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.

Appendix 1

Allied Health Professions Australia

Policy Brief

Allied health funding in residential aged care

July 2022

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

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About AHPA and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing Australia's allied health professions and is the only organisation with representation across all disciplines and settings. We have 25 allied health member organisations and a further 12 affiliates with close links to allied health. A full list of our members is available at https://ahpa.com.au/our-members/ . The scope of allied health encompasses preventive and primary care (including chronic illness), aged care, disability (including the NDIS) and veterans' care.

This breadth makes allied health Australia's second largest health workforce, with over 200,000 allied health professionals. AHPA provides representation for the allied health sector, working with a wide range of working groups and experts across the individual allied health professions to support all Australian governments in the development of policies and programs relating to allied health.

Introduction

The Royal Commission into Aged Care Quality and Safety concluded in March 2021 that allied health services are underused and undervalued across the aged care system.[1] As for allied health in general, there is scant data on the provision of allied health services in residential aged care, let alone on the types and frequency of allied health treatments provided to individual residents. The Commissioners' conclusions drew on evidence that included research undertaken in 2018 by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong.[2] That research was part of the Resource Utilisation and Classification Study (RUCS) which underpins the new Australian National Aged Care Classification model for funding residential aged care.[3]

The AHSRI research, led by Professor Kathy Eagar, asked staff involved in delivering care to residents to record the amount of time spent undertaking different types of activities during each shift.[4] Results included the finding that aged care residents receive an individual average of only eight minutes of allied health care a day.[5] Even this figure is probably an over-estimate, because the AHSRI definition of 'allied health' included lifestyle professions,[6] professions which are generally not included in allied health sector definitions developed by both the sector and the Department of Health.[7]

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[1] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83.
[2] 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.
[3] 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.
[4] 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.
[5] 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.
[6] McNamee J, Kobel C & N Rankin, *Structural and individual costs of residential aged care services in Australia. The Resource Utilisation and Classification Study: Report 3*, *Australian* Health Services Research Institute, University of Wollongong, 2019, Appendix 3.
[7] See eg https://ahpa.com.au/what-is-allied-health/ ; https://www.health.gov.au/health-topics/allied-health/about .

The Royal Commission concluded that the current gross under-provision of allied health care produces morbidity, mortality and quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[8]

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',[9] and for allied health to become 'an intrinsic part of residential care'.[10]

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 multidimensional view of wellbeing.[11] Recommendation 38 supported this more holistic approach through requiring the provision of a level of allied health care appropriate to each person's needs.

Although the previous Coalition Government supported Recommendation 38 'in-principle', the specific 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. At a minimum, AHPA would like to see provision made for the delivery of care by the suite of health professions listed in Recommendation 38 (b): oral health practitioners, mental health practitioners, podiatrists, physiotherapists, occupational therapists, pharmacists, speech pathologists, dietitians, exercise physiologists, music therapists, art therapists, optometrists and audiologists.

The current approach

The aged care reforms committed to by the Coalition Government, including the replacement of the Aged Care Funding Instrument (ACFI) by the Australian National Aged Care Classification model (AN-ACC), are now being developed and implemented.

AHPA's communication with the Department of Health ('the Department') prior to the federal election, together with the Department's Fact Sheet, 'How allied health care is supported under AN-ACC',[13] indicate that provider payment for allied health services in residential aged care is expected to be drawn from overall federal Government funding to providers under the new AN-ACC model.

At present there is no plan to increase access to allied health services as part of core or dedicated funding. While allied health care minutes will be required to be reported, there is no Government benchmark of proposed future allied health aged care in terms of minutes, and no detail on the level of reported data that will be mandated, such as individual types of allied health care provided.[14] Instead, 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.[15]

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[8] See eg Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.
[9] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[10] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101.
[11] 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.
[12] Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021.
[13] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .
[14] https://www.health.gov.au/resources/publications/what-are-care-minutes .
[15] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .

The Department assumes that this current proportion of spending will continue, and has also stated that AN-ACC funds will be greater than those under the ACFI, with the 4% therefore translating to approximately $700 million of the care funding the Government will provide in 2022–23.[16] AHPA was also verbally assured by the Department in April 2022 that funding for allied health would be, at worst, not less under AN-ACC than it has been under the ACFI.

Examining allied health funding

It is difficult to rigorously examine the current approach to allied health funding without access to costings. For example, if the Government will provide $700 million for allied health aged care in the next financial year, at 4% of total care funding this equates to a total spend of $17.5 billion across all services. However, this total is not obvious from the past two Budgets.

