Allied Health Professions Australia

# Submission to Consultation on A New Aged Care Act – The foundations (Consultation paper No. 1)

**September 2023**

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

Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
www.ahpa.com.au
office@ahpa.com.au

## 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

These recommendations should not be regarded as exhaustive, but they point to the key changes that AHPA submits are necessary for meaningful amendment of the Aged Care Act that supports a high quality aged care system focused on the individual needs of older people.

### Recommendation 1

The new Act and supporting material should clarify how different aspects relevant to provider obligations are intended to interrelate, such as the revised Quality Standards, current Schedule 1 of the *Quality of Care Principles 2014*, and the proposed Statement of Rights.

### Recommendation 2

The new Act and supporting material should clarify the interpretive interrelationship among the Statement of Purpose, Objects, Statement of Rights and Statement of Principles, including specifying where legally necessary that the Statement of Purpose, Objects and Statement of Rights have primary authority in interpreting the meaning of the Act as a whole.

### Recommendation 3

The Objects should clearly reference the Statement of Rights, to ensure that upholding the various rights are central to operation of the new Act. If deemed legally necessary, the Objects should also state that the new Act gives effect to Australia's obligations under various applicable, listed international human rights conventions.

### Recommendation 4

The Objects should provide a brief overview of the core rights in the Statement of Rights, and include reablement as a core function of the aged care system. Details are outlined in our responses to Questions 3 and 10-12.

### Recommendation 5

Subject to consultation with First Nations communities and aged care services, the Objects should include:

> 'To provide aged care to First Nations peoples that is culturally safe and recognises the importance of their personal connection to community and Country.'

### Recommendation 6

The Purpose should include upholding the rights in the Statement of Rights, including the right to high quality care and services. The Purpose should also state that where applicable, the Statement of Rights should be taken into account in interpreting the Act and any instrument made under the Act.

### Recommendation 7

The centrality of reablement to care that must be provided, with reablement defined as per Recommendation 4, should be included in the Statement of Purpose.

### Recommendation 8

The Statement of Purpose, Objects, Statement of Rights and Statement of Principles in the new Act should all clearly embed the concept of needs-based care. The Act should require use of a nationally consistent, evidence-based, assessment and care planning tool, to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care.

### Recommendation 9

The Statement of Rights should list the rights of people seeking and receiving aged care, using a level of generality adapted from Royal Commission Recommendation 2 (for detail, see our response to Question 7).

### Recommendation 10

Government should consult with the Australian public concerning whether to establish an independent entity to interpret and enforce the rights in the Statement of Rights, as well as providing education and training on those rights.

### Recommendation 11

In addition to Recommendation 9, the Statement of Rights should expressly include:

- the right to receive high quality aged care services; and
- the human right to a standard of food, nutrition and nutritional care that supports health, wellbeing and quality of life.

### Recommendation 12

In addition to Recommendations 9 and 11, and the human rights conventions currently proposed in the Consultation paper, the Statement of Rights should include the rights in:

- the International Covenant on Civil and Political Rights;
- the Convention on the Elimination of Racial Discrimination;
- the Declaration on the Rights of Indigenous Peoples; and
- the Convention on the Elimination of all forms of Discrimination Against Women.

### Recommendation 13

The Statement of Principles should make clear that it is intended as a non-exhaustive, guiding list of how the Statement of Rights is intended to operate in the aged care system.

### Recommendation 14

Proposed Principle 9 should not be included in the Statement of Principles.

### Recommendation 15

The definition of 'high quality care' included in the new Aged Care Act should be consistent with Royal Commission Recommendation 13(2).

### Recommendation 16

High quality care, as defined in Recommendation 15, should be embedded in the new Act as the compliance and enforcement standard, aligned with the Statement of Rights.

