Allied Health Professions Australia

Submission to Aged Care Taskforce

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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. In aged care AHPA works closely with its Aged Care Working Group, which is comprised of representatives from our member professions that provide aged care services.

Context: The place of allied health in the aged care system

It is important to provide the Aged Care Taskforce with background on the current state of allied health in aged care. Allied health is significantly underprovided and underfunded, and so aspiring to an aged care system that genuinely meets older people's assessed allied health needs will take resources that have not been sufficiently factored into aged care costing. These considerations are clearly relevant to any deliberations about future system planning and appropriate aged care funding strategies.

As consultation on in-home aged care reforms is still proceeding, we focus primarily on residential aged care, while noting that many of the themes below are relevant to the aged care system as a whole.

Royal Commission findings on allied health

In its Final Report, the Royal Commission into Aged Care Quality and Safety concluded that 'reablement' is critical to older people's physical and mental health and wellbeing and should be a central focus of aged care.[1] Due to incidents such as falls, or simply because of the ageing process, older people can suffer or be at risk of experiencing a loss of capacity, which can impact on their quality of life. Reablement is about preventing such losses where possible, and rehabilitating and restoring, or at least preserving as much as possible, older people's capacities.

[1] Royal Commission into Aged Care Quality and Safety, Final Report Volume 3A The new system (2021), 176; Royal Commission into Aged Care Quality and Safety, Final Report Volume 1 Summary and recommendations (2021), 101; and Recommendations 35 and 36. See also Exhibit 20-1, Australian Association of Gerontology Position Paper, Wellness and Reablement for All Australians, 31 July 2020.

Allied health practitioners provide clinical care with a focus on prevention of functional decline, along with early intervention and treatment to support a person's function and quality of life. As part of multi-disciplinary best practice, allied health professionals play an important role in:

- improving quality of life (for example, addressing pain, psychological and behavioural symptoms, communication, hearing loss and mobility);
- preventing deterioration and serious events (for example, through dietary and swallowing interventions, psychological management and falls prevention); and
- reducing emergency department admissions and preventable hospitalisations (for example, via early assessment and management of chronic conditions, falls risks and dysphagia).

The clinical expertise of allied health professionals is also essential for supervising and upskilling the care workforce to deliver client-centred care, together with ensuring that clinical care standards are met – and thereby mitigating provider risks of non-compliance.

During the Royal Commission's tenure there was scant data on the provision of allied health services in Australian residential aged care, let alone on the types and frequency of allied health treatments provided to individual residents. The Commissioners' findings therefore drew on evidence that included research undertaken in 2018 by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong.[2]

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.[3] Results included the finding that aged care residents received an individual average of only eight minutes of allied health care a day.[4] This finding was contrasted by the AHSRI to the allied health care figure in British Columbia, Canada of 22 minutes.[5]

The Royal Commission concluded that allied health service provision is essential for reablement, and that Australia's significant underprovision and undervaluing of allied health care produces

[2] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and 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. The 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 (Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N and K Quinsey, *AN-ACC: 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).

[3] Eagar K, McNamee J, Gordon R, Snoek M, Duncan C, Samsa P and 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.

[4] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and 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.

[5] Ibid, p24.

morbidity, mortality and negative quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[6]

Accordingly, the Royal Commission also concluded that allied health should be regarded as a fundamental element of the aged care system.[7] The Royal Commission made multiple associated recommendations, including concerning the importance of multidisciplinary care.[8]

The Royal Commission recommended that aged care provided to people at home and in residential facilities include a level of allied health care appropriate to each person's needs.[9] This level of service provision requires needs-based assessment, so the Royal Commission recommendations also emphasise clinically assessing each person, ideally via a 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.

Provision of allied health in residential aged care

Since July 2022, Quarterly Financial Reporting ('QFR') has provided some more data on allied health costs and time spent on residential aged care.[10]

However, it should be borne in mind that this data remains insufficiently granular. Although QFR now includes some data on staffing minutes for individual allied health professions in residential care, only physiotherapy, occupational therapy, speech pathology, podiatry and dietetic care, and the (undifferentiated) use of allied health assistants are distinguished. Provision of any other types of allied health services is reported under 'other'.

Allied health care provided is also not publicly reported against each of the 13 AN-ACC classes. It is therefore not easy to ascertain whether, for example, older people with high or complex needs receive more allied health services on average than higher functioning residents.

