Submission

Independent Hospital and Aged Care Pricing Authority (IHACPA) Consultation on the Pricing Framework for Australian Residential Aged Care Services 2025–26

Submission by the **Australian Physiotherapy Association**

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Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 32,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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1. Executive Summary

The Australian Physiotherapy Association (APA) is pleased to provide feedback to the Independent Hospital and Aged Care Pricing Authority (IHACPA) Consultation on the Pricing Framework for Australian Residential Aged Care Services 2025–26.

Despite significant residential aged care reform underway, IHACPA's ability to deliver on its vision of supporting the delivery of high quality, person-centred care[1] through appropriate costing continues to be limited by the inputs into its costing studies.

IHACPA pricing of essential healthcare services, such as physiotherapy, is restricted by its methodology and the data upon which it bases its calculations. Basing pricing on actual costs for healthcare provision at a time of documented declines in allied health care provision in residential aged care overlooks the cost of providing the high quality care that is required.

The Quarterly Financial Report that informs IHACPA pricing captures an inadequate measure of average minutes of physiotherapy care provided per resident per day. In the absence of clear benchmarks of acceptable levels of care and linkage to assessed need vs service delivery and outcomes, this data is an insufficient measure upon which to undertake costing of care.

The quality of aged care provision is affected by many variables – including importantly, individual needs assessment and care planning.

However, sweeping reforms in residential aged care funding have not been underpinned by a clear articulation of what quality of care entails.

Despite clear recommendations from the Royal Commission into Aged Care Quality and Safety to ensure critical allied health reablement care is embedded within facilities[2], there are no mandates to ensure it is delivered.

As a first step to meeting the recommendations of the Royal Commission, the APA is calling for a comprehensive review of the AN-ACC model and implementation. We have identified in this submission some changes to consider to ensure that reablement for those classed as independently mobility are made available to maintain mobility and independence.

Further, a shift in costing approach is required – undertaking cost of care studies from the ground up, factoring in variables across geographic locations, within facilities, accounting for different levels of complexity of care and enabling high quality care.

We have responded to the consultation questions as relevant to the profession and welcome the opportunity to contribute more expansive feedback to the review.

2. Summary of recommendations

Recommendation 1	Review the Australian National Aged Care Classification (AN-ACC) model to ensure ongoing reablement care is appropriately funded in Class 2 Independent Mobility category to ensure mobility and physical function is maintained.
Recommendation 2	Review the AN-ACC model Class 3 Independent Mobility with Compounding Factors category to ensure it is appropriately funded to recognise cognitive factors requiring more intensive and individualised therapy.
Recommendation 3	Undertake a comprehensive cost benefit analysis of delivery of needs-based multidisciplinary care, with physiotherapy at its centre, in residential aged care.
Recommendation 4	Fund needs-based assessment and ongoing reablement care for those entering respite care.
Recommendation 5	Consider the additional costs associated with delivering culturally safe care and incorporate this into the recommended base care tariff rates.
Recommendation 6	Consider flexibility in relation to pricing models, to support Aboriginal and Torres Strait Islander older people receiving aged care services when they move from rural, regional, or remote locations to urban locations, or live transient lifestyles
Recommendation 7	Introduce a separate and specific AN-ACC class to acknowledge and address the multifaceted challenges experienced by those with homeless status

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3. Responses to survey questions

Do the current AN-ACC classes in Figure 10 group independently mobile residents in a manner that is relevant to both care and resource utilisation (that is, require the same degree of resources to support their care delivery)?

Independently mobile categories (Classes 2 and 3) of the Australian National Aged Classification (AN-ACC) are not sufficiently funded for ongoing reablement care to prevent decline in mobility and balance and hence entry into a higher care funding category. Funded reablement to maintain mobility and physical function reduces falls risk, long-term clinical costs and personal care staffing costs, in particular those related to manual handling and supported activities of daily living such as showering.