Given the lack of specific allied health care Budget items, the Department's equation of 4% of provider spending with $700 million implies that provider spending on allied health is either currently $700 million or will be able to be raised to that level by other means in the immediate future.

How much are providers spending now?

Although the StewartBrown survey referred to in the Department's Fact Sheet is the source of the allied health '4%', the Fact Sheet does not translate this into dollar terms,[17] and nor does any publicly available report on this particular survey.

StewartBrown publishes results from a quarterly Aged Care Financial Performance Survey which relies on aged care provider reporting for both residential and home care. However, StewartBrown appears to have stopped regular public reporting of allied health care spending, other than as part of an aggregated total for direct care spending.[18] An approximation can still be obtained by using StewartBrown's apparently one-off, 2020 Allied Health Deep Dive Survey,[19] which does disaggregate allied health spending from other aged care contributions.[20]

To assess whether this approximation is reasonable, Dividing the Deep Dive allied health spend of $7.93 per occupied bed day (pbd) by the most recent StewartBrown report of average direct care revenue, $193.66 pbd,[21] gives 4%. It therefore seems reasonable to use the Deep Dive allied health spend to assess current spending by providers against the $700 million figure from the Department.

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[16] Ibid.
[17] Ibid.
[18] See various Aged Care Financial Performance Survey (ACFPS) reports at https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 which indicate that disaggregating allied health spending ceased after December 2018. See also Sutton, N, Ma, N, Yang, JS, Lewis, R, McAllister G, Brown, D, & M Woods, *Australia's Aged Care Sector: Mid-Year Report (2021–22)*, The University of Technology Sydney, 2022, 6-7.
[19] 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.
[20] Although the Deep Dive includes lifestyle officers as part of allied health, it itemises them separately, so because they are not regarded as part of the allied sector, they can be subtracted from the total spending. The survey also itemises diversional therapists despite their not being seen by the sector as part of allied health, so they can also be subtracted. There is also a category of 'other' that is assumed to be other allied health professions and so is included in the calculation. A possible overall limitation is that the Deep Dive represents only 12% of all homes nationally and 7% of providers in the sector.
[21] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192; 2022 04 StewartBrown Aged Care Financial Performance Survey, December 2021 – Video Presentation https://www.stewartbrown.com.au/news-articles/26-aged-care/260-2022-04-stewartbrown-aged-care-financial-performance-survey-december-2021-video-presentation (the report itself was not publicly available).

Applying the $7.93 pbd to the most recent data on people in residential aged care results in a total recent annual provider spend of between $511 million and $553 million on allied health.[22] If this is taken as a reasonable estimate, to be spending $700 million in the future, the previous Government must have committed extra allied health care funding of between $147 million and $199 million. Again, this item cannot be found in the 2021-22 Budget.

Will providers increase allied health spending?

The future scenario where providers spend, as 4% of their total care spending, $700 million on allied health services, relies on two unpersuasive premises.

The first premise is that providers are able to access additional funds outside direct Budget allocation. The total funds in AN-ACC will exceed those available under the ACFI, because in addition to the existing ACFI funding rolled over into AN-ACC, the 2021-22 Federal Budget also increases, from October 2022, AN-ACC funds by $3.9 billion over 4 years. The Department implies that this increase might expand provider spending on allied health care.

But this increase will not affect allied health spending, because the $3.9 billion is linked to care minutes. As previously noted, there is currently no Government commitment to allied health aged care in terms of minutes, and so this component of AN-ACC funding will only be spent on paying nurses and personal care workers.

The AN-ACC model also drops the ACFI's requirement for a resident to be reassessed and potentially reassigned to a lower payment class if the capability of the resident improves. This is a welcome change, as it is intended to encourage providers to invest in restorative care and reablement services, through the use of allied health amongst other services.[23] However, whether and at what point costs saved by providers might flow through into payment for allied health care for other residents is unknown and cannot be relied upon to guarantee the necessary expenditure.

The second and perhaps key premise is the Department's assumption that residential aged care providers will continue to spend 4% of their direct care funding on allied health. Despite the *Aged Care Act 1997* and the *Quality of Care Principles 2014* mandating the provision of care and services for all care recipients who need them,[24] as outlined above, the state of allied health service provision for aged care residents is so poor that it resulted in the Royal Commission's Recommendation 38. ACFI does not mandate even a minimum benchmark for allied health in aged care.

Under present ACFI funding, providers are not in a fiscal position to allocate greater than their current proportion of care spending to allied health. Even spending by providers of 4% of total care funding may be in doubt, because the present iteration of the AN-ACC funding model still does not mandate any minimum level of spending on allied health.