The most recent Quarterly Financial Snapshot (October to December 2022, 'QFS') – the first one to reflect the impact of the AN-ACC model – reports that the median total allied health minutes provided per resident per day is 4.6.[11] The minutes for some individual allied health professions are so low that only four professions are individually represented in the QFS, ranging from 0.04 minutes for speech pathology to 2.97 minutes for physiotherapy.

4.6 minutes represents a decrease since AN-ACC commenced. It also means that allied health service provision is now significantly less than the eight minutes criticised by the Royal Commission, let alone the 22 minutes in Canada's aged care system.

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[6] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83; and Recommendations 35–37. See also Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.
[7] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 101; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[8] See eg Recommendations 25, 28, 31, 35-38, 58 and 69.
[9] See eg Recommendations 36 and 38.
[10] Allied health data has only recently begun to be collected for home care, and solely at an aggregated level – see Department of Health and Aged Care, *Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022*, 26.
[11] Ibid, 13-14.

Feedback on draft aged care funding principles

AHPA largely supports five of the six draft principles, but we propose some modifications (in red text with deletions noted), and where relevant provide associated comments (in italics):

Principle 1

Reablement – rehabilitation and restoring, or at least preserving as much as possible, older people's capacities so that wellbeing is enhanced and/or maintained – is a central focus of residential and home aged care, and includes enabling and encouraging participants to remain in their home for as long as they wish and can do so.

Principle 2

Aged care funding arrangements and their outcomes should be fair, simple, ~~transparent~~ administratively efficient and sustainable.

'Fair' should include vertical, horizontal and intergenerational equity.

Principle 3

Government is and will continue to be the major funder of aged care. Government funding should be focused on care costs, including paying for 100% of healthcare delivered to aged care consumers.[12]

~~Personal contributions should be focused on accommodation and everyday living costs with a sufficient safety net.~~

Government continues to contribute to accommodation and everyday living costs, including paying up to 100% for those who cannot afford to contribute. Older Australians who can afford to pay should make personal contributions to the cost of accommodation and everyday living commensurate with their wealth (all income and assets, including superannuation and inheritance), as assessed by means testing.

Principle 4

~~Government and participant contributions should be sufficient to provide quality and appropriate care delivered by a skilled workforce, allowing and encouraging innovation by the health, hospital and aged care systems~~.

See new Principle 1a.

Principle 5

There should be transparency and accountability for funding received from government and participants, how it is spent, and the quality of the services provided.

This principle should be supported by:

a) provider reporting including, in residential aged care, of each type of care and service provided and the source of payment, by AN-ACC class;

b) independent monitoring against the mandatory benchmarks, including of needs assessment data; and

c) regular analysis of funding and expenditure data.

[12] See also our response to the 'sustainability' question below.

~~**Principle 6**~~

~~The residential sector should have access to sufficient, and new, capital to encourage the development of new accommodation and upgrades to existing accommodation.~~

AHPA does not support this principle, because it is inconsistent with the focus of the other Principles, at least as it pertains to for-profit provision of aged care.

We also propose two additional principles:

Principle 1a (*insert before Principle 2*)

Government and personal contributions should be sufficient for consistent provision of high-quality aged care to all by appropriately skilled staff, with associated mandatory benchmarks for healthcare, personal care, accommodation and everyday living, and which are disaggregated where appropriate (eg by each healthcare discipline).

Principle 1b (*insert before Principle 2*)

Healthcare, including allied health care, nursing, and other professions contributing to multidisciplinary teams, should be contemporary, evidenced- and needs-based, with needs clinically assessed on a nationally consistent basis.

Consultation questions

What does 'fairness' in aged care funding and care services look like?

We understand that the Taskforce seeks answers to this question which focus on funding strategies and the associated relevant Principles, which we discuss in our responses to the questions further below. With regard to our response here, as outlined in 'Context' above, considering what fair service provision should look like requires first addressing the fundamental unfairness that the current state of allied health in aged care does not match the Royal Commission's recommendations for needs-based allied health provision.

Benchmark needed for allied health

AN-ACC as a funding tool is not designed for allied health funding needs, nor for the provision of clinical care assessment and planning. AN-ACC also does not itself prescribe the amount or types of care to be provided. The recent introduction of mandatory minutes for personal and nursing care has in effect set benchmarks via which providers have begun to allocate portions of their overall AN-ACC funding for direct care spending. However, there is no comparable benchmark for allied health care provision, and consequently no ringfenced funding.

