size, determined such that the margin of error for mean daily costs was no more than $10, was calculated to be 2200 residents from 30 facilities. After the classification was developed, it was verified in a representative national sample of a further 69 facilities (data not reported in this article).[9]

Clinical data design and collection

Our resident assessment tool was designed after reviewing the relevant international literature and with the advice of four clinical advisory panels. The panels included clinicians and researchers with expertise in aged care, rehabilitation, geriatric medicine, psychiatry of older people, wound management, and palliative care. Each panel focused on one area of clinical need: function, cognition and behaviour; wound management; palliative care; and technical nursing. The design of the tool has been described in detail elsewhere.[10] The tool was designed to capture resident attributes that best predict differences in their need for care. Its development was guided by four principles:

- it should be suitable for use by independent clinical assessors;
- it should be possible to complete it in one session, with minimal burden for the resident;
- the validity and reliability of instruments comprising the tool should be established;
- the instruments should not be subject to royalty or copyright restrictions.

The final version of the assessment tool included seven existing instruments, as well as items related to palliative care, frailty, and technical nursing (Box 1).

Participating residents were assessed during March 2018 – June 2018 by registered nurses recruited and trained for the study.

Service data collection

Concurrent with resident assessments, service use data (staff time) were collected for one calendar month in each home. The data collection period was staggered over three months to allow the research team to support staff during data collection.

All care delivery staff recorded service use data each day using handheld barcode scanners and purpose-designed scan cards. Each staff member, resident, and type of activity undertaken during a shift were assigned unique barcodes. Staff scanned details of activities and uploaded the data from the scanner to a secure server at the end of each shift. This approach enabled data to be captured by shift in real time.

A unique feature of our study was the distinction between shared care and individual care. Individual care was defined as care tailored to the needs of an individual resident. Shared care was defined as care not tailored to individual resident needs; that is, care received equally by all residents, including general supervision in common areas, clinical care management and quality activities, and brief incidental interactions.

Data preparation

Prior to class-finding, the datasets were checked for completeness, consistency, accuracy, validity, and timeliness. The datasets were then linked to create one record for each resident, including both assessment and service use data. For the analyses, cost was defined as staff time per resident, as a preliminary analysis indicated that 92% of all care costs were for staffing.

Data analysis

The goal of our study was to develop a casemix classification system with classes that were:

- clinically meaningful to care staff and useful for clinical management;
- based on resident characteristics rather than on provided services;
- comprehensive, consistent, and mutually exclusive, so that each resident can be assigned to one, and only one, class;
- homogeneous with respect to resource use, so that the cost of care for residents in a given class is similar.

Clinical meaning was determined by the clinical advisory panels. We aimed to ensure that the classification was administratively and operationally feasible, and sufficiently flexible to allow progressive refinement in response to practice changes, technical advances, and the identification of new cost drivers. Moreover, its application should not give rise to perverse incentives.

We used classification and regression tree analysis — that is, a decision tree algorithm for generating regression tree predictive models — to develop the classification.[11] This procedure predicts values of the dependent variable (resource use) based on the values of independent variables (resident characteristics). Overall performance of the classification was assessed with the reduction in variation statistic (RIV; the variance explained by the classification as the proportion of total variance). The homogeneity of each class was measured as the coefficient of variation (standard deviation divided by the mean; online Supporting Information).

An iterative series of statistical analyses and clinical reviews were undertaken: initial statistical results were reviewed by clinical advisory panel members, and their advice was incorporated into subsequent analyses. This iterative process continued until an outcome was achieved that was both statistically robust and meaningful from a clinical perspective.

The stability and reliability of the classification model was determined with test–retest methodology, using 1042 records for the test dataset and 613 records for the validation dataset.

Statistical analyses were conducted in SPSS 21.

Ethics approval

This study was approved by the University of Wollongong and Illawarra Shoalhaven Local Health District Human Research Ethics Committee (reference, 2017/546).