## The place of allied health in the aged care system

It is important to contextualise our submission by providing background on the state of allied health in aged care. Allied health is currently significantly underprovided and underfunded, and for a human rights-infused Aged Care Act to be truly meaningful, this must be addressed. New foundations of the Act must embed an aged care system that genuinely meets older people's assessed allied health needs. In this sense, impacts on provision of needs-based allied health services can function as a litmus test for the efficacy of a new Act.

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 below are relevant to the aged care system as a whole. The submission also devotes a detailed section to discussion of the Quality Standards, because as outlined below, their content and place in the regulatory system is critical to the success of the new Act.

### Royal Commission findings on allied health

In its Final Report, the Royal Commission into Aged Care Quality and Safety ('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.[1]

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);

[1] 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.

- 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.

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.[2] 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.[3]

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

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.[7]

---

[2] 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.

[3] 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.

[4] 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.

[5] 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.

[6] Ibid, p24.

[7] 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.

Accordingly, the Royal Commission also concluded that allied health should be regarded as a fundamental element of the aged care system.[8] The Royal Commission made multiple associated recommendations, including for implementation of multidisciplinary care.[9]

The Royal Commission 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.[10] This 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 then follows that in order to meet the recommended 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 new AN-ACC model.

Although the AN-ACC is a funding tool, it does not itself prescribe the amount or types of care to be provided. As we outline in our response to Question 5, 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.[11] The AHSRI team emphasised that the current version is only the first step in a necessary development process,[12] and that adequately building allied health into the AN-ACC would take several years.[13]

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. Recent analysis of whether AN-ACC funding is sufficient, by the University of Technology Sydney Ageing Research Collaborative ('ARC'), appears to only factor nursing and personal care into its definition of direct care. Even with this limited definition, the ARC concludes that currently:

---

[8] 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.

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

[10] See eg Recommendations 36 and 38.

[11] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 180.

[12] 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.

[13] 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/ .

> '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.'[14]

Providers have also tended to use any surplus from direct care to try to address growing deficits in accommodation and cost of living expenses,[15] 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.

This is also having a flow on effect to costing, pricing and funding of future allied health services. AHPA supported the establishment of the Independent Health and Aged Care Pricing Authority ('IHACPA') to set aged care pricing. Residential aged care pricing principles include that payments should be based on residents' needs,[16] and IHACPA's 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.[17]

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.

### Provision of allied health in residential aged care

Before the commencement of Quarterly Financial Reporting ('QFR'), the Department assured stakeholders that allied health would be sufficiently funded under the AN-ACC, by referring to a yardstick derived from StewartBrown data.[18] 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.[19]

The October to December 2022 Quarterly Financial Snapshot ('QFS Quarter 2') – the first one to reflect the impact of the AN-ACC model – showed exactly this result of 4.6.[20] The latest QFS (January to March 2023, 'QFS Quarter 3') reports 4.55 minutes.[21] This means 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.

---

[14] 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.
[15] Ibid, 19.
[16] *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.
[17] Pricing Framework, 22; Consultation Report, 34-36.
[18] https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc , as of July 2022.
[19] https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ , 3-8.
[20] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23, October to December 2022, 13-14.
[21] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23, January to March 2023, 14-15.

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.[22]

### Provider underreporting?

After the July to September 2022 QFS ('QFS Quarter 1') reported 5.6 allied health minutes, 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 AN-ACC funding.[23] We have now seen subsequent QFSs report 4.6 and 4.55 minutes for allied health, showing that there has been a decrease in allied health minutes since AN-ACC commenced.

When the QFS Quarter 2 was published, the Department referred to the fact that the majority of providers did not report any allied health under categories such as occupational therapy, to suggest that the real problem was not service underprovision, but providers underreporting allied health service provision.[24] Departmental commentary in the QFSs for Quarters 2 and 3 accordingly suggests that providers may still be adjusting their approach to record-keeping for allied health services in order to align with the new QFR requirements.

However, it does not seem commonsense for providers not to report allied services that they are spending AN-ACC funds to provide. Moreover, the QFS 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.[25] 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.[26]

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,[27] 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.

