Allied Health Professions Australia

Policy Brief

Allied health funding in residential aged care

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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 found that allied health services are underused and undervalued across the aged care system.[1] These conclusions were based in part on University of Wollongong research led by Professor Kathy Eagar, chief architect of the AN-ACC,[2] which found that aged care residents receive an average of only eight minutes of allied health care a day.[3]

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.[4]

The Royal Commission concluded that there is 'a need for a change in culture in the aged care sector, to view allied health services as valuable rather than a burden on funding',[5] and that allied health should become 'an intrinsic part of residential care'.[6]

The Commissioners 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.[7] 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 federal Government supported Recommendation 38 'in-principle', provision of allied health services was omitted from residential aged care costings in the Government Response to

[1] Royal Commission into Aged Care Quality and Safety. Final Report. Volume 2 The current system, 83.
[2] AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations The Resource Utilisation and Classification Study: Report 6.
[3] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R. 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 . Eight minutes is also an over-estimate as the research definition of 'allied health' included lifestyle workers (RUCS 3, Appendix 3).
[4] See eg Royal Commission into Aged Care Quality and Safety, Hospitalisations in Australian Aged Care: 2014/15-2018/19. 2021.
[5] Royal Commission into Aged Care Quality and Safety. Final Report. Volume 3A The new system, 176.
[6] Royal Commission into Aged Care Quality and Safety. Final Report. Volume 1 Summary and recommendations, 101.
[7] Royal Commission into Aged Care Quality and Safety. Final Report. Volume 1 Summary and recommendations, 101, Volume 3A The new system, 176 and Recommendations 35 and 36.

the Royal Commission's Final Report,[8] and was absent from both the 2020-2021 and 2021-2022 federal Budgets.

Current approach

The aged care reforms committed to by the 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 and the Department's fact sheet, 'How allied health care is supported under AN-ACC',[9] indicate that payment for allied health services in residential aged care is expected to be drawn from Government funding to providers under the new AN-ACC model.

There is no current plan to increase access to allied health services as part of core or dedicated funding. Instead, a yardstick for allied health funding has been derived from a recent StewartBrown survey that identified that providers currently spend approximately 4% of their care funding on allied health.[10] That 4% is estimated to be approximately $700 million of the care funding the Government will provide in 2022–23.[11]

Our concerns

Lack of financial detail

It is difficult to interrogate the current approach without access to detailed financial data. For example, if $700 million is 4% of the care funding the Government will provide in the next financial year, this equates to a total care funding spend of $17.5 billion. However, this total is not obvious from reading the past two Budgets.

It is indisputable that the total funds in AN-ACC will exceed those under the ACFI. While existing ACFI funding will be 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. However, this increase relates to care minutes, which will not be mandated for allied health, and so this proportion of AN-ACC funding will only be spent on paying nurses and personal care workers.

4%/$700 million will not be enough

The '4%' is currently required under the ACFI, but that instrument 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.

It is therefore a positive development that the AN-ACC will removal the ACFI incentives. However, 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. Given that the Government bottom line for funding of allied health appears to

[8] Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety. May 2021.
[9] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .
[10] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .
[11] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .

be ‘no worse than under the ACFI’, any savings from restricting funding to evidence-based allied health treatment will not realistically cover the required increase in expenditure.

Another way to illustrate the allied health shortfall is to consider the $700 million figure. According to the Productivity Commission (February 2022), there were 305,842 people in residential aged care in 2020-21 (238,702 people in permanent aged care, and 67,140 in respite care).[12] Dividing $700 million by that total means that a maximum of $2,289 will be spent on allied health services per person in residential aged care, per year.

The Royal Commission’s ‘8 minutes a day’ translates to 49 hours per person per year, and at a highly conservative cost estimate of $100 per allied health hour of service, that translates to a spend of $4900 per person.

The assumption that the $700 million is sufficient to meet residential aged care allied health needs is therefore plainly wrong – in fact, $700 million would provide less than 4 minutes a day for each aged care resident.

Over-reliance on providers to ‘do the right thing’

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, including through the use of allied health services.[13] 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.

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, we also cannot just rely on a hope that they will ‘do the right thing’. The AN-ACC funding model as currently proposed, unlike the ACFI, does not mandate that 4% of providers’ budgets be spent on allied health. While allied health care minutes will be required to be reported, there is apparently no benchmark, and no detail on the level of data that will be mandated.

The AN-ACC is not designed for allied health

Finally, and most significantly, the AN-ACC is not designed for allied health funding needs, nor for provision of clinical care planning. The Royal Commission simply noted in passing that the AN-ACC ‘may’ achieve increased and appropriate allied health delivery.[14] Professor Eagar and her team have emphasised that the current version is only the first step in a necessary development process,[15] 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.[16]

[12] https://www.pc.gov.au/research/ongoing/report-on-government-services/2022/community-services/aged-care-services .
[13] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .
[14] Royal Commission into Aged Care Quality and Safety. Final Report. Volume 3A The new system, 180.
[15] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) *How Australian residential aged care staffing levels compare with international and national benchmarks*, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong (prepared for Royal Commission into Aged Care Quality and Safety), 33.
[16] AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations The Resource Utilisation and Classification Study: Report 6, 8-10; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .

The way forward

The National Aged Care Alliance Position Statement, 'Meeting the Allied Health needs of older people in residential aged care' (March 2022),[17] 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.
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.

[17] https://naca.asn.au/wp-content/uploads/2022/04/National-Aged-Care-Alliance-Position-Statement-Allied-Health-1.pdf . AHPA is a member of the Alliance.