Occupational Therapy AUSTRALIA

Independent Health and Aged Care Pricing Authority (IHACPA)

Consultation on the Pricing Approach for the Support at Home Service List 2025-26

Occupational Therapy Australia Submission

October 2024

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Introduction

Occupational Therapy and Aged Care

Occupational Therapy Australia (OTA) is the professional association and peak representative body for occupational therapists in Australia. There are more than 29,000 registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to engage in meaningful and productive activities.

Occupational therapy services are fundamental to aged care as they enable independence, prevent functional decline, increase quality of life, and reduce care needs. Occupational therapy is key to enabling older Australians to remain at home longer and facilitate a full and meaningful ageing experience in residential care settings.

Occupational therapists work with older people with age-related conditions such as poor balance and coordination, memory loss and confusion, and vision and hearing loss, which lead to changes in their ability to participate in the meaningful activities of everyday life.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, chronic disease management, assessments for assistive technology and the assessment of environment and safety risks.

Occupational therapists are a component of an effective home-based aged care service system. They provide service in the Commonwealth Home Care Program (CHSP), Short Term Restorative Care (STRC) program, and in Home Care Packages program. They will continue to be an integral part of Support at Home (SaH) as it rolls out in 2025, and as CHSP and STRC is incorporated into the new system from 2027/28.

OTA response to the IHACPA Consultation

Summary

OTA welcomes the engagement of IHACPA to provide independent advice to the Government on setting prices for SaH.

We also welcome the stated intention from IHACPA to include in its collection of cost and data activity a sample of in-home care providers who deliver HCPs and STRC services, and that the Support at Home Cost Collection 2024 study aims to expand existing data sets.

Notwithstanding this intention, OTA holds concerns about IHACPA's approach for setting SaH pricing, and its potential outcomes for the delivery of person-centred, needs-based care and support for older Australians. OTA has identified several issues related to the setting of prices for allied health, which we urge IHACPA to consider and advise Government on.

In addition to the discussion below which outlines our concerns related to the development of pricing for OT services in home-based care, OTA has also responded in brief to some of the questions posed in the IHACPA consultation paper. The consultation survey with OTA's responses to the required questions is attached (see Attachment 1).

OTA Recommendations

OTA recommends that:

The IHACPA pricing aligns with the Deloitte cost model projections, which reflect the true cost of service provision, with annual indexation applied on top of this.

IHACPA use the delay of the inclusion of CHSP into Support at Home to conduct a comprehensive data collection and activity costing process.

The fees available for providing independent clinical assessments and reporting reflects the reasonable time for their completion, and the expertise required to perform them.

Annual indexation is applied to reflect rising costs when relevant, including Consumer Price index and wage price index, costs of regulatory requirements and the costs of workforce enablement including CPD and supervision, and costs associated with hosting student placements, such as charges for delegated scope services by a student to enable upskilling of students.

Travel fees are, at a minimum, in line with the NDIS Price Guide, which lists travel fees at the same rate as other services, but without caps to ensure rural and other areas are not disadvantaged.

The fees should recognise and reflect OT expertise in facilitating and contributing to allied health multidisciplinary care, as with other government funding schemes such as the MBS, which has specific case conferencing line items.

Telehealth services be included.

Sole trader overheads be considered in IHACPA's cost modelling and that provisions are made to ensure providers pass on the full unit hourly price to contracted clinicians.

A regional and remote loading be applied for OT services, as with NDIS funding.

OTA also urges IHACPA to consider the following in developing their pricing advice to government, that:

- adding price caps that don't reflect the true cost of service provision will only further exacerbate existing workforce shortages, including difficulties in attracting allied health professionals to the sector.
- OTs are well-recognised experts in assessing clients' needs and estimating the supports they will require.
- support assistive technology and home modifications should be funded based on need and not only on 'maintaining independence'.

OTA Concerns about the Approach to Support at Home Pricing for Allied Health

Cost Data Collections

OTA raises concerns about the setting of prices across government funded schemes, particularly for allied health. The current approach for residential aged care is premised on the assumption that the amounts and types of allied health care currently provided is sufficient to meet the needs of residents. Allied health care is currently underprovided and underfunded, with the latest figure being just over half the amount that the Royal Commission into Aged Care Quality and Safety ('Royal Commission') at the time found to be grossly inadequate.