---

[22] Ibid, 15.

[23] Department meeting with Allied Health Professions Australia, 2 March 2023.

[24] See eg Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022, 14; Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23 January to March 2023, 15.

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

[26] Slightly older 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.

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

However, this is not evident from a comparison of QFS Quarter 3 with QFS Quarter 2. For Quarter 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.[28] For Quarter 3 the equivalent figure was 70 to 80 per cent.[29]

### Impacts on quality of care

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. Fewer average minutes mean allied health professionals can often only provide reactive care at best, rather than collaborating in best practice multidisciplinary team approaches. In a recent sector survey, allied health professionals noted deterioration in the quality of allied health care available to residents.[30]

There is also 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.

## Aged care regulation and allied health

The Department continues to state that the present aged care regulatory system guarantees a sufficient level of allied health.[31] We disagree.

### Quality Standards and allied health

Current regulation is centred on application of the Aged Care Quality Standards ('Quality Standards').[32] In particular, care and services, including allied health, must be provided in a way that complies with the Quality Standards.[33]

---

[28] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 2 2022-23 October to December 2022, 14.
[29] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 3 2022-23 January to March 2023, 15.
[30] https://ahpa.com.au/advocacy/3489-2/ .
[31] 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). See also 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.
[32] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5, and Schedules 1 and 2.
[33] *Quality of Care Principles 2014*, ss 6-7.

The implications for allied health have been noted:

> '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 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.'[34]

The 'proof in the pudding' of aged care regulatory effectiveness then rests on the content of the Quality Standards and how they are addressed 'on the ground' by providers and the regulator. Yet as we have outlined with regard to residential aged care, allied health is grossly underprovided and services are inappropriately substituted.

The failure to ensure quality (including sufficient provision) of allied health services stems from two main regulatory weaknesses. First, the process for monitoring compliance is weak. The existing regulator, the Aged Care Quality and Safety Commission ('ACQSC'), was found by the Royal Commission to have a poor track record,[35] and the recent Report of the Independent Capability Review of the ACQSC found significant problems with quality assurance, including inconsistent application of the Quality Standards.[36]

The second significant flaw is the content of the Quality Standards. The Royal Commission found that the current Quality Standards do not set a sufficiently high bar,[37] and that '[t]he lack of objectively measurable Standards in aged care is concerning.'[38] 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.[39]

The Department led a review of the non-clinical Quality Standards in 2021-22, with clinical care standards for aged care being similarly reviewed by the ACSQHC. 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.

---

[34] Regulatory Impact Statement for the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022, 198.

[35] 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.

[36] 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).

[37] 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.

[38] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3a A new system*, 2021, 123.

[39] In contrast, the Royal Commission recommended that the entire standard-setting role be transferred to the (renamed from Australian Commission on Safety and Quality in Health Care) Australian Commission on Safety and Quality in Health and Aged Care.

In November 2022 AHPA provided a submission on the ensuing set of draft 'strengthened' Quality Standards.[40] 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 a lack of concrete quality outcome measures and any mandated benchmark for allied health care minutes, together with 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 2022 submission considered how each of the proposed Quality Standards might be applied by the ACQSC in regulating compliance, and where deemed 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. AHPA also submitted that achieving and maintaining quality aged care entails scrutiny of other 'pieces of the puzzle', including the performance of the ACQSC.

AHPA's proposed amendments are not reflected in the draft 'strengthened' Quality Standards,[41] and we have not seen any new guidance material. Accordingly, even when the draft 'strengthened' Quality Standards are implemented, on the whole they will not help to ensure compliance with the definition of allied health proposed by the Royal Commission's allied health recommendations.[42]

The recent Report of the Independent Capability Review of the ACQSC 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.'[43]

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.'[44]

The Report also refers to the commencement by the ACQSC of a pilot of the draft 'strengthened' Quality Standards ('Pilot') which would test:

---

[40] https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ .

[41] Draft Revised Aged Care Quality Standards (strengthened Standards), received 23 February 2023.

[42] 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.

[43] *Report of the Independent Capability Review of the Aged Care Quality and Safety Commission* (David Tune, 31 March 2023), 62.

[44] Ibid.

> ‘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.’[45]

Neither AHPA nor our individual peak body members have ever been consulted about the Pilot, so it is unclear to us whether there has been any allied health input into the Pilot design. Despite a response to AHPA from the ACSQC that allied health professionals are highlighted in the draft ‘strengthened’ Standard 5 (Clinical Care), only the aged care providers who engage allied health professionals are involved in the Pilot itself.

## Structure, purpose and constitutional foundation of the new Act

### 1. Do you think the aged care legislative framework will be more accessible and transparent if there is a single piece of primary legislation and one set of Rules?

Yes, provided there is a clear structure to the new Act and the Rules, so that it is obvious where topics like regulation and funding sit.

**Recommendation 1**

The new Act and supporting material should clarify how different aspects relevant to provider obligations are intended to interrelate, such as the revised Quality Standards, current Schedule 1 of the *Quality of Care Principles 2014*, and the proposed Statement of Rights.

For more detail, see our responses to Questions 5, 9, 13 and 15.

The interpretive interrelationship among the Statement of Purpose, Objects, Statement of Rights and Statement of Principles also needs to be clarified, especially for the general public. In this regard, current consultation material is at best confusing, and at worst offers false hope, about the practical value of the rights in the proposed Statement of Rights.

For example, the Statement of Principles is proposed to be incorporated in the new Act to ‘help guide decision making to ensure the new Act is administered in a manner consistent with its purpose’ (Consultation paper No. 1 [‘CP’], 21). The proposed Statement of Rights is described as having a similar function (ibid), but it appears that where content covers similar ground, the Statement of Principles would be intended to ‘translate’ the Statement of Rights into obligations on aged care providers and workers (CP, 22).

The confusion in the Consultation Paper is that it suggests both that the two Statements have equivalent status, but also that one provides guidance for the other. As we outline in our responses to Questions 5, 6, 9 and 13, overall, there is an equivocal approach to rights in the proposed new Act. If the two Statements are to have equivalent ‘guidance’ status, AHPA is very concerned that the legislation will pay lip service to any notion of rights as genuinely capable of being upheld, and instead will treat them no differently to rights under the current Aged Care Charter.

In the Royal Commission’s recommendations for two separate Statements, it made it clear that rights – including to high quality care (Recommendation 1) – and the ability to enforce them, should be at the centre of the new Act (Recommendation 2), with the Statement of Principles providing guidance to that end (Recommendation 3).

[45] Ibid. See also https://www.agedcarequality.gov.au/about-us/stronger-standards-better-aged-care-program .

We prefer the Royal Commission's approach, with the proviso that the Principles should indicate what the Statement of Rights can practically mean 'on the ground' in the aged care system. For example, the right to life and the right to health in an aged care context translate into a Principle like 'ensuring the safety, health and wellbeing of people receiving aged care'. It will also be essential to develop associated guidance for providers and consumers (see our response to Question 6).

In addition, AHPA does not agree that the audiences for the two Statements are different. It should be incumbent upon every individual and entity operating in the aged care system to understand both rights and principles – particularly given that the ACQSC, which is not proposed by the Consultation Paper to be part of the 'rights' audience (CP, 21), is the present regulator.

It is also important that the Principles are not regarded as providing legal interpretive guidance on how those rights apply, given the considerable jurisprudence on various human rights conventions (see also our response to Question 6).

**Recommendation 2**

The new Act and supporting material should clarify the interpretive interrelationship among the Statement of Purpose, Objects, Statement of Rights and Statement of Principles, including specifying where legally necessary that the Statement of Purpose, Objects and Statement of Rights have primary authority in interpreting the meaning of the Act as a whole.