If providers continue to experience financial pressure, and as evident from outcomes to date following the recent $10 per day basic care funding increase for residential aged care facilities,[25]

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[22] The $511 million figure is derived from the 183,894 people receiving permanent residential care (Department of Health, *2020-21 Report on the Operation of the Aged Care Act*, 1997, 53), whereas the $553 million comes from the 191,000 people using permanent and respite residential care (Australian Institute of Health and Welfare, 'GEN fact sheet 2020–21 People using aged care', Canberra, 2022). Both are approximations for the calculation, as it cannot be assumed that bed occupancy is consistent across the year, and it is unknown how much allied health funding is spent on people in respite care.

[23] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .

[24] Division 54, *Aged Care Act 1997*; Schedules 1 and 2 (especially Standards 2, 3 and 7), *Quality of Care Principles 2014*.

[25] Sutton, N, Ma, N, Yang, JS, Lewis, R, McAllister G, Brown, D, & M Woods, *Australia's Aged Care Sector: Mid-Year Report (2021–22)*, The University of Technology Sydney, 2022, 24-53, 71-72.

with no benchmark for allied health minutes and no required proportion of allied health spending, we cannot just rely on a hope that providers will 'do the right thing'.

It therefore seems likely that allied health funding will be, at most, at the lower end of the Department's range – 4% of current funding under ACFI, equating to between $511 million and $553 million.

Funding remains insufficient

Irrespective of whether ongoing allied health funding is as low as $511 million or as high as $700 million, it will not be sufficient to address the gross under-provision of care identified by the Royal Commission.

The clearest way to demonstrate this is to translate the '4%' provider spending into allied health minutes per resident, and then compare it to the Royal Commission average of 8 minutes per day. Care minutes are also a better measure than costings because allied health care costs more per minute than, for example, personal care.[26] This means that once more recent allied health minutes are obtained, they need to be converted into costings using allied health rates.

Allied health minutes

StewartBrown's Aged Care Financial Performance Survey (ACFPS) Residential Care Report (March 2018) figure of 8.4 minutes is broadly consistent with the Royal Commission's (via AHRSI) 8 minutes.[27]

Since the Royal Commission, StewartBrown has been the main source of data on allied health minutes. The 2020 Allied Health Deep Dive Survey found that aged care residents received an average of 7.2 minutes of allied health care per day.[28] StewartBrown's most recent publicly available ACFPS report, for the three months ended 30 September 2021, counts allied health separately from lifestyle with the result of 6.6 allied health minutes for September 2021.[29]

The Ageing Research Collaborative (ARC) at the University of Technology Sydney has recently partnered with StewartBrown to publish its first biannual report on the delivery of aged care services.[30] This independent examination of the sector is intended to have a broad policy scope as StewartBrown narrows its future focus to benchmark reporting for aged care providers.[31] ARC analysis of StewartBrown data for the 6 months ending 31 December 2021 produced a December 2021 figure of 5.3 minutes.[32]

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[26] 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).
[27] StewartBrown, Aged Care Financial Performance Survey (ACFPS) Residential Care Report (March 2018) https://www.stewartbrown.com.au/news-articles/26-aged-care/158-march-2018-aged-care-sector-reports-released , 14. Like the AHSRI research, the 2018 survey does not disaggregate 'allied health and lifestyle'.
[28] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 . Slightly confusingly, lifestyle officers are included in the Deep Dive results not simply as added to allied health like earlier Aged Care Financial Performance Surveys, but as part of allied health itself. See also note 20.
[29] 2022 01 StewartBrown Aged Care Financial Performance Survey Sector Report - September 2021 https://www.stewartbrown.com.au/news-articles/26-aged-care/254-2022-01-stewartbrown-aged-care-financial-performance-survey-sector-report-september-2021 , 10.
[30] Sutton, N, Ma, N, Yang, JS, Lewis, R, McAllister G, Brown, D, & M Woods, *Australia's Aged Care Sector: Mid-Year Report (2021–22)*, The University of Technology Sydney, 2022.
[31] Ibid, 6-7.
[32] Ibid, 34.

In summary, with some allowance for variation in definitions and methodologies, and acknowledging that existing data is limited, it appears that the number of allied health care minutes has decreased since the Royal Commission's final report. This is also consistent with a trend identified by the National Aged Care Workforce Census and Survey of an overall decrease in allied health staff numbers (measured by Full Time Equivalents) in residential aged care.[33]

Costing allied health minutes

At best then, the most generous calculation of recent spending on allied health care starts with the Royal Commission's 8 minutes a day, which corresponds to 49 hours annually per person. The 2020 Deep Dive Survey costs allied health at a range from $33 per hour for internal allied health assistants to $124 for externally contracted speech pathology.[34] This appears highly conservative when compared to pricing in private practice and the NDIS, and allied health aged care price increases should be expected in the future.

