Allied Health Professions Australia

POLICY BRIEF

Ensuring quality allied health services in aged care – What needs to change?

October 2023

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 180,000 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 of our member professions that provide aged care services.

Key recommendations

Recommendation 1

The Australian Government commits to a model that:

a) ensures delivery of allied health services according to assessed need for older Australians in residential aged care; and
b) ensures that the aged care system focuses on reablement.

Recommendation 2

The Independent Hospital and Aged Care Pricing Authority adopts an approach that is consistent with our Recommendation 1, prices the delivery of high quality and safe allied healthcare, and enables providers to deliver needs-based care to a reablement standard.

Recommendation 3

The Australian Government develops, and funds provision to the level of, a benchmark for allied health similar to the current sector-wide care minute requirement for nursing and personal care. This includes implementing an interim benchmark comparable to the approach in British Columbia, Canada.

Recommendation 4

The Australian Government provides comprehensive data, including by AN-ACC class, on the use of allied health in aged care across all regions to enable an analysis and informed discussion of the ongoing provision of allied health across Australia, including development of a final benchmark under our Recommendation 3.

Recommendation 5

The Australian Government works with the allied health sector and relevant workforce and training entities to develop a National Allied Health Workforce Strategy, which is supported by a national minimum dataset and cognisant of the cross-sector character of many allied health professionals' work.

Recommendation 6

The Australian Government engages with and directly involves the allied health sector in the development of a best practice needs assessment and care planning tool as recommended in the Resource Utilisation and Classification Study informing development of the AN-ACC.

Recommendation 7

Use of, and assessment and service delivery outcomes resulting from, the best practice needs assessment and care planning tool is monitored and data publicly reported.

Recommendation 8

The Department, the Commonwealth and State and Territory Chief Allied Health Officers, Local Hospital Networks, Primary Health Networks and relevant workforce peak bodies work with the allied health sector to develop sustainable models of best practice multidisciplinary team care.

Recommendation 9

Providers are required to record the amount and payment source of allied health service provision according to the relevant Item in Schedule 1 of the Quality Principles.

Recommendation 10

The Australian Government ensures that provision of allied health services in aged care is consistent with Royal Commission Recommendation 69.

Recommendation 11

The Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission, and the Department of Health and Aged Care work with allied health peak bodies to evaluate the impact of the revised Quality Standards on the quality of allied health service provision in aged care.

Recommendation 12

The definition of 'high quality care' included in the new Aged Care Act is consistent with Royal Commission Recommendation 13.

Recommendation 13

High quality care is embedded in the new Aged Care Act as the compliance and enforcement standard, aligned with an enforceable Statement of Rights that includes the human right to health.

Introduction

This Policy Brief outlines how allied health is significantly underprovided and underfunded for people who receive aged care. 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 are relevant to the aged care system as a whole.

AHPA has regularly communicated with the Minister for Aged Care, the Department of Health and Aged Care (the Department) and other relevant entities regarding the parlous state of allied health

in residential aged care, and the barriers that must be overcome to implement the relevant recommendations of the Royal Commission into Aged Care Quality and Safety ('Royal Commission').

Embedding an aged care system that genuinely meets older people's assessed allied health needs requires decision makers to consider various interlinked elements and concepts relevant to Australia's aged care system.

It is important to first contextualise our arguments by summarising the conclusions of the Royal Commission concerning allied health, before discussing the current funding and actual provision of allied health services, and the impact of these on quality of care.

The Policy Brief next outlines two necessary features for quality allied health in aged care: needs-based assessment, care planning and delivery; and multidisciplinary team care. We then examine present and proposed future aged care regulatory mechanisms and consider whether they are capable of enforcing provision of quality allied health services.

The Policy Brief includes some key recommendations throughout (also summarised above), but for more detail, AHPA refers to our submissions on specific aged care topics.[1]

Royal Commission findings on allied health

In its Final Report, the Royal Commission concluded that 'reablement' is critical to older people's physical and mental health and wellbeing, and should be a central focus of aged care.[2]

Reablement

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.

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 multidisciplinary 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 – thereby mitigating provider risks of non-compliance.

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[1] See https://ahpa.com.au/policy-statements-and-submissions/ .

[2] 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.

Data on service provision

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.[3] This research was part of the Resource Utilisation and Classification Study ('RUCS') which underpins the new Australian National Aged Care Classification ('AN-ACC') model for funding residential aged care.[4]

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.[5] Results included the finding that aged care residents received an individual average of only eight minutes of allied health care a day.[6] This finding was contrasted by the AHSRI to the allied health care figure in British Columbia, Canada of 22 minutes.[7]

Royal Commission conclusions

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 morbidity, mortality and negative quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[8]

Accordingly, the Royal Commission also concluded that allied health should be regarded as a fundamental element of the aged care system.[9] The Royal Commission made multiple associated recommendations, including for implementation of multidisciplinary care.[10]

The Royal Commission also 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.[11] This

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[3] 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.

[4] 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.

[5] 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.

[6] 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.

[7] Ibid, p24.

[8] 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.

[9] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.

[10] See eg Recommendations 25, 31, 37-38 and 58.

[11] See eg Recommendations 36 and 38.

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.

Funding of allied health in residential aged care

It follows that in order to meet aged care consumers' assessed needs, coordinated care planning and sufficient aged care funding must be guaranteed. However, there is no dedicated funding of allied health services in residential aged care, and no associated mandatory benchmark equivalent to nursing and personal care minutes. Instead, the Department of Health and Aged Care ('the Department') expects provider payment for allied health services in residential aged care to be drawn from overall federal Government funding to providers under the AN-ACC model introduced on 1 October 2022.