Class 3 – Independent with compounding factors – is not sufficiently funded to account for factors often requiring more intensive and individualised therapy. For example, a resident within this class may be physically capable of independent mobility, cognitive factors may impact the level at which they may safely do so and require additional supervision and support to prevent in injury. Ongoing reablement care assists in maintaining physical function and benefits cognition, with positive impacts on overall wellbeing and mood – with reduction in personal care support requirements.

The De Morton Mobility Index (DEMMI), designed to measure changes in mobility in hospitalised elderly people across settings, is not sensitive to the requirements of care. Translation from the assessment of mobility and function that informs care needs, or minimum care needs, is lacking. This means there is no clear mechanism to inform consistent levels of care based on these assessments that will prevent loss of function.

There is long-standing data that shows that loss of function and mobility in first 12 months in RACF remains a major driver of care needs, costs, hospital admission and morbidity. Restorative and functional re-enablement services should be funded across all classifications to delay the progression of morbidity and decrease the associated cost burden.

What factors should be taken into consideration in developing any future refinement to the AN-ACC branching structure for independently mobile residents?

The relationship between funding and care planning is the key factor in whether the AN-ACC can deliver on its design intents.

The AN-ACC was implemented as a subsidy classification, not care planning, model with independent assessors undertaking assessments to distribute funding based on aged care residents' needs and the cost of care. The Department of Health and Aged Care website makes clear that "care planning is not part of the AN-ACC assessment process and remains the provider's responsibility."[3] In the absence of individualised needs-based assessment to directly inform care planning and measure service delivery against individual assessed need, there will continue to be limitations in data upon which IHACPA can determine the cost of care.

The Quarterly Financial Report that informs IHACPA pricing captures an inadequate measure of average minutes of physiotherapy care provided per resident per day. In the absence of clear benchmarks of acceptable levels of care and linkage to assessed need vs service delivery and outcomes, this data is an insufficient measure upon which to undertake costing of care.

The introduction of the 215 minutes of registered nursing and personal care has placed further pressure on the sector and it is unclear how the type and level of care provided to residents is being captured and measured other than by an arbitrary numerical value.

Care minutes do not record whether the numerical value meets needs or reflect the level of experience and skill of the healthcare professional/aged care worker providing them.

The APA supports a comprehensive review of the AN-ACC to understand how it is meeting the system design aim of subsidising provision of care based on service type and each residents' care needs. This review should examine how needs assessment will support providers meet Quality Standards by informing inform care planning, quality measurement and ultimately, pricing.

What evidence is there to support this?

Aged care residents with mild mobility impairment are at increased risk of falls and have a higher falls risk than those with independent mobility and are an appropriate target for falls prevention strategies.[4]

The Sunbeam Program[5] has demonstrated the effectiveness of exercise interventions, and should be used to guide future policy. The results of the trial demonstrated a 55 per cent reduction in falls by people who participated in the exercise program and a projected cost saving of $120 million per year for the Australian health economy.

The *Value of Physiotherapy in Australia* report, an independent study produced by The Nous Group, synthesised key clinical research (including the Sunbeam program) and compared the benefits they deliver with estimates of the cost of delivering the treatments. An economic analysis of the cost of a physiotherapy-led falls prevention program compared to the cost of not undertaking the program, resulting in a fall, was conducted. The average quality of life benefits of physiotherapy-led programs was calculated at $3000 per episode. The total cost of physiotherapy treatment averaged $1680 per episode. Nous concluded that the benefit of physiotherapy-led falls prevention programs (i.e. quality of life benefit minus the cost) equalled $1320 per falls episode.

A large allied healthcare provider has supplied the APA with outcomes of its delivery of the Sunbeam program and its Physiotherapy Program in residential aged care. It delivered the Sunbeam Program to 700 participants across 28 residential aged care facilities measuring functional improvement via increases in Short Physical Performance Batter (SPPB) score averages. The outcomes included:

- Walking speed: 61% increase
- Balance: 78% increase
- Ability to stand from chair without assistance: 41% increase

Anecdotal feedback from care teams, therapists & residents:

- Improved participant mood
- Improved social engagement
- Improved self-confidence in day-to-day activities

The Physiotherapy Program was delivered to almost 8,000 residents across more than 250 residential aged care facilities. Data collected in late 2023 demonstrated that of residents who participated:

- >30% achieved improvement in clinical outcomes (DEMMI & Individualised Therapy Goals)
- >55% achieved maintenance in clinical outcomes (DEMMI & Individualised Therapy Goals)

Any review of the AN-ACC model should include comprehensive cost benefit analysis of delivery of needs-based multidisciplinary care, with physiotherapy at its centre. Highly qualified healthcare professionals, such as a physiotherapists, working alongside nursing and personal care staff to manage the complex comorbidities of residents and instigate system improvement, such as best practice in manual handling, will contribute to cost efficiencies in addition to improved quality of life for older people.

For example, physiotherapists have a critical role in the management of continence and osteoarthritis, both of which are key contributors to increased risk of falls. The Nous Group Value of Physiotherapy analysis found a net benefit of physiotherapy for a person with stress urinary incontinence to be an average of $16,810 in quality of life gains, and an average of $3,880 for a person living with osteoarthritis, including reduced reliance on surgical interventions.

Any review of the AN-ACC must focus on how the model can be supplemented to ensure the delivery of high value, evidence-based multidisciplinary care on an ongoing and episodic basis.

Analysis of intra and inter-system cost benefits of high quality, needs-based multidisciplinary care within residential aged care and its interface with health is required to gain a full understanding of how AN-ACC can be refined to support long-term efficiencies.

What, if any, factors should IHACPA consider when looking at specialised BCT rates for Aboriginal and Torres Strait Islander peoples?

What, if any, additional cost variations and eligibility requirements are associated with the provision of care for Aboriginal and Torres Strait Islander residents?

IHACPA must consider the additional costs associated with delivering culturally safe care and incorporate this into the recommended base care tariff rates. This includes elements that are important to Aboriginal and Torres Strait Islander people such culture, kinship, Country, lore, and spirituality, and the costs associated with these, such as administrative, staffing and training costs, the provision of innovative care, support for communication in language and local place-based approaches.

IHACPA must also consider flexibility in relation to pricing models, to support Aboriginal and Torres Strait Islander older people receiving aged care services when they move from rural, regional, or remote locations to urban locations, or live transient lifestyles. At present, aged care packages, payments and supports are fragmented.

This may include a specific adjustment payment that recognises the additional costs associated with reablement focused care for Aboriginal and Torres Strait Islander people.

What, if any, factors should IHACPA consider when looking at specialised BCT rates for specialised homeless status?

What, if any, additional cost variations and eligibility requirements are associated with the provision of care for these residents?

The APA contends that homelessness requires a separate and specific AN-ACC class to acknowledge and address the multifaceted challenges experienced by those with homeless status that may include:

- increased likelihood of chronic disease and injury;
- unanticipated or early entry into residential aged care;
- lower capacity to fund addition items such as appropriate footwear;
- lack of family support to facilitate basic needs, such as clothes, toothbrushes;
- mental health issues or trauma;
- potential history of lack of engagement with health care; and
- greater requirement for multidisciplinary team input.

Homelessness is likely to accelerate entry into residential aged care in those under 65, who may benefit from increased multidisciplinary care to support them to address physical and cognitive health concerns and linkage to services, facilitating a safe return to the community.

What should be considered in any future refinement to the residential respite classes and AN-ACC funding model?

In terms utilisation of respite services, it widely understood that there is a “try before you buy” approach to residential respite. Anecdotally high volumes of residential respite users enter respite with a view to possible transition to permanency. This is a key consideration in how access to services should be determined. An “equivalency approach” should be perused where assessed need for services is funded in the same way it is for permanent residents.

The current funding of $156 per respite resident per day is adequate to cover food and accommodation and basic care costs. Broadly speaking, we understand that activities of daily living and urgent health care needs are being met.

However, with an average length of respite stay at 11 days and with the incidence of falls significantly higher in respite compared to permanent residents for all falls,[6] it is critical to also fund reablement services.

Where access to services for respite residents is reduced, acknowledging the high portion that move through to permanency, there is a significant window of time in which delayed re-enablement may accelerate advancement of care needs, loss of quality of life and morbidity.