A very crude and conservative approach to costing allied health minutes is to average the hourly rate for the six allied health professions priced in the Deep Dive,[35] which gives an hourly rate of $71.20. Using this pricing, the Royal Commission (AHRSI) 8 minutes, or 49 hours per year, then equates to an annual spend of $3489 per person ('conservative approach'). A more realistic estimate (but still a conservative estimate in respect to broader market pricing) of $100 per allied health hour of service equates to a spend of $4900 per person ('realistic approach') for 8 minutes of daily care.

Comparison of allied health minutes

	Allied health spending per person per year	**Allied health minutes per person per day**
Royal Commission (AHRSI)	$3489 (conservative[1])–$4900 (realistic[2])	8[3]
$511 million (Lower estimate of most recent provider spend under ACFI = 4%)	$2779	4.6 (realistic)–6.4 (conservative)
$700 million (Highest estimate from Department of Health)	$3807	6.3 (realistic)–8.8 (conservative)

1. Costed at $71.20 per hour 2. Costed at $100 per hour 3. Includes lifestyle spending

In comparison to the '8 minutes' figures, $511 million, as the lower estimate of recent – and therefore assumed future – spending on allied health, equates to $2779 per person per year.[36] If the amount to be spent on allied health in the future is actually $700 million, this equates to $3807 per person per year.[37]

[33] Aged Care Financing Authority, *Annual Report on the Funding and Financing of the Aged Care Sector – 2021,* Appendix D; Royal Commission into Aged Care Quality and Safety, Public Hearing, 14 October 2019 (Day 56) Evidence of Kathleen Margaret Eagar, 5775-5778.
[34] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 , 5.
[35] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 , 5. Our approach uses the costs per hour calculation that combines internal staff employed and external contractors, including allied health assistants.
[36] See note 22.
[37] See note 22.

Even $700 million is therefore grossly insufficient to meet residential aged care allied health needs. It would provide fewer than 9 allied health care minutes when allied health is priced conservatively (8.8 minutes), and 6.3 minutes using the realistic approach.

If we are simply to rely on the '4%' of recent provider spending ($511 million), and even assuming that providers voluntarily maintain a 4% spend, the conservative approach to the hourly rate produces an average of 6.4 minutes per person per day, while the more realistic approach produces 4.6 minutes of care per day. This lower estimate range is consistent with the most recent figure for allied health (from the ARC) of 5.3 minutes.

Skills mix and the range of allied health aged care

Additional factors underscore the inadequacy of 4%/$700 million funding. Results from the 2020 Deep Dive Survey demonstrate that while provision of allied health care is inadequate overall, most residential care homes – 71% – do not offer allied health services as part of their additional services.[38] This proportion is probably an underestimate, because the most popular form of 'allied health' provided was lifestyle services.[39]

Further, the ACFI has largely limited the allied health services procured to physical therapies with a strong emphasis on pain management. Even within this narrow range, built-in incentives in the ACFI have tended to favour the provision of specific allied health treatments that are not necessarily the most clinically appropriate for a resident.[40]

It is therefore a positive development that the AN-ACC will remove built-in ACFI incentives such as those for clinically ineffective pain management treatments. But any savings from restricting funding to evidence-based allied health treatment will not realistically cover the required increase in expenditure.

For example, the data on minutes of care suggests potential underutilisation of occupational therapy and podiatry, at 0.6 minutes each of the daily average total of 7.2 minutes.[41] Other allied health professions, such as counselling, psychology, exercise physiology, osteopathy and music or art therapy, do not even appear as categories, indicating a further unmet need to fund other forms of evidence-based allied health practice.[42]

To genuinely implement Recommendation 38, residents must be clinically assessed – in best practice, by a multidisciplinary team – against the full range of potentially available allied health services that could help maintain their wellbeing and assist reablement. Their assessed needs must then be met.

It is also critical that sufficient spending to meet allied health needs in residential aged care translates into an appropriate skill mix of allied health. The trend of decreasing allied health staffing in residential aged care identified via the National Aged Care Workforce Census and Survey showed that by 2012, of a total allied health FTE proportion of 5.3%, allied health

[38] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 , 2.
[39] Ibid, 6.
[40] Applied Aged Care Solutions, *Review of the Australian Classification Funding Instrument Report*, 2017, 135-6, 147-65; CR Goucke (ed), *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition*, Sydney, Australian Pain Society, 2018.
[41] 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.
[42] For the full range of allied health professions see https://ahpa.com.au/what-is-allied-health/ .

professionals contributed 1.7% and allied health assistants 3.6%.[43] By 2016, the proportion of allied health professionals had dropped to 1.1% with the remaining 2.9% being allied health assistants.[44] 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%.[45] This seems unlikely to signal any significant upward trend unless there are new funding commitments.