However, although the AN-ACC is a funding tool, it does not itself prescribe the amount or types of care to be provided. It is not designed for allied health funding needs, nor for the provision of clinical care planning. The Royal Commission simply noted in passing that the AN-ACC 'may' achieve increased and appropriate allied health delivery.[12] The AHSRI team emphasised that the current version is only the first step in a necessary development process,[13] and that adequately building allied health into the AN-ACC would take several years.[14]

The stark reality is that there is no clear and enforced benchmark for allied health care provision, unlike the care minutes requirements for nursing and personal care. For example, recent analysis of whether AN-ACC funding is sufficient has been undertaken by the University of Technology Sydney Ageing Research Collaborative ('ARC'). Even though the definition of direct care appears to only include nursing and personal care, 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.'[15]

Providers have also tended to use any surplus from direct care to try to address growing deficits in accommodation and cost of living expenses,[16] rather than spending more on allied health care.

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

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[12] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 180.
[13] 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 , 33.
[14] 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. See also https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .
[15] Sutton, N, Ma, N, Yang, JS, Lewis, R, Woods, M, Ries, N and D Parker, 2023, *Australia's Aged Care Sector: Mid-Year Report (2022–23)*, UTS Ageing Research Collaborative, 16.
[16] Ibid, 19.

This is also having a flow on effect to costing, pricing and funding of future allied health services. AHPA welcomed the establishment of the Independent Health and Aged Care Pricing Authority ('IHACPA') to set aged care pricing. Residential aged care pricing principles applied by IHACPA include that payments should be based on residents' needs,[17] and recent consultation reported that aged care stakeholders want IHACPA's Five-Year Vision to include a focus on ensuring the pricing system supports the delivery of high quality, person-centred care.[18]

But despite this, IHACPA determination of the value of the National Weighted Activity Unit and associated AN-ACC weightings is yet to reflect the true cost of providing needs-based allied health care to a reablement standard. For example, the Residential Aged Care Costing Pilot Study (Report, August 2022) undertaken for IHACPA by PricewaterhouseCoopers simply collected data on the allied health care currently provided, and the current Residential Aged Care Costing Study has not improved on this.

Aligning IHACPA costing of allied health and the ensuing AN-ACC funding with actual assessed clinical needs also requires costing other mechanisms that are not yet in place, despite Royal Commission recommendations. These include clinical assessment and planning of allied health needs, and multidisciplinary team delivery of services, such as team coordination and support, to meet those needs (see 'Multidisciplinary team care' below).

Another important task for future costing and planning is to map the existing pathways for provision of allied health (see 'Provider obligations: Schedule 1' below).

Recommendation 1

The Australian Government commits to a model that:

a) ensures delivery of allied health services according to assessed need for older Australians in residential aged care; and
b) ensures that the aged care system focuses on reablement.

Recommendation 2

The Independent Hospital and Aged Care Pricing Authority adopts an approach that is consistent with our Recommendation 1, prices the delivery of high quality and safe allied healthcare, and enables providers to deliver needs-based care to a reablement standard.

Provision of allied health services in residential aged care

Other than the Royal Commission research, it has been difficult to obtain reliable detailed data on allied health service provision to aged care consumers.

Before the implementation of Royal Commission Recommendations 122, 124 and (partly) 38, the main source of allied health data, and then only for a sample of residential care, was StewartBrown's Aged Care Financial Performance Survey ('ACFPS') Residential Care Report.

StewartBrown's ACFPS Residential Care Report (March 2018) figure of 8.4 minutes was broadly consistent with the Royal Commission's (via AHRSI) 8 minutes.[19] StewartBrown's later one-off

[17] *Pricing Framework for Australian Residential Aged Care Services 2023-24*, May 2023 ('Pricing Framework'); *Towards an Aged Care Pricing Framework Consultation Report*, May 2023 ('Consultation Report'), 17-18.
[18] Pricing Framework, 22; Consultation Report, 34-36.
[19] StewartBrown, Aged Care Financial Performance Survey (ACFPS) Residential Care Report (March 2018) https://www.stewartbrown.com.au/news-articles/26-aged-care/158-march-2018-aged-care-sector-reports-

Allied Health Deep Dive Survey (2020) found that aged care residents received an average of 7.2 minutes of allied health care per day.[20] StewartBrown's ACFPS Residential Care Report (September 2021) found 6.6 allied health minutes.[21]

In 2022 the Ageing Research Collaborative (ARC) at the University of Technology Sydney published its first biannual report on the delivery of aged care services, the result of partnering with StewartBrown.[22] This independent examination of the sector was intended to have a broad policy scope while StewartBrown narrowed its future focus to benchmark reporting for aged care providers.[23] ARC analysis of StewartBrown data for the 6 months ending 31 December 2021 produced a December 2021 figure of 5.3 minutes.[24]

A 2021-22 scoping study commissioned by the Department of Health and Aged Care also concluded that the level and breadth of allied health involvement in Australian residential aged care homes is 'limited' (for more detail, see 'Multidisciplinary team care' below).[25]

Quarterly Financial Reporting

Since July 2022, Quarterly Financial Reporting ('QFR') has provided some more data on allied health costs and time spent on residential aged care. However, data is still insufficiently granular.[26]

QFR now includes some data on staffing minutes for individual allied health professions in residential care, but only physiotherapy, occupational therapy, speech pathology, podiatry and dietetic care, and the use of allied health assistants (undifferentiated) are distinguished. Provision of any remaining 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 needs received more allied health services on average than higher functioning residents.

