Allied Health Professions Australia

What is needed for quality allied health in Australian aged care?

As the Royal Commission into Aged Care Quality and Safety concluded, allied health is a fundamental element of the aged care system, and is essential for 'reablement'.

Reablement is about rehabilitation and restoring (e.g. after a fall), or at least preserving as much as possible, older people's capacities. The Commissioners said that reablement is critical to older people's wellbeing and should be a central focus of aged care.[1]

The Royal Commission therefore recommended that provision of consistently safe and high quality aged care include delivery of allied health services appropriate to each person's needs.[2]

To achieve this standard of care, the aged care system must address the seven themes and related outcomes below.

1. Mandatory benchmark and associated funding for allied health

Outcomes needed

- A mandatory benchmark for allied health service provision (e.g. average minutes per resident per day), similar to the current approach to personal and nursing care. Subject to monitoring and evaluation, a preliminary benchmark could be 22 minutes, but include variation according to specific AN-ACC classes, as recommended by the Australian Health Services Research Institute.
- Associated additional core funding for care minutes.

Background

AHPA welcomed the recent care minutes reforms in nursing and personal care, but we are extremely concerned about the lack of mechanisms to similarly ensure sufficient allied health – as the third pillar of aged care – in residential aged care.

Research undertaken for the Royal Commission by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong – the same team which developed the Australian National Aged Care Classification (AN-ACC) – found that in 2019, aged care residents received, on average, only 8 minutes per person per day of allied health care.[3]

To meet the allied health needs of residents, the AHSRI recommended an average of 22 minutes' allied health care, and that funding for allied health service provision be built in to the AN-ACC model.[4]

This recommendation has not been implemented, and Australian allied health care still has no minimum required minutes. Identification of allied health needs and related necessary spending is instead left to the discretion of increasingly financially pressured providers, without any designated funding allocation.

The most recent figures are even more concerning than the Royal Commission's 8 minutes. Total allied health per resident per day now ranges, depending on the source, from 2.85 to 6.36 – at best, around a quarter of the 22 minutes recommended.[5]

A recent scoping study commissioned by the Department of Health and Aged Care concludes that the level and breadth of allied health involvement in Australian residential aged care homes is 'limited'.[6]

A survey undertaken by AHPA's Aged Care Working Group, of allied health professionals working in residential aged care, shows there are already serious impacts on both the workforce and residents. These trends include more than one in 8 allied health professionals losing their jobs, and another 30% planning to leave the sector, with professionals reporting particular distress about negative impacts on the quality of care they are able to provide.[7]

As the AN-ACC funding model did not commence until 1 October 2022, data reported by providers does not yet reflect its impact. However, without an allied health benchmark and targeted funding, the AN-ACC will not be sufficient to address the gross under-provision of care identified by the Royal Commission.[8]

2. National care assessment and planning tool

Outcomes needed

- Urgent development and implementation of a nationally consistent, evidence-based, care assessment and planning tool for both residential and in-home care.

Background

The AN-ACC team 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, for both residential and in-home care.[9]

This has not happened. In residential 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.

Currently, in home care, 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.

Although some work is being done to strengthen the Aged Care Quality Standards, it does not specifically address the need for the tool (see #4). In the foreseeable future then, many aged consumers will not receive the allied services best placed to meet their needs.

3. Multidisciplinary care

Outcomes needed

- Allied health services are an integral aspect of the trial models.
- AHPA and individual discipline peaks are part of collaborative design, implementation and evaluation of the trials.

Background

Many older peoples' needs, especially if complex, are best assessed and addressed via multidisciplinary teams which include various allied health professionals working alongside nurses, GPs and specialists.[10]

As an example of a multidisciplinary aged care model, AHPA originally proposed the Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project.[11] The EMBRACE project would include identification of pathways to the full range of allied service delivery, student placements, and outcome evaluation.

Our longer term vision is for multidisciplinary outreach care to be available for aged care residents, tailored to location so that appropriate services are available wherever older people live.

AHPA has since become aware that work has begun on a joint Commonwealth–States/Territories project, 'Multidisciplinary Outreach Service trials in Residential Aged Care Facilities'. The trials, with a concurrent evaluation, are intended to reduce emergency department attendances and potentially preventable hospitalisations.