OTA welcomes the stated intention of IHACPA to include in its collection of cost and data activity a sample of in-home care providers who deliver Home Care Package (HCP) and Short-Term Restorative Care (STRC) services, and that the SAHCC 2024 aims to expand existing data sets. We note that the Support at Home Costing Study 2023 Final Report recommended that

> *When the Support at Home program takes shape and the service list is finalised, IHACPA should develop a transparent cost allocation method and costing standards for the Support at Home program to improve the quality of data collection.* (Recommendation 13)

Nonetheless, OTA remains concerned about the potential process and outcomes of price setting for the SaH program, and the impact on delivery of high-quality needs-based services for older Australians.

Aged Care Financial Reports

OTA is concerned about the use of the Aged Care Financial Report and the Quarterly Financial Report for collecting the cost and data activity for allied health. The reported hours for allied health are very low and should not be taken as an indication that these amounts are appropriate or adequately address the needs of aged care recipients.

The Department's October to December 2023 Quarterly Financial Snapshot of the aged care sector[1] revealed that allied health staff are spending an average of just 4.11 minutes per resident per day and reflects a continuing decline each quarter. This figure is notably lower than the 8 minutes per resident per day criticised by the Royal Commission in 2021. The persistent decrease in allied health minutes raises concerns about the adequacy of care provided in aged care settings and the impacts on the health and well-being of older people requiring allied health services. Until the April-June 2024 Quarterly Financial Report there has been a continuing trend of more than half of QFR respondents not reporting any minutes of expenditure for the categories of occupational therapists, allied health assistants and other allied health categories specified in the QFR with the numbers for these categories being, at best, too small to be meaningful.

The Australian Institute of Health and Welfare (AIHW) 2023 Aged Care Provider Workforce Survey shows that between 2020 and 2023 the number of allied health professionals and assistants working in aged care homes decreased by 42 per cent.[2] It is clear from both the overall recorded decline and individual AIHW Workforce Survey data tables that allied health is significantly under provided.

Other Government Programs and Schemes

Fees for occupational therapy services across a range of funding schemes and sectors are currently inadequate to meet the cost of delivering services. Many OTA members tell us that current pricing in these sectors is impacting on their ability to provide high quality services. Surveys of OTA members indicate that occupational therapists have left the aged care sector or are considering leaving due to the cost impacts on their services. This puts at risk the loss of professional expertise and quality service provision.

While other Government schemes and programs may to some extent provide a basis for determining cost, fees for OT services across government funded programs vary significantly and all are flawed in the approach taken to set fees. The IHACPA consultation paper suggests that NDIS and DVA could provide such a basis, but OTA draws attention to issues with pricing in both schemes.

NDIS

NDIS hasn't had a price increase for allied health professions in 5 years. OTs are working from a place of deficit and OTA argues that the NDIS should not be the benchmark to work against but the starting point to build from.

We draw IHACPA's attention to the work undertaken by Ability Roundtable for NDIS pricing analysis and its data collection which was applied to the Deloitte Cost Model.[3] The table below shows the significant gap between the NDIS price limit and the full cost to deliver an hour of therapy supports for

[1] https://www.health.gov.au/sites/default/files/2024-06/quarterly-financial-snapshot-of-the-aged-care-sector-quarter-2-2023-24-october-to-december-2023.pdf

[2] Australian Institute of Health and Welfare (2024) *2023 Aged Care Provider Workforce Survey: Summary Report*, Australian Government.

[3] Deloitte Access Economics for Ability First Australia, Development of an allied health Cost Model for NDIS-funded services (2021).

the 2022 calendar year and the projected gap for the 2023-24 financial year, for the four major allied health disciplines, including occupational therapy.

