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.