AHPA had an initial meeting with the Department of Health and Aged Care in December 2022 concerning the models. We are now seeking further engagement.

4. Regulation of allied health quality and safety

Outcomes needed

- Systemic monitoring of allied health service provision via strengthening the Aged Care Quality and Safety Commission, including through own motion powers similar to those of the NDIS Quality and Safeguarding Commission.
- Quarterly Financial Reporting requirements for allied health service provision by residential aged care facilities include reporting against a recommended best practice minimum ratio of allied health professionals to allied health assistants.
- The Commonwealth works with States and Territories to develop a National Allied Health Assistant Delegation and Supervision Framework that applies across the care and support, and public and private sectors.
- A strong, independent, and well-resourced Inspector-General of Aged Care, with a focus on increasing the accountability of all aspects of Australia's aged care system, legislatively embedded in a consultative structure that requires input from the aged care sector on systemic concerns. One possible mechanism is a stakeholder consultative committee similar to those currently operating for the NDIS Quality and Safeguards Commission.
- An independent unit within the Office of Inspector-General for monitoring implementation and responses to allied health-related Royal Commission recommendations, including those concerning the workforce, funding, and the role of allied health in reablement. The unit is mandated to report on implementation of Royal Commission recommendations at least every 6 months.

Background

As outlined in #1, despite the previous Government's acceptance of Royal Commission Recommendation 36 and in-principle acceptance of Recommendation 38, there is still no accountable standard for allied health service provision.

Equally concerning is what seems to be a trend for aged care providers to substitute 'cheaper' workers from outside allied health, such as lifestyle coordinators, to provide services that considerations of quality and safety require to be delivered by an allied health professional.

Similarly, allied health assistants (AHAs) are sometimes 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, or are simply not suited to the task, which 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.

Currently the Aged Care Quality and Safety Commission (ACQSC) is the only statutory entity tasked with identifying any insufficient or inappropriate aged care provision. But the ACQSC's yardstick is mainly the Aged Care Quality Standards, and even if recently proposed reforms to them are implemented, they will not ensure consistency with the Royal Commission's allied health recommendations.[12] Possible future development of an allied health-related Quality Indicator will also not provide the accountability urgently needed.[13]

In addition, the ACQSC has not yet addressed systemic allied health issues, despite provision of needs-based allied health clearly being a quality and safety issue.[14]

AHPA therefore welcomes the federal Government's proposal to establish an office of Inspector-General of Aged Care.[15] Together with a stronger ACQSC to ensure sufficient allied health provision, the Inspector-General should play a key oversight role in ensuring systemic transparency and accountability of the aged care system, including for allied health.

It is particularly important that the Inspector-General review Commonwealth implementation of responses to the Royal Commission's recommendations, because this process has been especially lacking for most of the allied health-related recommendations. The Review should include examining how Commonwealth measures and actions taken correspond to the recommendations, and an analysis of their effectiveness (Royal Commission Recommendation 148).

5. Allied health data

Outcomes needed

- Allied health services are included in the National Aged Care Data Asset.
- Comprehensive allied health aged care data collection and public reporting, including of allied health service provision delineated by specific professions and AN-ACC class per resident per day.
- Full integration of allied health services into National Minimum Datasets linking health and aged care, to enable identification of whether a person has received aged care services, and the type of those services.

Background

An effective aged care system must be able to ascertain whether people are receiving allied health services according to assessment of their clinical needs, and if care is being appropriately delivered and coordinated. Consumers can use the data to inform their choices about aged care services or facilities, and future improvements can then be based on evidence.

Some data on allied health costs and time spent is now included in the new Quarterly Financial Report for residential aged care (QFR).[16] However, although the next iteration of the QFR will reflect the AN-ACC changes, allied health care provided will not be publicly reported against each of the 13 AN-ACC classes. It will therefore not be possible to know whether, for example, older people with high needs received more allied health services on average than higher functioning residents.

While the QFR means that at least some allied health data by individual profession will now be reported, in-home care data will only include an aggregated allied health figure. It is important that data is collected for each specific type of allied health service across the aged care sector, not only to address older people's particular service needs, but also for workforce planning (see #6).[17]

Currently there is also no way for the public to use the basic allied health data reported to assess whether care is being provided via appropriate allied health needs assessments, care planning, and the involvement of multidisciplinary teams to clinically assess residents and match them with the right types and levels of allied health care (see #3).