Table 1 –Therapy Supports Price Limits– NDIA Cost Model vs Deloitte Cost Model – four major allied health disciplines

	Current NDIA Price Limit	Deloitte Cost Model projections	Difference
2022 Calendar Year	$193.99	$207.81	-7.1%
2023-24 Financial Year	$193.99	$210.30	-8.4%

DVA

DVA made a marginal increase to OT rates in 2021 - after years of no inflation to reflect CPI or cost of living increases. However, even with this increase, the fee was still well below the true service cost and again is not a suitable figure to benchmark against. Many DVA OTs are not operating in profit, and doing their best to keep the necessary consumer contribution as low as possible. The Royal Commission into Defence and Veteran Suicide highlighted the impacts on veterans of delays in care and provider shortages. Recommendation 71 of the Commission's final report called for DVA fees to be raised, to at least match NDIS rates.

Recommendation: OTA recommends that the IHACPA pricing aligns with the Deloitte cost model projections, which reflect the true cost of service provision, with annual indexation applied on top of this. OTA recommends IHACPA use the delay of the inclusion of CHSP into Support at Home to conduct a comprehensive data collection and activity costing process. OTA also urges IHACPA to consider that adding price caps that don't reflect the true cost of service provision will only further exacerbate existing workforce shortages including difficulties in attracting allied health professionals to the sector.

Key considerations that must be included in fees for OT services

Clinical assessments and reports – Home based assessments is an essential component of the services provided by OTs, to ensure that environmental assessment is appropriate and can address risks such as for falls. Clinical assessments and reports must be conducted by qualified and experienced allied health professionals, with reasonable time allocated to ensure the person's needs, and required supports and assistive technology or home modifications, are identified.

All allied health professionals are degree qualified professionals, and unless they hold specialist accredited qualifications recognised by AHPRA, they should be paid a comparable price.

Recommendation: OTA recommends that the fees available for providing independent clinical assessments and reporting reflects the reasonable time for their completion, and the expertise required to perform them.

Annual indexation - Indexation should be applied to reflect rising costs when relevant, including Consumer Price index and wage price index. It should also recognise the costs of regulatory requirements eg aged care regulations, and AHPRA registration, the costs of workforce enablement including CPD and supervision, and costs associated with hosting student placements, such as charges for delegated scope services by a student to enable upskilling of students.

Recommendation: OTA recommends that annual indexation is applied to reflect rising costs when relevant, including Consumer Price index and wage price index, costs of regulatory requirements and the costs of workforce enablement including CPD and supervision and costs associated with hosting student placements, such as charges for delegated scope services by a student to enable upskilling of students.

Travel time and fees - Occupational therapists deliver community-based services, which requires travelling to the homes of their clients as well as other community-based settings such as clinics. This

characteristic sets them apart from most other health providers. Failure to include adequate travel time and rate creates a risk that clients living in rural/remote areas may be disadvantaged, as it reduces the incentive for occupational therapists to travel long distances.

A regional and remote loading should also be applied to enable services to be delivered to these areas, as it is with NDIS:

> "The NDIS Price Guide allows higher price limits for some supports in remote and very remote areas as a response to higher operational costs to deliver services in these areas. From 1 July 2019 these loadings increased from 20% to 40% for remote participants and from 25% to 50% for very remote participants."[4]

Recommendation: OTA recommends that travel fees are, at a minimum, in line with the NDIS Price Guide, which lists travel fees at the same rate as other services, but without caps to ensure rural and other areas are not disadvantaged.

In addition, OTA recommends that a remote loading be applied for OT services, as per NDIS funding for remote services in WA and SA.

Collaboration and communication with other treating practitioners - Occupational therapists operate as part of a multidisciplinary team and this involves the ability to initiate and coordinate multi-disciplinary input, as well as collaborate and case conference on shared care clients.

Recommendation: OTA recommends that fees should recognise and reflect OT expertise in facilitating and contributing to allied health multidisciplinary care, as per other government funding schemes such as the MBS, which has specific case conferencing line items.

Telehealth items - Occupational therapists can deliver some of their services via telehealth with the appropriate supports in place. While in-person is the preferred and most effective option, telehealth could be considered as a method by which OTs are able to be funded to deliver services.

Recommendation: OTA recommends that telehealth services be included.