1 Independent variables included in the Australian National Aged Care Classification, version 1

Independent variable	Description	Primary branch: Independent mobility	Primary branch: Assisted mobility	Primary branch: Not mobile
Modified De Morton mobility index (DEMMI)[12]	12 items, four subscales (bed, chair, static balance, walking); questions 13–15 of standardised DEMMI excluded. Used to assign resident to a mobility branch			
Australian modified functional independence measure (AM-FIM)[13,14]	17 items, two subscales (motor and cognition) and six domains (self-care, sphincter control, transfers, location, communication, social cognition)			
Motor	Self-care, sphincter control, transfers, location domains (12 items)		✓	
Transfers	Three items (bed/chair, toilet, shower)			✓
Eating	Single item			✓
Cognition	Communication and social cognition domains (five items)	✓✓		
Communication	Two items (comprehension and expression)		✓	
Social cognition	Three items (social interaction, problem solving and memory)		✓	
Resource Utilisation Group: activities of daily living (RUG-ADL)[15]	Four items originally included in RUG classification. Total score is used in AN-ACC	✓	✓	
Braden scale for predicting pressure sore risk[16]	Seven item scale			
Total score	All seven items			✓
Activity item	The activity item in the Braden scale		✓	
Australia-modified Karnofsky performance status (AKPS)[17]	Single score rating	✓	✓	
Rockwood clinical frailty scale[18]	Single score rating		✓	
Behaviour resource utilisation assessment (BRUA)[10]	Five items (problem wandering or intrusive behaviour; verbal disruption; physical aggression; emotional dependence; and danger to self and others)	✓	✓	✓
Obesity	Flag to identify requirement for bariatric care			✓
Falls during past 12 months	Flag to indicate number of falls in previous year		✓	✓
Daily injections	Proxy indicator of need for complex nursing	✓	✓	✓
Complex wound management	Proxy indicator of need for complex nursing		✓	✓

Results

Our initial sample included 1967 residents from 30 aged care facilities; 56 (2.8%) did not consent to participation, 19 (0.9%) were unavailable, and 15 who consented (0.7%) died before the study start date. A total of 1877 clinical assessments were therefore available for analysis. Staff time was reported for 60 990 resident days, comprising 315 029 staff time activity records collected by 1600 staff members.

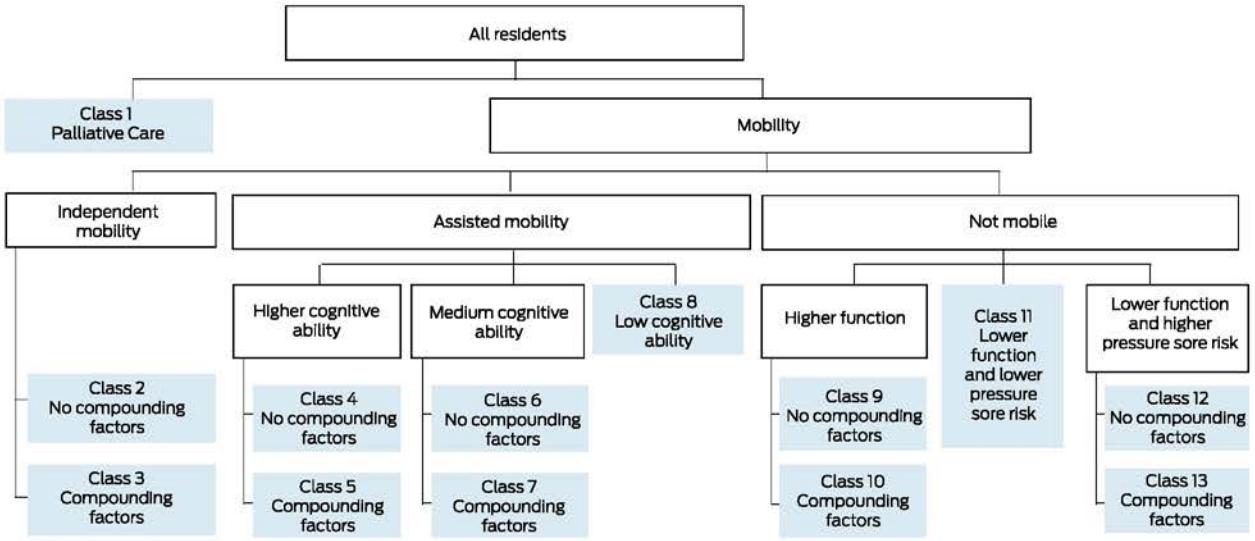
Classification and regression tree analysis produced a regression tree in which the first branching was determined by resident mobility classification, measured with the modified de Morton Mobility Index (DEMMI): independent, assisted and non-mobile.[12] Each branch was then split into further classes based on other clinical measures, such as cognitive and physical function and pressure injury risk (Box 1), producing a classification with 13 classes, the Australian National Aged Care Classification (AN-ACC) (Box 2; Supporting Information).

The AN-ACC includes a single class for people admitted for palliative care, based on clinical advice that these residents comprise a clinically discrete class and require considerable levels of additional resources. As insufficient data were available to calculate resource use for this group of residents, a relative value was imputed on the basis of clinical advice. Residents who required palliative care after admission to residential care can be re-assessed and re-assigned to a different class as their needs change.

Each of the other branches of the clinically informed regression tree model includes classes defined by whether a resident has compounding factors. These factors reflect the combined incremental resource use associated with other independent variables, such as frailty, falls, daily injections and wound management, and their impact was estimated by multiple regression analysis (summarised in Box 1).

