Royal Commission into Aged Care Quality and Safety

DRAFT PROPOSITION - ALLIED HEALTH

Introduction

The Royal Commission has heard evidence about the importance of allied health services for people accessing aged care services.[1] The Royal Commission has also heard that allied health is a key contributor to maintaining quality of life and independence.[2]

In Adelaide Hearing 4 on future aged care program redesign, Counsel Assisting made a number of submissions relevant to allied health, including that:

- the redesigned aged care program should have an increased focus on preventative and early interventions with the aims of maintaining and restoring function, sustaining independence, and enhancing wellbeing[3]
- wellness, reablement and rehabilitation services (including occupational therapy and physiotherapy) should be available for all Australians accessing aged care services, and should not be funded from the individual's budget for ongoing care, but should be available based on assessed need[4]
- there should be a comprehensive care assessment which should be face-to-face, taking into account the person's living environment and other relevant circumstances, and be conducted with a strong emphasis on certain principles, including: prioritising the person's quality of life and wellbeing, restoring or maintaining functioning, and sustaining independence.[5]

The Royal Commission has heard evidence that people accessing aged care services have limited access to allied health care.[6] Research has shown that the number of allied health professionals employed in the residential aged care workforce has reduced over time. As a proportion of direct care employees in the residential aged care workforce, allied health professionals and assistants decreased from 7.6% in 2003 to 4.0% in 2016.[7] Out of total staff working in residential aged care facilities in Australia, proportions of registered allied health professionals have reduced from 1.7% in 2012, to 1.1% in 2016.[8]

Counsel Assisting's submissions on the future of the aged care workforce made on 21 February 2020 included a submission that the Royal Commissioners should recommend that:

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[1] See for example: Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T2044.26-34; Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3402.6-10; Transcript, Sydney Hearing, Jennifer Lawrence, 12 May 2019 at T1584.28-34; Transcript, Sydney Hearing, Joseph Ibrahim, 16 May 2019 at T1807.5-7.

[2] See submissions in response to Aged Care Program Redesign Consultation Paper 1 – Program Design in Aged Care from: Allied Health Professions Australia; Australian Podiatry Association; Dietitians Association of Australia; Pharmaceutical Society of Australia; Occupational therapy academics, Flinders University; Speech Pathology Australia; Australian Physiotherapy Association; Audiology Australia.

[3] Submissions of Counsel Assisting, Adelaide Hearing 4: future aged care program re-design, 4 March 2020, p 4.

[4] Submissions of Counsel Assisting, Adelaide Hearing 4: future aged care program re-design, 4 March 2020, [47] and [217]-[218].

[5] Submissions of Counsel Assisting, Adelaide Hearing 4: future aged care program re-design, 4 March 2020, [193].

[6] See for example: Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3402.6-7; Transcript, Adelaide Hearing, Gerard Hayes, 21 February 2019 at T573.9-11; Transcript, Sydney Hearing, Dimity Pond, 14 May 2019 at T1638.32-39; Transcript, Perth Hearing, Gaye Whitford, 26 June 2019 at T2518.12-15.

[7] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0010.

[8] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0009-0010.

> An approved provider of a residential aged care facility should be required by law to have a minimum ratio of care staff to residents working at all times. The ratio should be set at the level that is necessary to provide high quality and safe care to the residents in its facility and should include at least 22 minutes of allied health care per resident per day.[9]

The draft proposition set out in this section (A5) is broadly consistent with Counsel Assisting's submissions, in that it envisages responsibility for the provision of frequent and ongoing allied health care should rest with aged care providers. However, it proposes a different approach to funding episodic allied health care for those receiving aged care services.

Following consideration of the evidence at the Canberra Hearing, staff of the Royal Commission have developed a proposition for a new model of funding for primary care (CH21 - set out below) in which general practices could apply to become accredited aged care practices.[10] People living in residential aged care or receiving level 3 and 4 home care packages could enrol with an accredited general practice, which would then receive an annual capitation payment for each enrolled person, based on their level of assessed need. Accredited practices would also be required to prepare an 'Aged Care Plan' for each enrolled person, which would include referrals for some allied health services.