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released , 14. Like the AHSRI research, the 2018 StewartBrown survey did not disaggregate 'allied health and lifestyle'.

[20] 2020 StewartBrown Allied Health Deep Dive Survey https://www.stewartbrown.com.au/index.php?option=com_content&view=article&id=192 . Data was obtained for the 2019-20 financial year. Slightly confusingly, lifestyle officers are included in the Deep Dive results, but not simply as added to allied health like earlier Aged Care Financial Performance Surveys, rather as part of allied health itself. However the Deep Dive itemises lifestyle officers separately, so they can be subtracted from the total spending. The survey also itemises diversional therapists despite their not being seen by the sector as part of allied health, so they are also subtracted. There is also a category of 'other' that is assumed in this submission to be other allied health professions, and so is included in our calculation. A possible overall limitation is that the Deep Dive represented only 12% of all homes nationally and 7% of providers in the sector.

[21] StewartBrown Aged Care Financial Performance Survey Sector Report - September 2021 https://www.stewartbrown.com.au/news-articles/26-aged-care/254-2022-01-stewartbrown-aged-care-financial-performance-survey-sector-report-september-2021 , 10. Note that this version of the report counts allied health separately from lifestyle.

[22] 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.

[23] Ibid, 6-7.

[24] Ibid, 34.

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

[26] 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.

AHPA has regularly raised our concerns with the Department about the underprovision of allied health services in residential aged care, ever since it has been possible to at least get a sense of the average minutes via QFR.

The first Quarterly Financial Snapshot ('QFS') was for July to September 2022 (Quarter 1) and reported 5.6 allied health minutes. At this time the Department indicated that if the next two QFSs showed a decrease in allied health, it might be cause for concern, because that data would be expected to reflect a positive impact flowing from the AN-ACC funding (AN-ACC commenced on 1 October 2023).[27]

Nevertheless, the Department assured stakeholders that allied health would be sufficiently funded under the AN-ACC, by referring to a yardstick derived from StewartBrown data which found that residential aged care providers spent 4% of their care funding on allied health.[28] AHPA's calculations based on the yardstick showed that, at worst, residents could end up receiving an average of only 4.6 minutes' allied health care per day.[29]

The October to December 2022 QFS (Quarter 2) showed exactly this result of 4.6.[30] The latest QFS (January to March 2023, Quarter 3) reported 4.55 minutes.[31] This shows that there has been a decrease in allied health minutes since AN-ACC commenced, and that allied health service provision is presently significantly less than the eight minutes criticised by the Royal Commission, let alone the 22 minutes in Canada's aged care system found by the AHSRI.

The three QFSs published so far have also provided some more detailed data on allied health costs and time spent on residential aged care. QFS Quarter 3 minutes for some individual allied health professions are so low that only four professions are individually represented, ranging from 0.05 minutes for speech pathology to 2.96 minutes for physiotherapy, with occupational therapy, allied health assistants and other allied health categories too low to even feature in the data.[32]

Provider underreporting?

When the QFS Quarter 1 was published, results were, as for Quarter 3 subsequently, not reported for occupational therapists, allied health assistants and other allied health categories. Departmental commentary suggested that providers might still be adjusting their approach to record-keeping for allied health services in order to align with the new QFR requirements.[33] The Department took a similar approach in the QFSs for Quarters 2 and 3, attributing both the lack of data for professions such as occupational therapy and the overall low minutes to providers underreporting allied health service provision, rather than to underprovision of services.[34]

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[27] Department meeting with Allied Health Professions Australia, 2 March 2023.
[28] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc , accessed July 2022.
[29] https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ , 3-8.
[30] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23, October to December 2022, 13-14.
[31] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23, January to March 2023, 14-15.
[32] Ibid, 15.
[33] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022, 10.
[34] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022, 14-15; Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23 January to March 2023, 15.

But it does not seem commonsense for providers not to report allied services that they are spending AN-ACC funds to provide. Moreover, the Quarter 3 result of 4.55 minutes is not far removed from the most recent StewartBrown Residential Care Report mean of 5.82 minutes for the nine months ended 31 March 2023.[35] The StewartBrown survey, although based on a smaller sample than QFR, has run for several years – and so it would be expected that at least those participants are familiar with reporting allied health service provision.[36]

Further, even assuming underreporting by an average of 1.27 minutes, rectification would still mean that, at best, average daily allied health minutes remain just over a quarter of the 22 minutes suggested to the Royal Commission by the AHSRI.

Consistent with its attribution of the low figures to underreporting, the Department has stated that it is actively engaging with the sector to understand and improve provider reporting,[37] and that therefore the data is expected to improve over time. The Department recently suggested that this kind of approach is bearing fruit, because the number of providers that do not report any allied health cost or hours for their services has reduced with each reporting period.

However, this is not evident from a comparison of the three Quarters. For Quarters 1 and 2, more than 75 per cent of QFR respondents did not report any expenditure for the categories of occupational therapists, allied health assistants and other allied health categories apart from physiotherapy, speech pathology, podiatry and dietetics.[38] For Quarter 3 the equivalent figure was 70 to 80 per cent.[39]

The Department has also more recently attributed the decrease in allied health minutes from Quarter 1 to the change from the former Aged Care Funding Instrument (ACFI) to the AN-ACC funding model. This seems at odds with the Department's previous verbal and written assurances to AHPA, based on the '4%' yardstick, that after the introduction of the AN-ACC, at worst, allied health funding would remain the same (see above).