The independent mobility branch has two classes defined by the combined effects of the compounding factors Resource Utilisation Group: activities of daily living (RUG-ADL), Australian modified functional independence measure (AM-FIM): cognition, Australia-modified Karnofsky performance status (AKPS), behaviour resource utilisation assessment (BRUA), and daily injections.

2 The Australian National Aged Care Classification, version 1.0



The assisted mobility branch has five classes, defined by cognitive ability, and then by the combined effects of the compounding factors Braden activity item, RUG-ADL, AM-FIM: motor, AM-FIM: social cognition, AM-FIM: communication, AKPS, Rockwood score, BRUA, falls during the past 12 months, daily injections, and complex wound management.

The not mobile branch has five classes defined by function and pressure sore risk, and then by the combined effects of the compounding factors Braden total score, AM-FIM: eating, AM-FIM: transfers, BRUA, falls during the past 12 months, obesity flag, daily injections, and complex wound management.

The RIV for the test dataset was 0.52, indicating that the classification performs well in explaining the variation in daily care costs between classes of residents. The RIV for the re-test dataset was 0.48; the similarity of the two values indicates that the classification model is reliable. The coefficient of variation for each class was quite small (less than 1.0: range, 0.34–0.62), indicating that each class is relatively homogenous with respect to resource use (Supporting Information, figure).

Relative value units for individual AN-ACC classes (that is, the ratio of mean costs for the class to mean costs for all residents) ranged from 0.37 (class 2) to 1.95 (classes 1 and 13).

Discussion

We report the first study to produce a useful casemix classification for people in residential aged care in Australia. An important feature of our study was that a resident's specific medical diagnoses (including dementia, mental health disorders, and physical disorders) are not captured as cost drivers per se. This is because underlying medical conditions result in frailty, impaired mobility, functional and cognitive decline, behavioural disturbance, and technical nursing needs. The care burden arising from these outcomes determines residential aged care costs. As the age and frailty of people entering residential age care are increasing, the prevalence of these cost drivers will increase in future and substantial increases in residential care funding will be required.

The AN-ACC is based on these key cost drivers, reflecting the functional consequences of health conditions rather than the conditions themselves. It captures not what a resident does, but rather their physical capacity (including pain), cognitive capacity (including ability to communicate, sequence, interact socially, and solve problems, and memory), mental health problems (including depression and anxiety), and behaviour (including cooperation, physical agitation, wandering, passive resistance, verbal aggression).

The statistical performance and clinical acceptability of the AN-ACC are adequate for its application for funding purposes. With only 13 classes and an RIV of 0.52, it compares favourably with related casemix classifications, including the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification (83 classes; RIV, 0.55),[19] the ACFI (64 classes; RIV, 0.20), the RUG-IV classification used in the US (66 classes; RIV, 0.62), and other variants of the RUG classification used overseas (34–53 classes; RIV, 0.12–0.56).[7]

Implementing the AN-ACC is now being considered by the Australian government in the context of the major structural and funding aged care reforms expected after the Royal Commission into Aged Care Quality and Safety publishes its final report in late 2020. In our final Resource Utilisation and Classification Study report, we recommended the AN-ACC not only for residential aged care but also in other aged care settings; we also proposed an ongoing aged care research and development agenda that builds on this study, including assessment, classification, costing, and outcome studies.[20]

The AN-ACC is not an end in itself, but an essential element in the broader reform of the national aged care funding system. This includes protocols for re-assessment that allow a resident to be assigned to a different class as their needs change.

The AN-ACC could provide a meaningful system for measuring and benchmarking both input measures (staff ratios) and resident outcome measures. Staffing requirements, mortality rates, and outcome rates (such as numbers of falls) vary markedly between AN-ACC classes. Reporting resident outcome measures by AN-ACC class would facilitate routine evaluation

of residential aged care outcomes, taking into account the mix of residents in a facility.

Strengths and limitations

Strengths of our study include the strong clinical and residential care staff engagement in study design, data collection, and data interpretation, the use of independent clinical assessors, and the use of barcode technology to maximise the accuracy of staff time data.

A further strength was the representativeness of the sample, confirmed by the follow-up study. The results of the verification study reflected those of the original study sample, indicating both the robustness of the classification and the representativeness of the original sample.[9] A further measure of the stability and reliability of the classification model was the fact that the characteristics of the validation dataset mirrored those of the dataset with which the classification was developed.

Limitations include our excluding respite care residents, and the small number of residents included in class 1 (palliative care); the latter problem was mitigated by combining class 1 and class 13 for funding purposes. We could not adequately investigate residents with special care needs (oxygen, enteral feeding, tracheostomy, catheter, stoma, dialysis) because of their very small numbers.

Conclusion

The AN-ACC enables the community, care providers, and governments to make meaningful judgements about the quality and outcomes of residential aged care and to fairly compare the quality of care provided at different facilities.

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Supporting Information

Additional Supporting Information is included with the online version of this article.