Although allied health assistants are valuable contributors to the allied health workforce, they are less qualified than allied health professionals, and therefore either require supervision or are simply not suited nor lawfully permitted to carry out some necessary allied health tasks in aged care. Underfunding risks further substitution not only of (cheaper) allied health assistants, but of non-allied health staff such as personal care workers and lifestyle and diversion therapy staff, at the expense of allied health professionals and, ultimately, aged care residents.

The AN-ACC is not designed for allied health

The AN-ACC is not designed for allied health funding needs, nor for the provision of clinical care planning. The Royal Commission simply noted in passing that the AN-ACC 'may' achieve increased and appropriate allied health delivery.[46] Professor Eagar and her team have emphasised that the current version is only the first step in a necessary development process,[47] and that adequately building allied health into the AN-ACC, including a best practice needs identification and care planning assessment tool, would take several years.[48]

The way forward

In summary, the Royal Commission found that there was a crisis in allied health service provision in residential aged care. When more recent care minutes are measured, the situation has deteriorated even further. The Coalition Government's proposal to replace the ACFI with the AN-ACC, while generally a positive development, does not include any mandated benchmark – or indeed any genuine benchmark at all – for the provision of allied health in aged care.

Instead, communication from the Coalition Government and the Department of Health has referred to three different yardsticks for future allied health funding, with potentially different outcomes. It is unclear how the highest amount, $700 million, will be guaranteed and provided. The second measure, 4% of providers' total care funding, assumes for its upper limit that allied health funding will increase under the AN-ACC. However, additional funding under the AN-ACC is intended for personal care work and nursing, and therefore the source of any increase for allied health is unknown. The third measure, equivalent to the amount currently funded and spent by providers under the ACFI, is clearly inadequate.

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[43] 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.
[44] Ibid.
[45] Department of Health, *2020 Aged Care Workforce Census Report*, 9-11.
[46] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 180.
[47] 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.
[48] 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/ .

Regardless, none of the yardsticks proposed is sufficient to remedy the chronic under-provision of allied health care. Even if they were, a significant influence on all three measures of funding is that under the AN-ACC it will still not be mandatory for providers to spend 4% of their care funding on allied health services. Instead, implementation simply relies on providers to decide whether to spend part of their inadequate total care funding on allied health.

Royal Commission Recommendation 38 requires provision of a level of allied health care appropriate to each person's needs. Effective implementation will require not only increasing the total amount of allied health care provided, but also ensuring that the full breadth of allied health services and associated skillsets are made available. Clinically assessing residents in order to match them with the right types and levels of care should be the task of multidisciplinary teams. Only then can the Australian residential aged care system be said to be truly informed by an understanding of reablement and wellbeing.

In March 2022, a Position Statement drafted by members of AHPA's Aged Care Working Group was endorsed by the National Aged Care Alliance. The Position Statement, 'Meeting the Allied Health needs of older people in residential aged care',[49] makes the following recommendations:

1. That the Commonwealth urgently address the lack of articulated plans regarding allied health funding in residential aged care. A clear action plan to achieve the recommendations for allied health of the Royal Commission into Aged Care Quality and Safety in a timely way must be developed, as part of the overarching plans to ensure access to the required multidisciplinary aged care workforce.

   As a matter of urgency, the Commonwealth must assure, clearly articulate and set out in a clear pathway for:

   - Funding in the aged care classification model to ensure the inclusion of the broad care workforce in addition to personal care staff and nursing including oral health therapists, recreational officers, lifestyle staff, diversional therapy, welfare officers, spiritual care and pastoral care
   - Funding a separate dedicated component for the assessment and delivery of allied health services responding to individual needs of older people in residential aged care; and
   - the mechanisms for appropriate clinical needs assessment and delivery; and
   - monitoring and public accountability for that assessment and service delivery by individual profession/service.

2. That the Commonwealth engages with and directly involves the allied health sector in the development of a best practice needs assessment and care planning tool as recommended in the development of AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations, The Resource Utilisation and Classification Study: Report 6.

[49] https://naca.asn.au/wp-content/uploads/2022/04/National-Aged-Care-Alliance-Position-Statement-Allied-Health-1.pdf .

