Allied Health Professions Australia

Submission to Department of Health and Ageing on Consultation Paper No. 1 – A New Model for Regulating Aged Care

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This submission has been developed in consultation with AHPA's allied health association members.

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Introduction

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.

Safety and quality are not balanced

Although AHPA broadly agrees with the Consultation Paper's identification of the current challenges in the current aged care framework (p9), we are concerned that despite its stated focus (p15), the Paper tends to emphasise safety more than quality.

For example, the first foundation of the model, a rights-based approach, is described as 'ensuring protections are in place to uphold the rights of older Australians' (p11). However, the language of protection is only elaborated upon in relation to safety – ensuring older Australians 'are protected from harm, abuse and neglect when receiving aged care services' (p12).

Quality is outlined in quite different language – 'ensuring that the wants and needs of older Australians are *valued* (emphasis added)', and helping older Australians 'feel confident that providers and the Regulator are overseeing the quality of their care' (p12). See also Foundation 4 (pp16-17) and Objectives of the new regulatory model (p20).

The Paper also uses language to refer to safety that at times veers into protectionism rather than protection. For example, Foundation 3 of the model, a risk-based approach, will 'establish appropriate regulatory safeguards and tools that proactively prevent the occurrence of risk' (p14). Preventing the occurrence of risk is impossible, inconsistent with all recognised approaches to risk management, and incompatible with respect for older people's choices and empowerment.

If not corrected in future approaches, the overall imbalance risks prioritising protection over dignity of risk and reablement (or maintenance of existing capacity where reablement is not possible).

Giving equal weight to considerations of how to maximise safety and quality in policy development and law reform is particularly important to allied health practitioners, due to the

strong connections made by the Royal Commission into Aged Care Quality and Safety ('Royal Commission') between allied health and reablement.

Regulatory stewardship

AHPA is yet to be convinced about the value of a regulatory stewardship approach, at least as it is described in the Paper (p10).

No understanding of potential conflicts of interest

The approach does not acknowledge that interests of different stakeholders may at times be in conflict, and that there is considerable variation among stakeholders in terms of resources, power and influence. Australia's aged care system would not continue to be in such a parlous state after the Royal Commission's Final Report if all stakeholders already had at least the impetus to 'work together proactively and collaboratively to achieve the desired outcomes.'[1]

To illustrate, as the national peak body for allied health, AHPA has advocated for some years for federal Government to honour the Royal Commission's recommendations that allied health services should be provided in both home and residential aged care to all people who need them. Despite this, unlike the Commonwealth Government response concerning nursing and personal care, there is no minimum of allied health minutes proposed in the aged care reforms, or indeed any kind of allied health benchmark (see Regulatory Safeguard 2 below).

It is clear in this case that Government decision making is shaped by a rationale that is different to that underpinning the stances of the Royal Commission, the architects of the AN-ACC, consumers and allied health providers. In this respect at least some underpinning Government interests are also at odds with Foundation 2 of the proposed new model (p13).

This example epitomises a broader problem in which allied health is sidelined in comparison to the two other pillars of the proposed improved aged care system, nursing and personal care. The new regulatory system must reject the 'nice to have, but not essential' approach to allied health, and instead embed accountability for the provision of allied health services as a critical element of the aged care system.

Over-emphasis on voluntary compliance

Under this kind of proposed stewardship, all aged care providers are assumed to operate with goodwill and the interests of consumers at heart – and hence compliance requirements are located more at the voluntary end rather than the enforcement pole of the spectrum of regulatory mechanisms.

Burden of enforcement on consumers

There is an associated risk that much of the burden of compliance will fall on aged care consumers, many of whom, particularly in residential aged care, are not in a position to effectively advocate for their rights without external assistance. As discussed further below, a human-rights based aged care system should not rely on people receiving aged care, or their families, having to make complaints and to try to ensure market standards by 'choosing' services and residential facilities via (to date, unclear and untested) star ratings.

[1] See eg Older Persons Advocacy Network, The National Aged Care Advocacy Program Presenting Issues – Report 2 January–June 2022.

Regulatory mechanisms

Regulatory Safeguard 1

Consistent with many of the Department's aged care reform consultative mechanisms, the Paper is not clear on whether and how registration and the definition of 'worker' apply to allied health (pp23-24). AHPA notes that allied health professionals are already rigorously regulated, and we strongly endorse the submission of our member Occupational Therapy Australia (OTA) that further allied health registration requirements would be both unnecessary and unproductive.

Regulatory Safeguard 2

Current and, as far as we are aware, proposed, provider responsibilities (pp25-26) do not ensure the quality of allied health care services provided to older people.

As stated above, there is no proposal for an allied health equivalent of nursing and personal care minutes. Further, allied health spending from total Australian National Aged Care Classification (AN-ACC) funding is to be left to the discretion of increasingly financially pressured providers.