6. Workforce planning and support

Outcomes needed

- As a 2-year interim measure, AHPA is funded to work with individual allied health peak bodies to enhance existing workforce data collection.
- The Commonwealth Government invests in the development and implementation of a nationally consistent survey of all allied health professionals.
- The Commonwealth Government funds a national repository for allied health workforce data.
- The aged care sector collaborates with the disability, veterans' care and primary health care sectors to develop a funded National Allied Health Workforce Strategy.

Background

To genuinely enhance the capabilities of the aged care allied health workforce, long-term neglect of the sector must be addressed.

Despite allied health being the second largest health workforce, there is no national allied health workforce strategy and no clear picture of the various settings, sectors and locations in which allied health professionals work.[18] Without these we cannot effectively address areas of particular disadvantage and lack of access, such as where older persons in rural and remote areas cannot obtain particular allied health services.

Workforce planning needs to be supported by a national minimum dataset (see #5) so that we can accurately predict workforce shortfalls and ensure the right flow of new graduates. Allied health students should also have guaranteed placements so that they can fulfil practical training requirements. Students and clinicians must be provided with access to supervision and mentoring, regardless of where they are based.

7. Digital integration

Outcomes needed

- Adequately funded integration between My Health Record and allied health clinical information systems, with practical support from the Australian Digital Health Agency.
- A modernised My Health Record that enables allied health professionals to contribute critical health information via automated reports.
- Implementation of the Australian Digital Health Agency National Healthcare Interoperability Plan, which identifies ways to overcome interoperability barriers for allied health professionals.
- Funded development of education packages to support allied health professionals to rapidly integrate digital reforms into their practices, and incentives for practices to rapidly adopt digital health and new digital technologies.

Background

Interoperable, accessible digital systems are required to enable the efficient and timely sharing of allied health aged care information (Royal Commission Recommendations 68, 109).

Allied health professionals are essential to aged care multi-disciplinary teams (see #3). The client knowledge they share helps other professionals to improve older people's health outcomes.

Yet allied health remains largely disconnected from digital initiatives aiming to enhance service delivery and collaboration within the broader health and aged care systems, such as My Health Record.

This is not due to allied health lack of interest and unwillingness. It is the result of past Government failure to provide appropriate mechanisms to build system capacity that would facilitate the digital integration of allied health, which in the private sector often consists of small and even sole trader practices.

Endnotes

1 For more detail, see https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/, pp 3-4.

2 See especially Recommendations 36 and 38.

3 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 , 2.

4 Ibid, 33-35; 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, 8-10.

5 2.85 from Mirus for January 2023; 4.9 from University of Technology Sydney Ageing Research Collaborative for FY22; 5.07 from StewartBrown for FY22; 5.6 from Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022; 6.36 from StewartBrown for the three months ending 30 September 2022. These figures are averages, except for the Department's which is the median.

6 https://www.health.gov.au/resources/publications/scoping-study-on-multidisciplinary-models-of-care-in-residential-aged-care-homes-summary.

7 https://ahpa.com.au/advocacy/3489-2/.

8 https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/.

9 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, 8-11; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/. See also Royal Commission Recommendations 25, 28, 31, 37 and 38.

10 See e.g. Royal Commission Recommendations 28, 58.

11 https://ahpa.com.au/advocacy/aged-care-system-needs-emergency-first-aid-say-allied-health-professionals/.

12 https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ , pp 6-11.

13 For example, current Residential Aged Care Quality Indicators contribute a total of 15% weighting to Star Ratings, which inform consumer choice rather than mandating quality.

14 https://ahpa.com.au/advocacy/submission-to-capability-review-of-the-aged-care-quality-and-safety-commission/.

15 https://ahpa.com.au/advocacy/submission-exposure-draft-of-the-inspector-general-of-aged-care-bill-2022/ . See also Royal Commission Recommendation 12.

16 Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022.

17 For more detail see https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ , pp 8-9.

18 https://ahpa.com.au/advocacy/pre-budget-submission-2023/ . See also Royal Commission Recommendation 75.