The draft allied health proposition set out below is concerned with improving access to primary allied health care by people receiving residential care and level 3 and 4 home care packages. The proposition suggests two funding mechanisms for allied health care to facilitate improved access. In summary:

- fund residential aged care and home care providers to deliver 'frequent and ongoing' allied health services; and
- increase funding for 'infrequent or episodic' allied health services through a new MBS benefit structure for people accessing aged care services.

Draft proposition - allied health

Proposition A5: new allied health funding for aged care

By 1 July 2022, the Australian Government should implement a new funding model to support the delivery of allied health care to aged care recipients.

Two funding mechanisms should be used to achieve a sustainable funding model to support high-quality allied health for aged care:

1. **Fund residential aged care and home care providers to deliver 'frequent and ongoing' allied health services; and**
2. **Increase funding for 'infrequent or episodic' allied health services through a new MBS benefit structure for people accessing aged care services under an 'Aged Care Plan'.**

Permanent aged care residents and people accessing level 3 and 4 home care packages should be eligible for allied health services under the new funding model.

The levels of funding for allied health services should be raised to a level that removes the current disincentive to provide MBS services and the need for service providers to charge fees that result in large gap payments by patients.

The table below outlines the proposed distribution of allied health services by setting and type of care:

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[9] Submissions of Counsel Assisting, Adelaide Hearing 3: the future of the aged care workforce, 21 February 2019, RCD.0012.0061.0001 at 0034.

[10] This draft proposition is set out in more detail at the end of this document.

Aged care setting	Type of allied health care	
	Frequent and ongoing: *Podiatry, occupational therapy, speech pathology, maintenance physiotherapy, dietetics*	**Infrequent or episodic: *Psychology, rehabilitative physiotherapy, audiometry, optometry, rehabilitative physiotherapy***
Home care (level 3 & 4)	Need assessed as part of aged care entry assessment. Aged care provider funded to deliver assessed level of care.	Referred by primary care practice. Provided by allied health professionals reimbursed through Medicare Benefits Schedule.
Residential care	Need assessed as part of aged care entry assessment. Funding built into shared cost base; services provided by professionals remunerated by the aged care provider (either employees or contractors).	Referred by primary care practice in collaboration with the aged care provider. Provided by allied health professionals reimbursed through Medicare Benefits Schedule.

1. This proposition is directed at creating two new funding mechanisms to facilitate more holistic allied health care for aged care recipients, allowing for a broader range of service provision beyond one-on-one treatment. It seeks to promote continuity of care by funding providers directly to support frequent and ongoing allied health needs, while also taking advantage of the benefits of the fee-for-service model for infrequent or episodic allied health care.

2. The first aspect of the proposition relates to allied health services care recipients are likely to need on a 'frequent and ongoing' basis, including:
    a. Podiatry
    b. Occupational therapy
    c. Speech pathology
    d. Maintenance physiotherapy
    e. Dietetics

3. It is proposed that providers of residential and home care services (with respect to level 3 and 4 home care packages) will be responsible for and funded for the provision of frequent and ongoing allied health services.

4. This approach may support allied health professionals to provide beneficial services beyond treatment for individual care, such as building the expertise of aged care staff (both in residential and home care) through training, advice and improvement initiatives. In addition, older people with complex needs may not be well served by short assessments and treatments by different service providers.[11]

5. Under this aspect of the proposition, providers would receive additional funding to support the delivery of these services.

6. The second aspect of this proposition relates to allied health services needed on an 'infrequent or episodic' basis, including:
    a. Psychology

[11] See: Allied Health Reference Group Submission to Medicare Benefits Schedule Review Taskforce, 2019, p 23.

b. Rehabilitative physiotherapy

c. Audiometry

d. Optometry

7. With respect to current MBS funding for allied health, under the Chronic Disease Management package, medical practitioners can refer people with chronic conditions for subsidised allied health services under a management plan.[12] People with a management plan can access five MBS-funded allied health services in a calendar year.[13]

8. This proposition suggests new MBS items for 'infrequent or episodic' allied health care for aged care recipients. Older people enrolled with an accredited aged care general practice would be eligible for this MBS funding.