Related Issues

OTA supports AHPA's recent submission to the IHACPA Pricing Framework 2025-26 for residential care[5]. While OTA acknowledges that many of the contributing factors to the current context are outside IHACPA's ambit and mandate, OTA believes it is important to highlight improvements that need to be made in order for IHACPA to fulfill its function.

OTA would like to highlight the below issues for IHACPA to be aware of while it is developing its price setting advice to Government.

Setting Budgets and Pricing Caps

OTA notes the intention that the total cost of ongoing services delivered to a participant must be within the participant's budget, determined at assessment, as identified in Point 3 under the features of the SaH funding model.

However, OTA considers that the cost for the delivery of comprehensive clinical occupational therapy services can only be determined once a comprehensive clinical OT assessment has been conducted. OTA is concerned that by setting a fixed allocation of funding, and/or hours, prior to the comprehensive clinical assessment, thereby requiring the participant to reapply for additional hours of care, there is a risk of not delivering a needs-based service for aged care recipients, as was highlighted as a requirement of the new aged care system by the Royal Commission.

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[4] https://www.ndis.gov.au/about-us/strategies/rural-and-remote-strategy

[5] AHPA, Submission to Independent Health and Aged Care Pricing Authority on Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2025–26, September 2024.

OTs are clinical professionals who have experience in assessing clients' needs and estimating the supports they will require and should be involved in the assessment process.

Assistive Technology and Home Modifications

OTA notes that the Department of Health and Aged Care will be responsible for elements of the SaH program that are outside the scope of IHACPA's remit, and that features of the proposed SAH funding model include participants receiving funding for supports to maintain independence, such as assistive technology and home modifications or short-term restorative care.

The consultation paper notes that prescription of items by allied health professionals will be aligned to the allied health pricing on the service list.

OTA is concerned that with the separate funding of equipment and home modifications, funding for the assessment of the item or home modification and the related prescription, trialling, training and handover will not be adequately factored in. This process is essential to mitigate the serious risk of injury if there is not adequate time to ensure the older person is able to use the equipment correctly and confidently.

OTA's preference would be that the assessment and trialling activities be identified under clinical care, and funding for the assessment, prescription and handover and training for these items be separate to the funds available under the proposed AT HM scheme.

Under Point 4 of the list of features of the proposed SaH funding model, identifies that participants will receive funding for supports to maintain independence, such as assistive technology and home modifications or short-term restorative care. OTA is concerned that this excludes services and supports, including assistive technology and home modifications, that is necessary for a person with a degenerative condition.

OTA preference is for assistive technology and home modifications to be funded based on need and not on 'maintenance of independence' alone.

Hidden costs for contracted allied health services

In relation to the cost of resources to deliver aged care services it is important to note some allied health professionals operate as sole traders and can bear significant costs that may not be factored into pricing considerations. These costs include vehicle, collections of assistive technology equipment to trial with older people, and insurances that are relevant to provision of outreach services.

OTA is also concerned by reports from our members about unintended consequences of the reforms being implemented. Members are reporting that with the introduction of the new Quality Standards, contracted allied health professionals are being required to report on their services against the quality standards, without payment. We are also concerned by reports that providers are taking a component of contracted OT rates to cover 'administrative charges' associated with producing the service. This practice has the potential to significantly impact the financial sustainability of sole trading OT's and may disincentivise them from working across the sector.

Recommendation: That sole trader overheads be considered in IHACPA's cost modelling and that provisions are made to ensure providers pass on the full unit hourly price to contracted clinicians.

IHACPA Consultation Paper Questions

OTA's key concerns and recommendations related to the development of pricing for OT services in the Support at Home program are discussed in the previous section. In this section OTA responds in brief to other relevant questions posed in the IHACPA consultation paper.

3. What, if any, changes do you suggest to the proposed pricing principles to guide the development and operation of the Pricing Framework for Australian Support at Home Aged Care Services 2025-2026?

Generally, OTA supports the pricing principles outlined in the consultation paper.

However, we provide the following comments

- *Access to Services - The price does not create a barrier to access for those assessed as needing in-home aged care services.*

OTA requests IHACPA take into consideration that adding price caps inconsistent with comparable sectors will only exacerbate workforce challenges and access to OT services.