Impacts on care quality and safety

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. Within six weeks of AN-ACC commencing on 1 October 2022, AHPA conducted a survey of 279 allied health professionals across a range of disciplines to determine the impact of the introduction of the new funding tool on their employment and provision of allied health services in residential aged care facilities.[40]

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[35] https://www.stewartbrown.com.au/news-articles , 10.

[36] Data from other sources also produce results broadly consistent with QFR. The QFS Quarter 1 figure of 5.6 sits within the range produced by other aged care provider surveys that have been regularly undertaken for some time: 2.85 (Mirus for January 2023); 4.9 (University of Technology Sydney Ageing Research Collaborative for FY22); 6.36 (StewartBrown for the three months ending 30 September 2022). Note that these figures are averages, whereas the Department's is the median.

[37] See eg https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers .

[38] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2022-23 July to September 2022, 10; Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022, 14.

[39] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23 January to March 2023, 15.

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

The survey results indicated:

- More than 1 in 8 respondents (13%) had already lost their job;
- 37% of respondents had their clinical role or employment change, generally for the worse, including reduced hours of work and experiencing cuts to overall health services in their workplaces;
- 43% of respondents whose role had changed had their hours reduced;
- 41% of respondents indicated their clinical team structure had changed, with 84% of those (a third of all respondents) indicating there had been a decrease in the number of allied health professionals;
- 45% indicated that services provided by their profession had changed, with 58% of these respondents saying available services had decreased; and
- 30% of respondents indicated that they expected to cease working in residential aged care in the foreseeable future due to job insecurity, deterioration in roles and concerns about quality of care.

The effects were being particularly felt in physiotherapy and occupational therapy, as these were the allied health professions most likely to have been employed under the former funding model.

Many respondents stated they could now only provide reactive care to referrals, rather than collaborate in multidisciplinary care. They also noted deterioration in the quality of allied health care available to residents.

Analysis of a further survey one year later is currently in progress. Preliminary results suggest the same themes.

Recommendation 3

The Australian Government develops, and funds provision to the level of, a benchmark for allied health similar to the current sector-wide care minute requirement for nursing and personal care. This includes implementing an interim benchmark comparable to the approach in British Columbia, Canada.

Recommendation 4

The Australian Government provides comprehensive data, including by AN-ACC class, on the use of allied health in aged care across all regions to enable an analysis and informed discussion of the ongoing provision of allied health across Australia, including development of a final benchmark under our Recommendation 3.

Other workforce effects

There is 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. It also means that the Royal Commission's vision of reablement as central to aged care is not being realised. At best, the vast majority of aged care residents are receiving occasional and even one-off allied health services rather than coordinated care delivery based on the range of allied health disciplines suited to their particular needs.

With no clear plan in sight for allied health in residential aged care, there is also a real risk that allied health professionals – a largely part-time and contractor workforce – will seek greater job security in other sectors.

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 still no national allied health workforce strategy and no clear picture of the various settings, sectors and locations in which allied health professionals work. 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 also needs to be supported by a national minimum dataset, so that we can accurately predict workforce shortfalls and ensure the right flow of new graduates – as required by Royal Commission Recommendation 75. 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.

Recommendation 5

The Australian Government works with the allied health sector and relevant workforce and training entities to develop a National Allied Health Workforce Strategy, which is supported by a national minimum dataset and cognisant of the cross-sector character of many allied health professionals' work.

Allied health needs-based assessment, care planning and service delivery

Royal Commission Recommendation 25(b) emphasises 'an entitlement to all forms of support and care which the individual is assessed as needing'.[41] However, neither costing and pricing methodology nor QFR facilitates mapping of whether residents actually receive the amount and types of services that they are clinically assessed as needing – or even whether they have been appropriately clinically assessed.

The AN-ACC assessment tool is also not designed for the provision of clinical care assessment and planning, and the AHSRI recommended the separation of assessment of residents for funding purposes, from the assessment of residents for delivery of appropriate care.[42] The first type of assessment is now undertaken under the AN-ACC model, but the second type requires nationally consistent assessment of allied health needs, as recommended by the Royal Commission. This has not been implemented.

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[41] See also Royal Commission Recommendations 37 and 38.

[42] 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/ .

In residential aged care, once the assessor workforce determines the AN-ACC funding classification level, 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, evidence-based, 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.

Recommendation 6

The Australian Government engages with and directly involves the allied health sector in the development of a best practice needs assessment and care planning tool as recommended in the Resource Utilisation and Classification Study informing development of the AN-ACC.

Recommendation 7

Use of, and assessment and service delivery outcomes resulting from, the best practice needs assessment and care planning tool is monitored and data publicly reported.

Multidisciplinary team care

Provision of care via multidisciplinary teams 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 other 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.[43] 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.

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

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.

As far as we can ascertain, there have been two main relevant Government multidisciplinary aged care projects.

HealthConsult project

AHPA and many of our members took part in consultations on this, which was funded for $0.49 million in 2021-22 to:

> 'identify an in-reach multidisciplinary service delivery model for residential aged care homes that reduces avoidable hospital presentations and admissions. HealthConsult were contracted to deliver a scoping study and model of care. This project has concluded, with the final report submitted to the Department in June 2022. A published summary of the findings is available on the Department's website.[44]
>
> The published summary details some of the key findings from the data analysis and stakeholder engagement in relation to drivers of hospitalisations. This includes that drivers of hospitalisations for residents are primarily falls, chronic cardiovascular disease and chronic respiratory disease. The HealthConsult project highlighted the important role of multidisciplinary care in preventing function decline, maintaining and improving function to prevent hospitalisations, and details a proposed best practice model of care addressing the key drivers. The model of care is currently with the Department for consideration within the Government's broader aged care reform agenda.'[45]

The Department released a summary of the HealthConsult report. AHPA requested a copy of the full report, but the Department stated that it cannot be released.