9. Under this proposition, the referral pathway for people to access MBS funded allied health services would depend on the type of aged care received:

    a. aged care recipients living in the community would be referred by a primary care practice;

    b. aged care residents would be referred by a primary care practice in collaboration with the aged care provider.

10. It is proposed that there would still be a cap or limit on allied health services funding under the MBS and that Government should set this limit based on clinical advice. For example, it might be that rehabilitative physiotherapy should be available weekly, psychology monthly, and optometry and audiometry annually.

11. Consideration should also be given to whether there should be different approved limits for people in residential aged care compared with people accessing level 3 and 4 home care packages.

12. Approved providers of residential and home care (with respect to level 3 and 4 home care packages) would be responsible for arranging attendance by allied health practitioners to provide episodic or infrequent allied health care.

13. Aged care providers could choose whether to contract allied health practitioners or organisations and/or employ in-house allied health professionals to cover any or all of the allied health services identified.

14. Consideration should be given to:

    a. which allied health services should be defined as 'frequent and ongoing' and which 'infrequent and episodic' in an aged care context

    b. how care recipients' allied health care needs could be identified

    c. how approved providers could be held accountable for the identification of need for allied health services and/or the delivery of adequate and appropriate allied health services

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[12] Department of Health, *Chronic Disease Management (formerly Enhanced Primary Care or EPC) – GP services*, https://www1.health.gov.au/internet/main/publishing.nsf/content/mbsprimarycare-chronicdiseasemanagement#:~:text=The%20Chronic%20Disease%20Management%20(formerly,require%20multidisciplinary%2C%20team%2Dbased%20care, viewed 9 January 2019.

[13] Department of Health, *Chronic Disease Management – Provider Information Fact Sheet*, https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-factsheet-chronicdisease.htm, viewed 16 June 2019. A person with a diagnosis of type 2 diabetes can also access up to 8 additional group allied health services following assessment by a relevant allied health practitioner. See MBSOnline, *Medicare Benefits Schedule MN.9.1 Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes – Eligible Patients*, http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=MN.9.1, viewed 16 June 2019.

d. the impact of this recommendation for smaller scale aged care providers and providers in regional, rural and remote Australia

e. the need for allied health services to be provided at an individual's place of residence, and to the possibility of allied health services being delivered via telehealth, particularly in rural and remote areas

f. access to allied health by people receiving level 1 or 2 home care packages.

Draft proposition – new primary care model

Draft proposition CH21: the Australian Government implement a new primary care model for aged care recipients by 2022

1. Under this new primary care model, general practices apply to the government to become accredited aged care practices.
2. This model could have the following features:
    a. The initial accreditation criteria might simply be RACGP accreditation, participation in after hours cooperative arrangements and utilisation of My Health Record, but over time these could be strengthened to include features such as formal relationships with geriatricians and other specialists, or attainment of geriatric medicine or gerontology qualifications by GPs or other practice staff.
    b. People with an ACAT assessment can enrol with an accredited practice.
    c. The practice would receive an annual capitation payment according to an enrolled person's level of assessed need.
    d. In return for the capitation payment the practice agrees to meet the primary medical care needs of the person for the year, including cooperative arrangements to provide after-hours care if required.
    e. Practices can agree with people and their aged care providers on how care will be provided, including use of telehealth services, use of nurse practitioners, and so on.
    f. Practices must agree to accept any person who wishes to register with them (subject to geography).
    g. The capitation payment will be reduced by the value of benefits paid when an enrolled person sees a GP in another practice.
3. Practices will be held to account against a range of performance indicators, including immunisation rates and prescribing rates. They will be required to use My Health Record in conjunction with aged care providers, and required to initiate and take part in regular medication management reviews.
4. Practices will be required to prepare an "Aged Care Plan" (in collaboration with a geriatrician and the aged care provider if there is one) for each enrolled person, which includes referrals for appropriate allied health services and dentistry.