### 2. Would you prefer to access separate topic-based subordinate legislation (like the current Quality of Care Principles 2014 and the Subsidy Principles 2014)?

No – see our response to Question 1.

### 3. What else would you like to see included in the Objects of the new Act?

The Objects should include a brief framing of the core themes of the new Act, and should clearly reference the Statement of Rights (see our responses to Questions 5-7), to ensure that upholding the various human rights are central to operation of the new Act.

AHPA leaves it to others to determine whether in order to provide significant authoritative weight, it is also necessary to still include under the Objects that the new Act gives effect to Australia's obligations under various applicable international human rights conventions. If that is deemed necessary, the conventions and other international agreements listed should mirror those we propose for inclusion in the Statement of Rights (see our responses to Questions 6–8).

With regard to framing, AHPA broadly supports the wording of Royal Commission Recommendation 1(3), subject to these additions from the Consultation paper (CP, 11):

- assists older people to live active, self-determined and meaningful lives
- assists older people accessing funded aged care services to effectively participate in society on an equal basis with others
- promotes innovation in aged care based on research and supports continuous improvement

In addition, the Objects should incorporate any material currently in the proposed Principles that is not clearly linked to the human rights in the Statement of Rights, so that those rights carry the same authoritative weight as those in the Statement of Rights (see our responses to Questions 10-12).

We also propose an additional Object that could be added into the wording of Royal Commission Recommendation 1(3((a), consistent with our response to Question 5. This could be along the lines of Royal Commission Recommendation 25(a):

> 'A system of aged care that works to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to live independently as well as possible, for as long as possible'.

Alternatively, an object of the aged care system could be defined as having as a core function:

> 'To support reablement – rehabilitation and restoring, or at least preserving as much as possible, older people's capacities so that wellbeing is enhanced and/or maintained, including enabling and encouraging participants to remain in their home for as long as they wish and can do so.'

Lastly we propose addition of an Object, subject to consultation with First Nations communities and aged care services, along the lines of:

> 'Aboriginal and Torres Strait Islander people are entitled to receive support and care that is culturally safe and recognises the importance of their personal connection to community and Country.'

**Recommendation 3**

The Objects should clearly reference the Statement of Rights, to ensure that upholding the various rights are central to operation of the new Act. If deemed legally necessary, the Objects should also state that the new Act gives effect to Australia's obligations under various applicable, listed international human rights conventions.

**Recommendation 4**

The Objects should provide a brief overview of the core rights in the Statement of Rights, and include reablement as a core function of the aged care system. Details are outlined in our responses to Questions 3 and 10-12.

**Recommendation 5**

Subject to consultation with First Nations communities and aged care services, the Objects should include:

> 'To provide aged care to First Nations peoples that is culturally safe and recognises the importance of their personal connection to community and Country.'

**4. Do you think it is a good idea to include a 'Purpose Statement' in the new Act, as well as objects provisions? What do you think the purpose of the new Act should be?**

Yes. See our response to Question 5.

**5. Do you have any other feedback on the proposed structure of the new Act?**

AHPA uses this Question to make some general comments about the proposed new legislative approach.

The proposed new Act purports to be the Government response to recommendations from the Royal Commission into Aged Care Quality and Safety. However, AHPA is concerned that there are very significant differences between the Government approach and the Royal Commission's vision.

*Weak approach to rights*

The Royal Commission recommended a rights-based approach to guarantee universal access to the supports and services that an older person is assessed as needing. The Commissioners envisaged the new system as 'enshrining' rights, 'leav[ing] no doubt to all involved in the system about the importance placed on these rights', and 'guarantee[ing] universal access to the supports and services that an older person is assessed as needing.'[46]

The model as currently proposed in the Department's consultation material is considerably weaker, and does not provide confidence that the relevant human rights of older people receiving aged care will be able to be meaningfully and consistently upheld. The differences compared to the Royal Commission findings lie primarily in the approaches to the definition and regulation of high quality care, and the function of the Statement of Rights.