4. Are there any additional pricing principles for in-home aged care services that should be added? If so, please advise what they are.

- *Efficiency - Prices should ensure the sustainability of aged care services over time and optimise the value of the public investment in aged care.*

OTA welcomes this principle, but we don't think it adequately addresses the need for regular review of the pricing. Pricing should not only be reviewed every 2 years.

6. Do you support IHACPA's proposal to establish unit pricing using a cost-based approach that reflects the available data? Please provide a rationale.

OTA supports a cost based approach provided it reflects the true cost of service provision, taken from open market data.

See previous sections for discussion and recommendations on this matter.

14. For future years, what do you see as the priority areas for IHACPA to consider when developing advice on adjustments to the service list unit prices? Please provide supporting evidence, where available.

In relation to the priorities for future consideration outlined on p.20 of the consultation paper, OTA, raises the following concerns.

Pt 1 - Pricing implications related to the transition of the Commonwealth Home Support Programme into the Support at Home program no earlier than July 2027
The current fee under CHSP is too low at around $120 per hr.
This funding is issued in a lump sum to approved providers. Those providers are usually businesses that are operating with multiple funding sources and as such have buffers in place for covering overheads associated with delivering these services.
The current fee does not reflect the cost of those delivering services as a sole trader/independent business operator.

15. Providers are required to provide safe and high-quality care. What safety and quality of care issues should be considered as part of IHACPA's pricing advice?

OTs deliver safe and quality care as they meet regulatory requirements including AHPRA and aged care requirements.

Conclusion

OTA thanks IHACPA for the opportunity to comment on the Consultation on the Pricing Approach for the Support at Home Service List 2025-26. OTA would be happy to meet with IHACPA to expand on any of the matters raised in this submission.

Contact : For further information or to discuss the contents of this submission, please contact OTA via policy@otaus.com.au.

Attachment 1- Additional Survey Questions

1. Full name (Required)

Debra Parnell

2. Email address (Required)

Debra.parnell@otaus.com.au

3. Phone number

0419552717

4. Organisation name

Occupational Therapy Australia

5. What statement best describes your involvement with in-home aged care? (tick multiple if applicable)

☐ I am receiving in-home aged care services

☐ I am a carer, representative, or family member of someone receiving in-home aged care services

☒ I am from a peak body or similar organisation

☐ I am an in-home aged care provider

☐ I work for an in-home aged care provider

☐ I am a health professional/clinician

☐ I work for a Commonwealth, state or territory government department or agency

☐ I work for a Primary Health Network

☐ I work for a Local Health Network or public hospital

☐ I work for a research institute, university, policy institute or consulting group

☐ I work for an information technology provider

☐ I am a member of the general public
☐ Other (please provide details):

6. If you work for/are an in-home aged care provider, what type of organisation do you represent?

☐ Government-owned

☐ Private

☐ Not-for-profit

☒ N/A

7. For those who work for an in-home aged care provider or are answering on behalf of a provider, which best describes your role in the organisation?

☐ Owner

☐ Manager

☐ Aged care worker (non-clinical)

☐ Personal care worker

☐ Nurse

☐ Allied health professional

☐ Other (please provide details)

8. If you work for/are an in-home aged care provider, what states and/or territories does your organisation provide in-home aged care services in? (tick all that apply)

☐ New South Wales

☐ Victoria

☐ Queensland

☐ South Australia

☐ Western Australia

☐ Tasmania

☐ Northern Territory

☐ Australian Capital Territory

☒ N/A

9. If you work for/are an in-home aged care provider, which of the following areas does your organisation provide in-home aged care services in? (tick all that apply)

☐ Metropolitan

☐ Regional

☐ Rural

☐ Remote

☒ N/A

10. If you work for/are an in-home aged care provider, which of the following in-home aged care service/s does your organisation provide? (tick all that apply)

☐ Home Care Package Program (HCP)

☐ Short-Term Restorative Care Programme (STRC)

☐ Commonwealth Home Support Programme (CHSP)

☐ National Disability Insurance Scheme

☐ Residential Aged Care

11. If you work for/are an in-home aged care provider, please tick the services delivered by your organisation (or arranged for delivery through your organisation via a sub-contractor) [tick all that apply].