The Department of Health and Aged Care ('the Department') continues to simply insist that AN-ACC funding adequately caters for allied health service provision. Recent analysis of whether AN-ACC funding is sufficient, by the University of Technology Sydney Ageing Research Collaborative ('ARC'), appears to only factor nursing and personal care into its definition of direct care. Even with this limited definition, the ARC concludes that currently:

> 'the overall increase in AN-ACC funding shows that it is sufficient to cover the cost of direct care, even with the new staffing requirements and pay rise, *but with little additional surplus*.'[13]

[13] Sutton, N, Ma, N, Yang, JS, Lewis, R, Woods, M, Ries, N and D Parker, *Australia's Aged Care Sector: Mid-Year Report (2022–23)*, UTS Ageing Research Collaborative, 16, emphasis added.

Providers have also tended to use any surplus that does presently result from their direct care funding allocation to try to address growing deficits in accommodation and cost of living expenses,[14] rather than spending more on allied health care when there is no clear minimum enforceable standard (for more detail, see our discussion of quality care below).

Accurately costing the allied health care actually needed may also impact not just on the required funding amount but also as a result, on preferred funding mechanisms. For example, in residential aged care, a very rough calculation based on the Canadian yardstick of 22 minutes a day raises the QFR labour cost of allied health from $5.80 to $27.74.

Accordingly, while AHPA welcomed the recent care minutes reforms, we are extremely concerned about the lack of mechanisms to similarly ensure fully funded provision of allied health – as the third pillar of aged care – in residential aged care.

Consistent assessment of allied health needs

The other 'elephant in the room' is the lack of nationally consistent assessment of allied health needs, despite the Royal Commission recommendations. The AN-ACC developers recommended the separation of assessment of residents for funding purposes, from the assessment of residents for delivery of appropriate care. The latter requires development and implementation of a nationally consistent, evidence-based, care assessment and planning tool,[15] with data on its use and resulting service delivery outcomes being monitored and publicly reported.

This has not happened. In residential aged 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 ends up receiving allied health services 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, and may vary by provider facility and even among individual staff.

Home care, at least at present, is also variable in terms of allied health needs assessment. 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 again depends upon whether the assessor has the training and knowledge to decide on referral to an appropriate allied health professional.

The aged care system therefore needs a national assessment and care planning tool, to be used consistently to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care. This reform is not only necessary to ensure high quality care (see below) – it is essential for true costing of allied health service provision, with the associated implications for funding.

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[14] Ibid, 19.

[15] Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N and K Quinsey, *AN-ACC: 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, 8-11; https://www.australian-ageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ . See also Royal Commission Recommendations 25, 28, 31, 37 and 38.

What does quality and appropriate care mean to you?

AHPA began to address this question in 'Context' and our response to the 'fairness' question above. Inadequate funding of allied health services has flow-on effects to the allied health aged care workforce, including deterioration in the quality of care available to residents. Fewer average minutes mean allied health professionals can often now only provide reactive care at best, rather than collaborating in best practice multidisciplinary team approaches. In a recent survey, allied health professionals noted deterioration in the quality of allied health care available to residents.[16]

There is also at least anecdotal evidence that aged care providers are substituting 'cheaper' workers from outside allied health, such as personal care workers and lifestyle staff, to provide services that considerations of quality and safety require to be delivered by an allied health professional.

Similarly, AHPA is aware that allied health assistants ('AHAs') are sometimes being used to carry out essential allied health tasks. Although valuable contributors to the workforce, AHAs are less qualified than allied health professionals. AHAs therefore either require supervision by an allied health professional, or are simply not suited to the task, which then exposes residents to unacceptable risks.

Compromising allied health quality and safety in these ways exacerbates Australia's already considerable health sector burden, via outcomes such as increased hospitalisations and surgeries.

Accountability for quality

The Department asserts that allied health is provided to an acceptable standard, and refers to provider obligations to provide allied health services under aged care legislation, including most notably the Aged Care Quality Standards ('Quality Standards'),[17] which have recently been amended and await enactment subject to piloting and development of guidance material.

However, as AHPA has submitted elsewhere,[18] the current aged care regulatory system fails to ensure quality (including sufficient provision) of allied health services.[19] Quality allied health care has a direct relationship with current underfunding, but the present regulatory system does not recognise this. The process for monitoring compliance with the legislation is weak, and there appears to be no clear and practical translation or monitoring of provider obligations via the Quality Standards and Schedule 1 of the *Quality of Care Principles 2014*.

Aged care regulation must embed accountability for the provision of allied health services as a critical element of the aged care system. An effective system must be able to demonstrate that

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[16] https://ahpa.com.au/advocacy/3489-2/ .