AHPA has since been informed by the Department that any model resulting from the HealthConsult research will not actually be implemented, but rather is only intended to be a 'gold standard' to build into relevant reforms. This mirrors the other flaws in the aged care system relevant to allied health, where there are no mandated approaches or allocated funding.

AHPA was also informed that at the time of report completion, the Department was also waiting on the first round of QFR to see what amount of allied health is actually being provided. As detailed above, we now have data reflecting the first tranche of the AN-ACC funding model, and which shows that allied health minutes have further decreased.

Multidisciplinary Outreach Service in Residential Aged Care Facilities project

It has been difficult to obtain information about this project, but AHPA understands that the project is in its initial stages.

The project was funded from the 2022–23 Budget which included $22.1 million over 3 years from 2022-23 to provide more comprehensive health care with hospital-led access to specialists, allied health professionals, geriatricians and palliative care specialists.

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

[45] Mark Richardson, Assistant Secretary, Residential Care Funding Reform, Home and Residential Division, Ageing and Aged Care Group, Australian Government Department of Health and Aged Care**,** email to Chris Atmore, 20 October 2022.

It involves 50:50 cost share arrangements between the Commonwealth and the States and Territories via establishment of a fund, and an invitation to States and Territories to put forward proposals to trial new models of multidisciplinary outreach care for people in residential aged care facilities. The project will examine potentially multiple models via the different States and Territories, with preliminary agreement to a trial in each jurisdiction. The project will then consider what might be turned into a national approach. There will be a concurrent evaluation and at the time of our inquiry, the Department was developing a procurement process.

The trials respond to Royal Commission Recommendation 58 and are expected to run for two years, and to be managed by Local Hospital Networks (LHNs). The trials are intended to reduce emergency department attendances and potentially preventable hospitalisations. They also aim to increase access to health practitioners already employed in the public health system, without duplicating existing primary care services.

There are various allied health elements relevant to the project on which AHPA, and particularly our clinical members, can make important contributions. These include the breadth of allied health services to be included in the trial models, and questions about how these will be sourced if they are not already available via LHNs in that area. As of December 2022, it had also not been determined how comprehensive assessment of care needs will be addressed, given that as outlined above, there is no nationally consistent assessment and monitoring of allied health needs and care planning.

AHPA does not know whether any progress has been made since March 2023 when the Commonwealth Chief Allied Health Officer stated to us that no further progress had been made.

Feasibility study on providing higher levels of in-home aged care

The Department has also been working with Deloitte and clinical research partner Applied Aged Care Solutions to conduct a feasibility study on providing higher levels of in-home aged care to support older people with complex needs.

The study entailed:

> 'using the draft integrated assessment tool with residential aged care clients and other older people with a disability, and interviewing older people and their families etc including about what affected decisions to enter residential care. That information will be used to form some judgements about the levels and types of care that might be needed in the home for different groups of more complex clients (including insights about informal care arrangements).'[46]

AHPA understands that the study has now concluded, but we have not yet seen a published report or been engaged in any subsequent consultation.

As a cornerstone of the aged care system and crucial in reablement and multidisciplinary team care, allied health would expect to be collaborating in these types of projects.

[46] Nick Morgan, Assistant Secretary, Support at Home Reform Branch, Home and Residential Division, Department of Health and Aged Care, email to Chris Atmore 13 July 2023.

Recommendation 8

The Department, the Commonwealth and State and Territory Chief Allied Health Officers, Local Hospital Networks, Primary Health Networks and relevant workforce peak bodies work with the allied health sector to develop sustainable models of best practice multidisciplinary team care.

Accountability for allied health care quality and safety

As this Policy Brief has outlined, without an enforceable 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. Consequently, Australia will not achieve the recommended key focus on reablement and associated quality of life benefits for older people.

Nevertheless, the Department continues to assert that allied health is provided to an acceptable standard, and that the present aged care regulatory system ensures this.[47] Current regulation of allied health service quality in aged care is undertaken primarily via provider obligations to provide allied health services, as set out in the *Aged Care Act 1997* and the Aged Care Quality Standards ('Quality Standards') and other Schedules to the *Quality of Care Principles 2014* ('Quality Principles').[48]

The legislation mandates the provision of care and services for all care recipients who need them, and on its face has a definition similar to the Royal Commission's 'level of allied health care appropriate to each person's needs'. For example, providers' legal responsibilities include maintaining an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met.[49]

Yet as we have outlined with regard to residential aged care, allied health is grossly under-provided and services are inappropriately substituted. It is therefore evident that the current aged care regulatory system is failing to ensure quality and safety of allied health services.

There are two main causes of this failure. First, the performance of the regulator is weak and inconsistent. But even if these problems were addressed, there are also systemic flaws in the content of providers' legal obligations, which make it difficult to enforce meaningful standards for allied health service provision.

The regulator

The present regulator, the Aged Care Quality and Safety Commission ('ACQSC'), was found by the Royal Commission to have a poor track record. The Royal Commission found that the ACQSC and its predecessors:

> 'have not demonstrated strong and effective regulation. The regulatory framework is overly concerned with processes and is not focused enough on outcomes. The system is insufficiently responsive to the experiences of older people. The oversight of home care is underdeveloped. There is a poor track record — in both home care and residential care — on

[47] See eg Department of Health and Aged Care, 'Questions and answers: Residential aged care funding reform webinar', 16 May 2023, 14; (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 Hansard transcript, and the Aged Care Quality and Safety Commission's Compliance and Enforcement Policy (14 July 2021), 7-9.
[48] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5, and Schedules 1, 2, 3 and 5.
[49] *Aged Care Act 1997*, s 54-1(1)(b); see also Quality Standards 2(1)-(2), 3 and 7.