3. That the Commonwealth outlines an appropriate funding mechanism to ensure all older Australians in residential aged care have access to the allied health services to meet assessed need, regardless of where they live.
4. That the Commonwealth take responsibility for and recognise allied health professionals as part of the broader aged care workforce across all workforce initiatives.
5. That the Commonwealth take action to retain and support a strong and sustainable allied health workforce including appropriate remuneration, career pathways and supervision/training opportunities.
6. That the Commonwealth invest in research and health economic analysis of best practice models to contribute to service design inclusive of allied health in aged care.
7. That the Commonwealth ensure mechanisms are in place to collect and review data on allied health service usage and expenditure in residential aged care, in accordance with Royal Commission recommendations.

Appendix 2

Allied Health Professions Australia

Proposed Allied Health Aged Care Solutions for Jobs Summit

August 2022

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

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About AHPA 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

The role of allied health in aged care is importantly distinct from that of nursing and personal care. As AHPA conveyed at the Aged Care Workforce Roundtable convened by Minister Wells on 17 August 2022, Government responses to the findings and recommendations of the Royal Commission into Aged Care Quality and Safety have so far not sufficiently addressed the specific challenges and barriers for allied health.[1]

For example, in contrast to recent and ongoing nursing and personal care reforms, there are no current proposals for allied health service provision targets/benchmarks, nor for related accountability mechanisms. In residential aged care, despite the Royal Commission's condemnation of the finding of only 8 minutes' average allied health care being provided per resident per day, allied health spending under the new AN-ACC model is to be left to the discretion of increasingly financially pressured providers.

Alarmingly, the most recent figures show a further decrease in allied health, to 5.3 minutes. Even this extremely low average is mainly contributed to by physiotherapy services, with occupational therapy and podiatry less represented, and other services such as speech pathology, counselling, psychology, exercise physiology, osteopathy and music or art therapy either non-existent or provided so rarely that they do not register in the data. For more detail see our separately attached Policy Brief, *Allied Health Funding in Residential Aged Care*.

More broadly, despite years of advocacy and recommendations from such authorities as the National Rural Health Commissioner, there is still no national allied health workforce planning strategy, nor a minimum dataset to assist that process. Allied health also remains largely disconnected from digital initiatives aiming to enhance service delivery and collaboration, such as

[1] All specific references to recommendations in this document are to those from the Royal Commission that are key to our particular proposed solution.

My Health Record. Again, 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.

We emphasise these urgent broader priorities for reform to provide a context for our proposed allied health workforce solutions. To truly enhance and make the most of the capabilities of the aged care allied health workforce, long-term neglect of the sector must first be addressed.

The Royal Commission stressed that reablement, or where this is not possible, at least preserving capacity, is critical to wellbeing and should be a central focus of aged care. The Royal Commission's Final Report makes a strong direct connection between reablement and allied health care:

> 'The aged care system must support the delivery of allied health care in a way that is person-centred and focuses on the whole person, their goals and quality of life. It must focus on wellness, prevention, reablement and rehabilitation and extend beyond physical health to a multidimensional view of wellbeing.'[2]

The Commissioners held that allied health must become 'an intrinsic part of residential care', and that home care should include:

> 'the allied health care that an older person needs to restore their physical and mental health to the highest level possible – and to maintain it at that level for as long as possible – to maximise their independence and autonomy. Throughout our inquiry, many witnesses described the crucial role of allied health in maintaining mobility and functionality and providing restorative care in response to acute events.'[3]

A clear Government commitment to reablement must therefore include guaranteed provision of allied health needs-based assessment and service provision. Royal Commission recommendations emphasise clinically assessing each person, ideally via a coordinated multidisciplinary team, against the full range of potentially available allied health services that could help maintain their wellbeing and assist reablement. These assessed needs must then be met via ringfenced funding and coordinated care planning.

The Government response to date does not embed automatic allied health assessment in 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.

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

[2] Royal Commission into Aged Care Quality and Safety, Final Report Vol 3A, 176. See also Exhibit 20-1, Australian Association of Gerontology Position Paper, Wellness and Reablement for All Australians, 31 July 2020.
[3] Royal Commission Final Report Volume 1, 101. See also Royal Commission, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.

again depends upon whether the assessor has the training and knowledge to decide on referral to an appropriate allied health professional.

In either context, the onus is then on the provider to deliver the right care needs/case mix to meet the person's identified needs. The developers of the AN-ACC recommended implementation of a standardised care planning tool, but this is not currently proposed for residential or home care, and as previously noted, there is no dedicated funding mechanism to ensure provider delivery of any required allied health services. These factors combine to mean that many aged consumers will not receive the allied services best placed to meet their needs.