What, if any, changes should suggest IHACPA consider for the proposed updated residential aged care pricing principles, which take into consideration a move toward revised funding model terminology?

The APA makes the following recommendations related to terminology, excluding the principles themselves:

a) Guidelines that inform the implementation of allied health input

i. At present there is no clear mechanism to support and inform RAC providers about when a resident should have access to allied health supports. This means that this is left to the market and the response for the resident is varied with some experience issues related to access to services.

b) Early diagnostic and intervention from residential aged care facilities

i. Limitations in the assessment model mean that assessments that inform care structures may not be implemented. Access to diagnostic and assessment services by an allied health professional should occur.

c) **Incentivisation of wellness and QOL outcomes should be considered in the model**

i. Residential aged care facilities must be supported and incentivised to implement re-enablement programs without the risk of funding penalisation. A model that supports incentivised wellness that works alongside a care needs assessment should be considered. Outcomes will include decreased hospital admission and injurious falls and maintenance of quality of life measures and functional capacity.

d) Increased access to Re-enablement services

i. The APA is unable to collate specific data of the negative impact of RACFs who are not engaging in reablement physiotherapy programs. We are advised by some of our members that they have noted increases in clinical risk and clinical incidents including functional decline, falls and pressure injuries increasing the burden of care. Anecdotally, we are advised that there appears to be a greater reliance on aged care staff to perform out of scope services, for example exercise programs, balance programs and pain management interventions.

e) Improved Data collection

i. As a rule, the impact on resident outcomes is difficult for the industry to capture. Functional decline is particularly difficult to capture via the National Mandatory Quality Indicator Program due to limitations in reporting requirements, and the DEMMI is not sensitive enough to capture changes to burden of care. For example, if a resident declines from requiring the assistance of 1 person, to requiring the assistance of 2 with a standing machine, their score remains the same. Similarly, it is difficult to track resident self-confidence and social engagement in Activities in Daily Living measures.

f. Determination of care needs

i. An-ACC classifies and does not determine need.

g. Minimum spend on allied health services and guaranteed access to services

i. Royal Commission into Aged Care Quality and Safety recommendation 38 related "to ensure residential aged care includes a level of allied health care appropriate to each person's needs" is met.

ii. Variance in the market indicates that there is no consistent framework for the delivery of allied health services leaving residents vulnerable to decreased access.

iii. Essential services, such as physiotherapy, must be mandated in the funding principles to ensure physiotherapists are engaged to deliver critical highly skilled services to promote positive clinical outcomes, and minimise clinical risk.

References

[1] IHACPA, Towards an Aged Care Pricing Framework Consultation Report, May 2023 ('Consultation Report'), 34-36.

[2] Royal Commission into Aged Care Quality and Safety Final Report: *Care, Dignity and Respect*, Recommendation 38, pg 235

[3] Department of Health and Aged Care, About the Australian National Aged Care Classification funding model, https://www.health.gov.au/our-work/AN-ACC/about#:~:text=Reporting-,What%20is%20AN%2DACC,needs%20for%20care%20funding%20purposes.

[4] A. Barker, J. Nitz, Nancy L. L Choy, T Haines, Mobility has a non-linear association with falls risk among people in residential aged care: an observational study, Journal of Physiotherapy, Volume 58, Issue 2, 2012, Pages 117-125, ISSN 1836-9553, https://doi.org/10.1016/S1836-9553(12)70092-9.

[5] Hewitt J. Progressive Resistance and Balance Training for Falls Prevention in Long-Term Residential Aged Care: A Cluster Randomized Trial of the Sunbeam Program. Journal of the American Medical Directors Association, 2018

[6] Wabe N, Seaman KL, Nguyen AD, Siette J, Raban MZ, Hibbert P, Close JCT, Lord SR, Westbrook JI. Epidemiology of falls in 25 Australian residential aged care facilities: a retrospective longitudinal cohort study using routinely collected data. Int J Qual Health Care. 2022 Jul 9;34(3):mzac050. doi: 10.1093/intqhc/mzac050. PMID: 35588391.