> enforcement, and a reactive approach to monitoring and compliance. The oversight of residential providers has relied far too heavily on a three-year cycle of accreditation audits against fixed standards. The three-year cycle of audits is inefficient and is not risk-based. It has not been effective in preventing, detecting or responding adequately to instances of poor quality care.
>
> The current approach to regulation takes insufficient account of other intelligence that might point to substandard care, such as the experience of people receiving care, complaints, reports of serious abuse or assaults, coronial reports and signs of provider financial distress. Where problems have been identified, the regulator has lacked curiosity about underlying patterns of performance and has been too ready to accept the assurances of providers in relation to their own performance. . .
>
> Another key problem is a weak approach to enforcing the responsibility of providers to provide high quality and safe care. . .We are concerned that the regulator has had a mindset of managing every provider back to compliance.'[50]

The Royal Commission's findings remain pertinent. For example, the recent Report of the Independent Capability Review of the ACQSC found significant problems with quality assurance, including inconsistent application of the Quality Standards during audits.[51] Audits rely on assessment of conformance with the Quality Standards, which are discussed further below.

The only other mechanisms via which the ACQSC would potentially be able to monitor access to allied health services are complaints and incident reporting. But these are reactive conduits which rely on consumers, families and whistleblowers. To illustrate, as outlined in 'Allied health needs-based assessment' above, a key current problem 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, and hence would be unlikely to raise the fact of not being provided with them.

Complaints and reports to the ACQSC therefore seem unlikely to catch allied service under-provision, although information is too scarce to make a definitive conclusion. For example, as presented in the ACQSC's Sector Performance Report January–March 2023, clinical care (current Quality Standard 3) features prominently in both complaints and provider non-compliance with quality assessment and monitoring. However, it is not possible to ascertain how many of these examples involved allied health, the nature of the issues and how they were resolved.

More broadly however, it appears that the provision of a sufficient quantity of allied health is not regarded as a quality matter. This is not assisted by the fact that the issue falls between the two stools of the Department and the ACQSC. The Department's regular statements that aged care

[50] Royal Commission into Aged Care Quality and Safety, Final Report Volume 2 The current system (2021), 226-230; see also (Hansard Proof) Senate Community Affairs Legislation Committee Estimates, Parliament of Australia, Canberra, 10 November 2022, 111-118.

[51] https://ahpa.com.au/news-events/the-independent-capability-review-of-the-aged-care-quality-and-safety-commission-released/ ; *Report of the Independent Capability Review of the Aged Care Quality and Safety Commission* (David Tune, 31 March 2023). See also (Hansard Proof) Senate Community Affairs Legislation Committee Estimates, Parliament of Australia, Canberra, 10 November 2022, 111-118.

regulation guarantees sufficient allied health is concurred with by the ACQSC.[52] However, when Assistant Commissioner Peterson was asked recently about the gross under-provision of allied health, she referred the issue back to the Department. And even if one entity was to take responsibility, there is no concrete standard, such as a mandatory benchmark, to enforce.

Provider obligations: Schedule 1

With respect to allied health services in residential aged care, the Quality Principles specify the relevant care and services that an approved provider must provide.[53] In particular, residential care and services that are provided under Schedule 1 of the Quality Principles must be provided in a way that complies with the Quality Standards.[54] The specified care and services, including allied health, must be provided for all care recipients who need them.

There are five different Items in Parts 2 and 3 of Schedule 1 that are relevant to allied health care and services.

From *Quality of Care Principles 2014*, Schedule 1, Part 2

2.6 **Rehabilitation support**
Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a care recipient's ability to perform daily tasks for himself or herself, or assisting care recipients to obtain access to such programs.

2.7 **Assistance in obtaining health practitioner services**
Arrangements for aural, community health, dental, medical, psychiatric and other health practitioners to visit care recipients, whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients, or are made direct with a health practitioner.

2.8 **Assistance in obtaining access to specialised therapy services**
Making arrangements for speech therapists, podiatrists, occupational or physiotherapy practitioners to visit care recipients, whether the arrangements are made by care recipients, relatives or other persons representing the interests of care recipients.

2.9 **Support for care recipients with cognitive impairment**
Individual attention and support to care recipients with cognitive impairment (for example, dementia and behavioural disorders), including individual therapy activities and specific programs designed and carried out to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for

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[52] (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, 35-36 (Aged Care Quality and Safety Commissioner Janet Anderson). See also the Commission's Compliance and Enforcement Policy (14 July 2021). See also IHACPA's *Pricing Framework for Australian Residential Aged Care Services 2023-24* (May 2023, p5) which delineates the responsibilities as follows: 'The Department of Health and Aged Care retains policy and system management responsibility for matters including. . .the aged care workforce. . . [and[the operation and implementation of AN-ACC, determining how AN-ACC assessments are undertaken and reviewed, and the requirements for re-classification . . . The Aged Care Quality and Safety Commission retains responsibility for functions including. . . assessing and monitoring the quality of care and services against the Aged Care Quality Standards.'

[53] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5, and Schedule 1 Parts 2 and 3, and Schedule 5, Part 1.