The current aged care reform agenda therefore also poses a practical difficulty for presenting more finely tuned allied health workforce recommendations. 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 their casemix significantly incorporates patients under Government-funded or private insurance arrangements, meaning that any potential hands-on experience in private practice for students is limited to 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.

However, given the lack of benchmarks and funding guarantees in aged care, together with the ongoing absence of allied health needs-based assessment, we simply cannot know how many and what kinds of allied health professionals will be required by the new residential and home care systems. We cannot accurately predict shortfalls and ensure a flow of new graduates, nor 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 (Recommendation 54), in any useful way.

We do know that allied health professionals are already leaving the aged care sector, and that some large providers are disbanding their in-house allied health professional teams, due to the uncertainties around funding for their services.[4]

Equally concerning is an apparent trend for providers to substitute, for cost reasons, allied health assistants or workers from outside allied health such as lifestyle coordinators, to provide services that are within the scope of practice of an allied health professional. Although valuable contributors to the workforce, allied health 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.

[4] See eg (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).

To put this another way, the neglect of allied health as a crucial third pillar of aged care is in imminent danger of turning the whole aged care sector into a 'thin market' that compromises safety and quality. It will ultimately exacerbate Australia's already considerable health sector burden, via outcomes such as increased hospitalisations and surgeries. In this climate, there are no quick fixes and no point in advocating for strategies such as training, attracting and retaining the allied health workforce, until the current crisis has been addressed.

As part of developing an integrated system for the long-term support and care of older people (Recommendation 4), both residential and home-based care sectors must be made capable of delivering allied health services to a reablement standard. Proposed human rights reforms to the Aged Care Act (Recommendations 1–3) will demand nothing less.

Our solutions

Most of our solutions can be commenced as soon as possible, with #1–#4 able to be achieved within 6 months. Residential aged care crisis response and pathway mapping (#5) is our proposed temporary solution, because there are urgent allied health service needs that cannot wait for the completion of solutions #8–#13.

As an active member of the National Aged Care Alliance, AHPA is also keenly aware that discussions will be needed on the financial sustainability of the aged care sector. The approach in #5, together with the EMBRACE project (#6), will assist Government and key stakeholder deliberations as part of #12 and #14.

To be completed within 6 months

1. *Monitoring of implementation of Royal Commission allied health-related recommendations*

Establish an independent unit for implementation and monitoring of allied health-related Royal Commission recommendations, including those concerning the workforce, funding and the role of allied health in reablement. This unit might be located within the Office of the Inspector-General (Recommendations 12, 148), and should include in its staff, or draw upon in a funded partnership, a diversity of allied health professional knowledge.

2. *Allied Health Assistants*

As part of ongoing regulatory alignment reforms (eg Recommendation 69), the Commonwealth works with States and Territories to nationally embed an Allied Health Assistant Delegation and Supervision Framework.[5]

3. *Best practice allied health workforce ratio*

Amend Quarterly Financial Reporting requirements for allied health service provision by residential aged care facilities to include reporting against a recommended best practice minimum ratio of allied health professionals to allied health assistants.

4. *National Allied Health Workforce Strategy Part 1*

Commence development of a National Allied Health Workforce Strategy in collaboration with the disability, veterans' care and primary health care sectors, beginning by addressing duplication of regulatory systems (Recommendations 69, 75).

[5] As an example see https://www.health.vic.gov.au/publications/supervision-and-delegation-framework-for-allied-health-assistants-and-the-support-0 .

To be completed within one year

5. *Residential aged care crisis response and pathway mapping*

In consultation with the assessment and care planning teams in #8 and #9, assign and fund a provisional allied health service provision benchmark (average in minutes per resident per day). This benchmark will be conservative, because at this stage needs-based assessment and care planning will not be in place, and a more thoroughly investigated standard will result from #8.

In addition to providing immediate systemic 'first aid' in the current crisis, the intention of this ad hoc solution is to supplement the provisional benchmark-associated funding with temporary utilisation of other identified pathways, and to use the resulting data to inform a conversation about funding and sustainability as part of #8.

A representative sample of residential aged care facilities should be incentivised to supplement their existing required reporting with summarised documentation of the pathways used to provide allied health care and associated funding sources. This mapping should begin with identification of how the resident's allied health needs came to the facility's attention eg via AN-ACC assessment, referral to clinical allied health assessment, via nursing staff at the facility, visit by GP etc. Documentation of allied health service provision should include whether this came from employees on staff or contactors, and any use of permanent or temporary Medicare items and/or residents' private insurance for external services. Residents' out of pocket or entire personal payments should be recorded.