[17] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5, and Schedules 1 and 2. See also (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), the Aged Care Quality and Safety Commissioner's response in the same transcript, and the Aged Care Quality and Safety Commission's Compliance and Enforcement Policy (14 July 2021), 7-9.

[18] https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ ; https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .

[19] See also https://ahpa.com.au/news-events/the-independent-capability-review-of-the-aged-care-quality-and-safety-commission-released/ .

people are receiving allied health services according to assessment of their clinical needs, and that care is being appropriately planned, delivered and coordinated.

High quality care

The definition of 'quality' care is another vexed issue. AHPA has serious concerns about the current Commonwealth Government proposal to simply aspire to 'high quality', while mandating only the provision of 'quality' care.[20] We believe this sets the regulatory bar too low, and it is also at odds with the Royal Commission's recommendation.[21]

To genuinely commit to reablement in aged care, with the associated realisation of associated quality of life benefits for older people, requires enforcement of high quality care standards, including for allied health. Without this commitment, high quality care risks being treated as a luxury item rather than a universal right based on assessed needs.

AHPA therefore also supports the submission of our member Occupational Therapy Australia ('OTA') that there should be acknowledgment that Australia's aged care funding system aims to uphold the human rights of aged care consumers. While as OTA proposes this could perhaps be added into Principle 2, it may be more appropriate that references to funding mechanisms are incorporated into the proposed new Aged Care Act, including the Statement of Rights. As with the standard of high quality aged care, it is important that those rights are enforceable.

Is funding for Australia's aged care system sustainable? If not, what is needed to make it sustainable?

No, it is not currently sustainable. AHPA therefore supports a combination of strategies for sustainable funding of a high quality aged care system, informed by the Principles we support and propose above.

Aged care should continue to be a substantial element of Govt expenditure, analogous to Australia's approaches to welfare and the broader health system. Any public perception of 'unaffordability' should be tempered by published analysis of how much income the sector also generates, as with the National Disability Insurance Scheme.[22]

General approach

Everyone who earns a reasonable income or has significant assets should contribute, via mechanisms such as taxation and through consumer co-contributions, toward the costs of accommodation and everyday living services and amenities (food, shopping, cleaning, laundry, gardening, utilities, transport).

It is also important not to unfairly burden the present younger and future generations. We are therefore not inclined to support social insurance, at least at this stage. Our preferred initial strategy is to make the tax system more equitable, starting with rescinding the proposed Stage 3 tax cuts and raising the company tax rate.

If after modelling the impact of these changes, projections of the working age to retirement ratio, and the consumer co-contributions discussed below, it appears that further funding will be needed, other strategies should be considered. These 'second-tier' mechanisms could include an

[20] https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .
[21] Ibid; Royal Commission Recommendation 13.
[22] See eg *False Economy: The economic benefits of the National Disability Insurance Scheme and the consequences of government cost-cutting*, Per Capita, November 2021.

aged care levy, with the possibility of supplementing this via an inheritance tax (discussed below) and by raising personal tax rates. Together with setting minimum income thresholds, consideration should be given to a sliding scale of increases for both the levy and tax rates.

Healthcare funding

AHPA supports using a combination of taxation and, if necessary, an aged care levy, to fund 100% of healthcare expenditure according to the assessed clinical needs of aged care consumers. This funding should also cover specialised equipment and assistive supports.

In addition to taking into account the present underfunding of allied health care, there should be public debate about whether there is any place in a fair and sustainable aged care system for the use of channels outside the aged care system to fund care. AHPA is aware that at present some healthcare, including some allied health, is simply paid for privately by aged care consumers. Other services are provided through Medicare, Veterans' Care, private insurance, and State and Territory health services. The breakdown of this funding of service provision is not currently visible in QFR.

Spending via these 'outside' channels does not come close to meeting likely allied health care needs, in part because of limited access to the various avenues, together with restrictions on the amount and type of care that can be obtained. Many consumers are also increasingly out-of-pocket due to gap fees and limited rebates, and so may simply not pursue treatment.

In addition, the impact on other health consumers of the use of external pathways such as the annual maximum of five Medicare allied health items per year to, in effect, subsidise aged care providers, must be investigated. Deliberations must also take into account Government acceptance of Royal Commission Recommendation 69, which proposes that allied health care for people receiving aged care be generally provided by aged care providers.

Personal care funding

We also express provisional support for taking the same approach to Government funding of personal care as for healthcare, subject to public discussion of the definition, aims and outcomes of care.