[54] *Quality of Care Principles 2014*, ss 6-7. Our analysis focuses on Schedule 1 because Schedule 5 is concerned only with short-term restorative care.

such care recipients and ongoing support (including specific encouragement) to motivate or enable such care recipients to take part in general activities of the residential care service.

From *Quality of Care Principles 2014*, Schedule 1, Part 3

3.11 **Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services**

(a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain care recipients' levels of independence in activities of daily living;

(b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow care recipients to reach a level of independence at which maintenance therapy will meet their needs.

Excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.

Despite AHPA's correspondence with the Department, it is not clear how these requirements are practically translated into provider practices. For example, how do providers decide which Item applies to a particular allied health service required by a resident, and thereby understand the nature and extent of their obligations?

Item selection is also important because Items 2.7 and 2.8 do not require providers to pay for the service, but only require access to the service to be provided. 'Access' means the provider is responsible for making arrangements for the service, but the actual appointment fee, and any transport/escort costs, can be passed on to the resident.

This means that payment for those services, and perhaps associated costs, has to come from outside the AN-ACC funding that providers receive for care and services, including allied health. We do not know the quantity and types of allied health services to which Items 2.7 and 2.8 pertain. QFR does not separately record allied health services provided according to the various Items, and providers are not obligated to record or report data concerning which delivered services fall under the different Items, and the source of payment.

It is nonetheless evident that some allied health in aged care is being paid for by means other than AN-ACC funding. AHPA is aware that at present some allied health services are simply paid for privately by aged care consumers. Other services are provided through Medicare, Veterans' Care, private insurance, and State and Territory health services.

Spending via these 'outside' channels is highly unlikely to come close to meeting allied health care needs in aged care. This is due to the limited access to the various avenues, and other restrictions on the amount and type of care that can be obtained, such as the annual limit of five Medical Benefit Service allied health items per year. Many consumers are also increasingly out-of-pocket due to gap fees and limited rebates, and so may simply not pursue treatment.

AHPA strongly believes that allied health care for aged care consumers should be provided as part of a universal right to health.[55] Allied health in aged care is part of core aged care that should be funded 100% from Government sources, not subsidised by consumers who are already paying for aged care via mechanisms such as taxation.

[55] https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .

It is also essential for decision makers to understand that allied health professionals delivering services in aged care need to be resourced to operate in a context that prioritises reablement of older people and multidisciplinary collaborative care. This is different from most episodic care funded through the health system.

We further note 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.

Recommendation 9

Providers are required to record the amount and payment source of allied health service provision according to the relevant Item in Schedule 1 of the Quality Principles.

Recommendation 10

The Australian Government ensures that provision of allied health services in aged care is consistent with Royal Commission Recommendation 69.

Provider obligations: Quality Standards

The Regulatory Impact Statement for the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 highlights the key role played by the Quality Standards:

> 'there is a risk that providers reduce allied care services within residential aged care when the requirement to provide certain treatments to access additional funding [the previous ACFI model, replaced by AN-ACC] is removed. This risk is minimised by the Aged Care Quality Standards requiring the delivery of clinical care in accordance with the consumer's needs, goals and preferences to optimise health and well-being' (198).

The 'proof in the pudding' of aged care regulatory effectiveness therefore rests on the content of the Quality Standards and how they are addressed 'on the ground' by providers and the regulator.

However, the Royal Commission found that the current Quality Standards do not set a sufficiently high bar,[56] and that '[t]he lack of objectively measurable Standards in aged care is concerning.'[57] Government response to the associated Royal Commission recommendations included transferring responsibility for the formulation of clinical care standards for aged care to the Australian Commission on Safety and Quality in Health Care (ACSQHC), with the Department retaining responsibility for non-clinical aged care standards.

The Department led a review of the Quality Standards in 2021-22, with clinical care standards for aged care being similarly reviewed by the ACSQHC.[58] AHPA participated in both consultations and welcomed some of the proposed changes, but we continued to have significant concerns about the Quality Standards, including their wording and intent, and applicability and enforceability regarding allied health.

[56] Royal Commission into Aged Care Quality and Safety, Final Report Volume 3a A new system (2021), 119-125. See also KPMG, Evaluation of the Aged Care Quality Standards: Evaluation Report (January 2022), 3-5.
[57] Royal Commission into Aged Care Quality and Safety, Final Report Volume 3a A new system (2021), 123.
[58] In contrast, the Royal Commission recommended that the entire standard-setting role be transferred to the Australian Commission on Safety and Quality in Health Care.

In November 2022 AHPA provided a submission on the ensuing set of draft strengthened Aged Care Quality Standards.[59] The submission contended that the draft revised Quality Standards did not substantially improve upon the gaps and lack of detail identified in the present Quality Standards. This was particularly the case for allied health, where the connection between allied health services and reablement was largely absent from the proposed Quality Standards. This absence, combined with an absence of concrete quality outcome measures, the lack of a mandated benchmark for allied health care minutes, variable allied health needs assessment processes and inadequate data reporting, meant that the new Quality Standards were unlikely to address the problems in allied health provision.

AHPA's submission considered how each of the proposed Quality Standards might be applied by the ACQSC in regulating compliance, and where useful, suggested amendments to the Quality Standards to make them at least somewhat more effective. We also advocated for a more explicit focus on exactly what is required for compliance under each Quality Standard, via new guidance material, including supplementary key performance indicators or recommended guideline targets. As outlined above, AHPA also submitted that achieving and maintaining quality aged care entails scrutiny of other 'pieces of the puzzle', including the performance of the ACQSC.