Extend existing and recent allied health programs such as the Allied Health Group Therapy Program designed to improve function and mobility and prevent falls in aged care residents,[6] including where appropriate, expanding the list of types of eligible providers; and document the use of such programs.

To further enable solution #5, direct referrals to allied health professionals through My Aged Care should be enabled. Similarly, gateways to Medicare programs such as Better Access should be facilitated so that prior GP referral is not required.[7]

6. *Aged care data*

Fully integrate allied health services into National Minimum Datasets linking health and aged care that enable identification of whether a person has received aged care services, and of the type of those services. Include allied health services in the National Aged Care Data Asset (Recommendations 67, 108).

7. *Digital systems and interoperability*

As an integral part of implementing a new service-wide client relationship management system interoperable with My Health Record for care management, case monitoring and reporting systems built around older people's care, the Australian Digital Health Agency must prioritise giving practical support to allied health providers of aged care services so that they can adopt My Health Record (Recommendations 68, 109).

[6] This 12-week, evidence-based, restorative program was introduced in specific COVID-affected residential aged care facilities in response to COVID-19, but perversely, its implementation was hindered by the pandemic.

[7] Recent research shows the current Better Access model is not working in residential aged care: https://www.australianageingagenda.com.au/clinical/aged-care-residents-underusing-mental-health-services/ .

To be completed within two years

8. *Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project*

Develop and complete the project, including real-time evaluation, which tests at 1-2 residential aged care trial sites the efficacy of a block-funded multidisciplinary approach to assessment, care planning and delivery of needs-based allied health care, founded on best practice reablement.

The project will provide core allied health professions (dietetics, physiotherapy/exercise physiology, occupational therapy, speech pathology, podiatry, psychology/counselling, music therapy) on site, and identify and use secure pathways to other allied health disciplines as required. Allied health clinicians will be funded to supervise allied health assistants, together with students who will undertake practical placements at the trial site(s) in partnership with their training university.[8]

Impact outcome measures will include resident health and wellbeing, Emergency Department presentation, staff retention and satisfaction, Serious Incident Response Scheme reporting and management, and use of restraints. Totals of each type of allied health service assessed and provided will be reported by minutes and by cost.

(Recommendations 25, 28, 31, 37-38, 54, 58-59)

9. *Needs assessment and care planning tool for residential aged care*

To be undertaken in tandem with #8. Develop a national best practice needs assessment and care planning tool for residential aged care as recommended in *AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations, The Resource Utilisation and Classification Study: Report 6* (Recommendations 25, 28, 31, 37-38).

10. *Needs assessment and care planning tool for home care*

Develop a national best practice needs assessment and care planning tool for home care, if deemed necessary (Recommendations 25, 35-36).

To be completed within three years

Refining the model(s)

11. Build in to the EMBRACE project in #8, through partnering with appropriate university research teams, a cost and efficiency analysis which measures the total value of the model and compares it to reporting from residential aged care facilities in #5.[9]

12. Use findings in #5, #8 and #11 to determine appropriate national residential aged care model(s) to roll out.

13. Draw on #12 and other findings to, for residential aged care:

a) legislate mandatory minutes or a similar benchmark for allied health;
b) increase allied health reporting requirements and accountability so that levels and standards are equivalent to those for nursing and personal care, allied health is reported by profession, and relevant information can contribute to star ratings; and

[8] See eg https://www.tandfonline.com/doi/abs/10.1080/17549507.2020.1779346 .
[9] Cost and efficiency to be assessed on a holistic basis. For an example of full costing, see Access Economics, *The Cost of Domestic Violence to the Australian Economy*, and KPMG's updated report at https://www.dss.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/economic-cost-of-violence-against-women-and-their-children?HTML#1 .

c) enhance quality standards and indicators by introduction of specific allied health measures.

(Recommendations 13-14, 20-24)

14. Utilise the residential aged care findings and associated reforms to consider potential reforms to home care in addition to #10 (Recommendations 35-36, 41, 54, 58-59).[10]

15. *National Allied Health Workforce Strategy Part 2*

Complete the aged care sector's contribution to the co-development of a National Allied Health Workforce Strategy (begun in #4), utilising findings from #5, #8 and #14 to establish the numbers and distribution of allied health professionals required in aged care as part of national broader workforce planning. Use that information to identify and roll out strategies to address potentially relevant factors such as inter-sector competition for allied health professionals, student placements and supervision (Recommendations 54, 67, 75, 82-83).

[10] As the Support at Home reforms are currently being developed, including through consultation, it is not yet appropriate to provide detail.