☐ Nursing (Registered, enrolled, or nursing assistant)

☐ Care management (Clinical, non-clinical)

☐ Personal care (Assistance with selfcare, activities of daily living, medications, skin integrity, continence management

☐ Domestic assistance (General house cleaning, assistance with household activities, laundry services, shopping delivery)

☐ Home maintenance (Light gardening, maintenance of outdoor areas, minor house repairs)

☐ Meal preparation (Assistance with food preparation, where the older person is unable to prepare meals independently)

☐ Social support and community engagement (Group activities, individual support, cultural support, accompanied activities, digital education and support, maintain personal affairs)

☐ Respite (Flexible respite, community and centre-based, cottage respite)

☐ Aboriginal and Torres Strait Islander health practitioner

☐ Aboriginal and Torres Strait Islander health worker

☐ Meal delivery (includes meals provided to a person's home or a community venue, accessing information on person's specific dietary needs)

☐ Transport (includes meals provided to a person's home or a community venue, accessing information on person's specific dietary needs)

☐ Allied health – please specify below.

☐ Occupational therapist

☐ Physiotherapist

☐ Podiatrist

☐ Dietician or nutritionist

☐ Exercise physiologist

☐ Speech pathologist

☐ Psychologist

☐ Counsellor or psychotherapist

☐ Social worker

☐ Allied health assistant

☐ Other (please provide details):

12. Have you heard of the Independent Health and Aged Care Pricing Authority (IHACPA) prior to this public consultation?

☒ Yes

☐ No

13. A Do you identify as a member of any of the following groups? (tick multiple if applicable)

☐ Aboriginal and Torres Strait Islander peoples

☐ Culturally and linguistically diverse communities

☐ People living with dementia

☐ People experiencing or at risk of homelessness

☐ LGBTQIA+ identifying people

☐ Veterans

☐ Older people with a disability

☐ Other (please provide details)

14. Do you or your organisation represent any of the following groups? (tick multiple if applicable)

☐ Aboriginal and Torres Strait Islander peoples

☐ Culturally and linguistically diverse communities

☐ People living with dementia

☐ People experiencing or at risk of homelessness

☐ LGBTQIA+ identifying people

☐ Veterans

☐ Older people with a disability

☐ Other (please provide details)

15. Does your organisation provide specialist care to any of the following groups? (tick multiple if applicable)

☐ Aboriginal and Torres Strait Islander peoples

☐ Culturally and linguistically diverse communities

☐ People living with dementia

☐ People experiencing or at risk of homelessness

☐ LGBTQIA+ identifying people

☐ Veterans

☐ Older people with a disability

☐ Other (please provide details)

16. If you are a provider of in-home aged care services, how many older people does your organisation provide care to?

☐1-50

☐ 51-100

☐ 101-200

☐ 201-500

☐ 501-1000

☐ 1001+

17. How many people does your organisation employ on a regular basis? (including casual staff and business owner)

☐ 1 (I am self-employed/sole trader)

☐ 2-4

☐ 5-19

☐ 20-100

☐ 101 or more

18. What are you most interested in hearing about from IHACPA?

19. How did you hear about this public consultation?

☐ Social media (for example X, LinkedIn)

☒ Department of Health and Aged Care newsletter

☒ IHACPA email

☐ Peak body or similar organisation

☐ Commonwealth, state or territory government department or agency

☐ From an aged care provider

☐ Online advertisement in aged care networks/newsletters

☐ Other (please provide details)

20. Would you like to sign up to IHACPA's mailing list to receive updates on our Support at Home / in-home aged care work?

☐ Yes

☐ No

Final questions

1. Please indicate if there are specific sections of your submission that you wish to remain confidential and the reasons for this.

19. I consent to IHACPA publishing my submission. (Required)

☒ Yes, I consent
☐ No, I do not consent

20. I consent to IHACPA contacting me for further information or clarification about my submission.

☒ Yes, I consent
☐ No, I do not consent

21. What is your preferred method of contact?

☒ Email
☐ Phone