Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

12 August 2022

Aged Care Amendment (Implementing Care Reform) Bill 2022 [Provisions]

Dear Secretary

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide a submission to the Senate Standing Committee on Community Affairs on the Aged Care Amendment (Implementing Care Reform) Bill 2022 [Provisions].

We support the purpose of the Bill and its place in a suite of recent and forthcoming reforms to implement the Government's response to the recommendations of the Royal Commission into Aged Care Quality and Safety.

However, we endorse the submission of our member the Australian Physiotherapy Association that genuine implementation of essential care reform in residential aged care, including the Royal Commission's recommendations, requires more than the introduction of the Australian National Aged Care Classification (AN-ACC) funding model and average carer and nursing care minutes per resident.

The Bill before the Committee is silent concerning allied health services in residential aged care; nor are we aware of any proposed legislation to address this gap. This is in contrast to the Royal Commission's conclusion that allied health services are underused and undervalued across the aged care system. Indeed, research undertaken for the Royal Commission found that an average of 8 minutes per day of allied health is provided for each aged care resident.[1]

The Royal Commission concluded that this 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. The Commissioners therefore called for 'a change in culture in the aged care sector, to view allied health services as valuable rather than a burden on funding', and for allied health to become 'an intrinsic part of residential care'.

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

[1] Please see our separately attached Policy Brief 'Allied Health Funding in Residential Aged Care' (July 2022).

AHPA submits that despite assertions by the Department of Health and Ageing that this level of care is addressed under the present *Aged Care Act 1997* and associated Quality Standards, the Royal Commission's finding clearly demonstrates otherwise.

Indeed, we have analysed the available data on the provision of allied health services to aged care residents, and concluded that since the Royal Commission research, the average number of minutes has actually decreased, to just over 5 minutes per day. In the attached Policy Brief, AHPA also presents a detailed analysis of Department claims that the AN-ACC and associated changes in the present Bill will further ensure sufficient funding for allied health.

Our Policy Brief concludes that at a most generous and unlikely estimate, this increased funding will result in 8.8 minutes per resident per day. Much more likely are lower estimates of 4–6 minutes. As the Policy Brief explains, there are two main barriers to meeting residents' allied health needs. The first is that unlike nursing and personal care, there will be no mandated benchmark for allied health services.

AHPA has some sympathy for providers who will need to allocate spending to meet the nursing and care minutes of the Bill, particularly in view of future aged care worker wage increases. Even if allied health services were not already grossly underprovided, it is therefore clear that given the second barrier – provider discretion to spend a proportion of their allocated funds on allied health – this is the area of care in which providers will attempt any necessary cost savings.

AHPA does not support an allied health benchmark, such as mandated minutes, being funded at the expense of the existing nursing and care minute targets. Allied health requires its own separate standards, together with a designated funding mechanism to channel spending on allied health.

As our Policy Brief outlines, a full suite of allied health services must be made potentially available to each resident who needs them, supported by clinical needs assessment and delivery via a multidisciplinary teams approach. None of these issues are addressed in the current Bill or, as far as we are aware, in any proposed future reforms.

Accordingly, we request that the Committee read the accompanying Policy Brief and give particular consideration to its recommendations, which have been endorsed by the National Aged Care Alliance.

AHPA is available to appear at any hearing to expand on our submission.

Regards

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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]

[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]

[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.