Allied health data reporting

Until recently, aged care data on the provision of allied health in home care was not even required to be reported. While there has been some past reporting of equivalent allied health data for residential aged care, it has lacked detail to the extent that for its finding that aged care residents receive an individual average of only eight minutes of allied health care a day, the Royal Commission relied on research undertaken in 2018 by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong.[2] That daily average has decreased since, to at last count, 5.3 minutes.[3]

Discipline-specific data on the types and frequency of treatment by different allied health professions provided to residents is even more difficult to obtain.[4]

The recent Government commitment to including allied health costs and time by individual allied health profession in the Quarterly Financial Report for residential aged care is therefore welcome.[5] However, providers will only be required to distinguish the cost and time spent delivering physiotherapy, occupational therapy, speech pathology, podiatry and dietetic care, together with the use of allied health assistants (undifferentiated). The rest of allied health will be aggregated into 'other'. Allied health in home care will also be reported for the first time soon, but as an undifferentiated category.[6]

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[2] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 25. That research was part of the Resource Utilisation and Classification Study (RUCS) which underpins the AN-ACC model (Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019).

[3] Sutton, N, Ma, N, Yang, JS, Lewis, R, McAllister G, Brown, D, & M Woods, *Australia's Aged Care Sector: Mid-Year Report (2021–22)*, The University of Technology Sydney, 2022. For more detailed analysis, see https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ .

[4] The exception for residential aged care is the 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 .

[5] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers ; https://health.formsadministration.com.au/dss.nsf/DSSForms.xsp .

[6] Department of Health, Quarterly Financial Report (QFR) Webinar, 18 August 2022. Not available on website.

Lack of benchmarks

However, when the lack of benchmarks is considered, the purpose of even this level of reporting is unclear. The Department has simply stated:

> 'This information is important because it will allow the Department to understand how allied health is delivered in residential aged care facilities. The reporting of allied health care minutes will help the Department to monitor the overall cost of care to aged care facilities.'[7]

The Department has also stated that the Aged Care Quality and Safety Commission ('the Commission') will identify any instances of insufficient allied health provision.[8] This raises questions about how potential quality concerns will be identified and assessed by the Commission.

Identification and assessment of allied health quality issues

Other than via audits, complaints or incident reporting, we are uncertain how the Commission will be able to effectively monitor the quality of allied health services provided. Complaints or incident reporting are reactive mechanisms which rely on consumers, families and whistleblowers. One of the largest barriers to reporting is the lack of consistent clinical assessment of allied health needs in both residential and home care. Consequently, consumers may not even be aware of particular allied health services that would benefit them.

AHPA therefore strongly endorses the recommendation of our member Speech Pathology Australia for provider responsibilities to include providing a multidisciplinary 'Health and Wellbeing Assessment' which would be conducted in partnership with relevant allied health professionals.

Given the lack of benchmarks or any clear standard, even audits seem likely to identify only the most egregious examples. Regulatory oversight of the provision of allied health services relies on interpretation of the *Quality of Care Principles 2014*, and in particular assessing whether the provision of residential care and services in Schedule 1, and of home care and services in Schedule 3, comply with the Quality Standards in Schedule 2.

Assessment of allied health provision in residential care will now also be shaped by the recent AN-ACC-associated reform to Schedule 1, to the effect that now no additional fees are payable by any care recipient for the provision of any of the care and services in any Part of that Schedule.

It is also therefore unclear how the Paper's proposal for graded assessments (p26) will align with requirements under the Quality of Care Principles, particularly to allied health service provision under Schedule 1.

AHPA seeks further engagement with the Department concerning the impact of these changes and how they will relate to issues of compliance and enforcement.

Regulatory Safeguard 3

The Paper describes enforcement as:

> 'applying regulatory powers or actions in a proportionate and effective way in response to breaches or non-compliance with the aged care legislation and provider responsibilities.

[7] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers .
[8] (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 enforcement actions are intended to oblige the provider to address quality and safety risks and comply with its responsibilities as quickly as possible. These actions also help to deter the provider from future non-compliance.' (p28)

As previously outlined, where allied health services are at issue, there are no clear yardsticks in either provider responsibilities or legislation for measurement of breaches or non-compliance. The only accountability mechanism is via the Quality Principles, as we discuss above in relation to Regulatory Safeguard 2.

Regulatory Safeguard 4

Regulatory intelligence (p31) will not meaningfully include allied health providers and practitioners without first addressing the almost complete failure to date to integrate allied health into aged care data and digital systems, and the lack of any national allied health workforce strategy, let alone one specific to aged care.

AHPA supports OTA's submission concerning information sharing.

We look forward to responding to more detailed consultations on all of the regulatory aspects relevant to allied health professionals working in aged care.