Funding of accommodation and living costs

To the extent necessary once the projected impact of consumer co-contributions has been assessed (discussed below), and consistent with Principle 3, government funding via the taxation mechanisms described above should subsidise accommodation and living costs where appropriate.

What costs do you think consumers in aged care should contribute to and to what extent? How is this different for care, compared with everyday living expenses or accommodation?

AHPA supports increasing consumer contributions toward the costs of accommodation and everyday living services and amenities (food, shopping, cleaning, laundry, gardening, utilities, transport). The distinction from health and personal care is that if an older person did not require aged care, they would still be paying for accommodation and living costs. Nevertheless, we appreciate that there may be some blurring of boundaries in some instances. Means testing and safety nets are also essential.

Factors to consider

Personal co-contributions should be provisional – that is, to be made only if people actually end up needing aged care. Government co-contributions should also be regarded as applying to each consumer across the whole aged care system, rather than necessarily meaning that for each person, expenditure on both accommodation and everyday living, must entail a Government contribution.

If consumers are being asked to pay more, there must also be more open scrutiny of provider accounting, and in particular, of those who are continuing to make a profit.

In assessing required consumer contributions, all income and assets, including superannuation and potential inheritance – shorthanded here as 'wealth' – should be considered. The concept of a 'floor' rather than a 'ceiling' as the limit for assessment of the value of the primary residence has considerable merit.

How consumers finance payments when most of their wealth is not in the form of liquid assets could be via loan schemes and/or reverse mortgages.

The percentage of the Basic Daily Fee ('BDF') that residential aged care consumers are required to pay should be raised for those with more wealth than the pension. The BDF and income-tested fee payments should be enforced in home care (excluding direct care) using similar principles, with the proviso that there is a payment-free threshold for those with short-term needs.

Annual and lifetime caps on aged care payments should be revised upwards, with a sliding scale. For example, people whose total wealth falls under a specified limit contribute nothing, but those over that limit pay incrementally higher percentage contributions to the total cost, up to the specific annual or lifetime cap. If the total wealth is higher than a certain amount (to be determined), the consumer pays 100% of the costs for as long as necessary.

We make no specific comment on the role of Refundable Accommodation Deposits or Daily Accommodation Payments.

Inherited wealth

Wealthy people could use their superannuation, perhaps supplemented by other income, including some liquidated assets, to fund their own aged care entirely (except for healthcare, and, ideally, personal care). There would likely still be a substantial inheritance.

The question is then whether such people and their families should contribute to the cost of not only their own potential aged care, but other people's. If costing projections appear to require a further funding mechanism, AHPA supports public discussion of an inheritance tax if the wealth bequeathed is above a certain level, in order to help support those without means.

Additional services

While we are aware that at present consumers sometimes pay (or pay more) for additional services, we strongly oppose any shift to a two-tiered aged care system distinguished on quality of care. Services such as alcohol with meals and pay-TV may be appropriate, but certainly not 'more exercise physiology' or basic recreational opportunities such as regular accompanied walks.

What does innovation in aged care mean to you? How can funding support it?

AHPA has largely addressed this in our responses to the 'fairness' and 'quality' questions above, where we point out that system and care innovations recommended by the Royal Commission, such as consistent needs-based assessment and planning, are yet to be implemented.

Another important example of an innovation that needs to be embedded in aged care before even considering allocating funding to developing future initiatives concerns the provision of care via multidisciplinary teams. This approach was viewed by the Royal Commission as the most appropriate and effective way to meet the needs of individual aged care consumers, especially if those needs are complex. As a cornerstone of the system and crucial in reablement, allied health providers must be key members of those teams, working alongside nurses, GPs and specialists.

At a minimum, provision should be made for the delivery of care by the suite of health professions listed in Royal Commission 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.

As an example of a multidisciplinary aged care model, in August 2022 AHPA proposed the Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project.[23] The EMBRACE project includes identification of pathways to the full range of allied service delivery, student placements, and outcome evaluation. AHPA provided this model to the Minister for Aged Care as part of our response to the aged care Jobs Summit, but the model has not progressed any further.

Despite the obvious relevance and interest of allied health professionals, AHPA has had great difficulty in getting engagement, and even obtaining information, about what is being done by Government in implementing multidisciplinary team approaches.

What is the role of Government versus private investment in funding upgrades and constructing new facilities? Is the role different in rural and remote locations?

We make no comment, except to emphasise that Government should not fund for-profit facility construction and upgrades.

[23] https://ahpa.com.au/advocacy/aged-care-system-needs-emergency-first-aid-say-allied-health-professionals/, especially 7.