However, in the main AHPA's proposed amendments are not reflected in the draft 'strengthened' Quality Standards,[60] and we have not seen any new guidance material. Accordingly, AHPA fears that even when the draft 'strengthened' Quality Standards are implemented, on the whole they will not help to ensure compliance with the approach proposed by the Royal Commission's allied health recommendations.[61]

The recent Report of the Independent Capability Review of the Aged Care Quality and Safety Commission refers to concerns about 'allied health needs not being explicitly assessed as part of the [present] Standards, resulting in the risk of consumers being left with unmet needs even while providers may be found to have met the Standards.'[62]

The Review considers that 'these shortcomings should be addressed through the design of a new regulatory system for aged care and a new assessment methodology for strengthened standards',[63] and refers to the commencement by the ACQSC of a pilot of the draft 'strengthened' Quality Standards ('Pilot') which would test 'a re-designed approach to auditing and assessment across a variety of service types and sizes and considering how graded assessment can be used to better differentiate performance.'[64]

Neither AHPA nor our individual peak body members have ever been consulted about the Pilot, so it was unclear to us whether there had been any allied health input into the Pilot design. Despite a response from the ACQSC that allied health professionals are highlighted in the draft

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[59] https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ .
[60] Draft Revised Aged Care Quality Standards (strengthened Standards), received 23 February 2023.
[61] https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ , 6-11. See also Review of the Aged Care Quality Standards: Consultation Summary Report (May 2023), Department of Health and Aged Care, 25.
[62] Report of the Independent Capability Review of the Aged Care Quality and Safety Commission (David Tune, 31 March 2023), 62.
[63] Ibid.
[64] Ibid. See also https://www.agedcarequality.gov.au/about-us/stronger-standards-better-aged-care-program .

'strengthened' Standard 5 (Clinical Care), only the aged care providers who engage allied health professionals, and not the professionals themselves, are involved in the Pilot.

AHPA has attempted on various occasions to inquire of both the ACQSC and the ACSQHC how the draft 'strengthened' Quality Standards might work in practice with respect to allied health. For example, when we consider the audit process, we do not know in any useful detail how providers are currently assessed regarding their obligations concerning allied health service provision. It does not seem that application of the current Quality Standards catches the inappropriate use of non-allied health professionals or allied health assistants. Certainly as yet, it is unknown whether the draft 'strengthened' Quality Standards would offer any improvement in that regard.

Recommendation 11

The Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission, and the Department of Health and Aged Care work with allied health peak bodies to evaluate the impact of the revised Quality Standards on the quality of allied health service provision in aged care.

Future developments in quality regulation

In summary, quality allied health care is compromised by current underfunding, but the present regulatory system does not recognise this. 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 also be able to demonstrate that people are receiving allied health services according to assessment of their clinical needs, and that care is being appropriately planned, delivered and coordinated.

The question then becomes whether there are other existing or proposed future mechanisms that can be used to address allied health quality issues.

Allied health quality indicator

In AHPA's meetings with the Department concerning the lack of an allied health benchmark, the Department has mooted future development of an allied health Quality Indicator. However, this is also unlikely to provide sufficient accountability for quality, because Quality Indicators are not enforceable by the regulator but instead go toward informing consumer choice via Star Ratings. This indirect accountability is also highly likely to be insufficient because, for example, currently Residential Aged Care Quality Indicators contribute a total of only 15% weighting to Star Ratings.

Proposed new Aged Care Act

There are key elements in the proposed new Aged Care Act that, if implemented, would have the potential to address allied health quality issues. These elements include the inclusion of a Statement of Rights, new Objects and Purpose, and a duty of care for providers. However, to date it is not clear how strong these elements will be and whether they will be enforceable in a meaningful way. For example, AHPA is concerned about how the current Quality Standards and Schedule 1 of the Quality Principles are intended to align with the Statement of Rights.[65]

We are also perturbed by the proposed definition of enforceable 'quality' care. The Royal Commission said that high quality care must be the foundation of aged care. Recommendation 1

[65] See our detailed submission https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .

states that one of the Act's objects should be that the aged care system is based on a universal right to high quality, safe and timely support and care.

Recommendation 13 refers to 'embedding high quality aged care', and defines this standard of care as:

> 'designed to meet the particular needs and aspirations of the people receiving aged care' and including 'enhanc[ing] *to the highest degree reasonably possible* the physical and cognitive capacities and the mental health of the person' (emphasis added).

Recommendation 13 further states that high quality care shall:

> . . .(2)(c) *be provided on the basis of a clinical assessment, and regular clinical review, of the person's health and wellbeing*, and that *the clinical assessment will specify care designed to meet the individual needs of the person receiving care*, such as risk of falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care (emphasis added)

Accordingly, the wording in Recommendation 13 is aligned with what is required for the provision of high quality allied health services.

In contrast, the current Commonwealth Government proposal is to simply aspire to 'high quality', while mandating only the provision of 'quality' care. We believe this sets the regulatory bar too low. Genuinely committing 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.

We expect 'high quality' to be the regulatory benchmark, as it should be for any care or support system, particularly one that receives substantial taxpayer funding. Without this commitment, high quality care risks being treated as a luxury item rather than a universal right based on assessed needs.

The overall aged care regulatory approach must reject the current 'nice to have, but not essential' approach to allied health, and instead embed accountability for the provision of allied health services, to a reablement standard, as a critical element of the aged care system.

Recommendation 12

The definition of 'high quality care' included in the new Aged Care Act is consistent with Royal Commission Recommendation 13.

Recommendation 13

High quality care is embedded in the new Aged Care Act as the compliance and enforcement standard, aligned with an enforceable Statement of Rights that includes the human right to health.