The proposed ideal level of care recommended by the Royal Commission – high quality – is only aspirational in the new Act (see our response to Question 13). The Consultation paper's proposed function of the Statement of Rights is also weaker. The general language in the Department's consultation material is more equivocal than that required by a goal of enshrining rights – 'takes into account' (Objects, CP, 11), 'where possible' (CP, 12), 'balance the diverse needs of older people accessing aged care services and the challenges facing the sector' (CP, 28), '*encourage* delivery of high quality care' (Fact Sheet 1, emphasis added).

Overall, this kind of language is consistent with an approach that blends a rights-based framework with a voluntary compliance model, as also flagged in the Consultation on A New Model for Regulating Aged Care. As outlined in our submission to that consultation, it is an approach that AHPA strongly rejects.[47]

**Recommendation 6**

The Purpose should include upholding the rights in the Statement of Rights, including the right to high quality care and services. The Purpose should also state that where applicable, the Statement of Rights should be taken into account in interpreting the Act and any instrument made under the Act.

### Reablement

The proposed new Act's weaker approach is also demonstrated by some of the proposed content of the Purpose, Objects, Statement of Rights and Statement of Principles. One illustration is the place of the concept of reablement in the new Act. Royal Commission Recommendation 25(a) sets out as one of the core features of the new aged care program that there should be:

> 'a common set of eligibility criteria identifying a need (whether of a social, psychological or physical character) to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to live independently as well as possible, for as long as possible'.

In comparison, the nearest the Consultation paper gets is in the Principles:

> 'maintaining or improving their physical and cognitive capabilities for as long as possible, with a focus on enablement, except where palliative care outcomes are discussed and agreed to. . .(CP, 22).'

[46] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 79.
[47] https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .

The proposed Purpose Statement merely has the aim of assisting older people 'to continue to live active, self-determined and meaningful lives as they age' (CP, 12). The proposed Objects simply include: 'assists older people to live active, self-determined and meaningful lives' (CP, 11).

In order to avoid any interpretive confusion about the centrality of reablement to care that must be provided, reablement along the lines of the Royal Commission wording should be included in the Purpose as well as the Objects.

**Recommendation 7**

The centrality of reablement to care that must be provided, with reablement defined as per Recommendation 4, should be included in the Statement of Purpose.

### Needs assessment

Royal Commission Recommendation 25(b) emphasises 'an entitlement to all forms of support and care which the individual is assessed as needing'.[48] In contrast, the proposed new Act is inconsistent: while the Purpose includes 'facilitate access by older people to quality and safe, funded aged care services, based on their individual needs' (CP, 12), the Objects simply refer to '[taking] into account the individual needs of older people' (CP, 11). The Statement of Rights refers to 'available aged care services' that older people 'have been assessed as needing' (CP, 16), and the Statement of Principles simply refers to older people 'in need' (CP, 23).

Provision of allied health services and other aged care should be based on clinical assessment of residents' needs. However, current QFR does not facilitate analysing 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 not designed for the provision of clinical care assessment and planning. The AHSRI recommended the separation of assessment of residents for funding purposes, from the assessment of residents for delivery of appropriate care.[49]

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. 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

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

[49] 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/ .

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 nationally consistent, 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 8**

The Statement of Purpose, Objects, Statement of Rights and Statement of Principles in the new Act should all clearly embed the concept of needs-based care. The Act should require use of a nationally consistent, evidence-based, assessment and care planning tool, to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care.

Other aspects of the proposed approach are difficult to comment on at this stage because the detail has not yet been provided, such as how provider obligations and regulatory enforcement under the Quality Standards are intended to relate to the Statement of Rights. However, see our responses to Questions 6 and 13.

## Statement of Rights and enforcement pathways

### 6. Do you support a Statement of Rights being included in the new Act?

Yes, but the legal status of the Statement of Rights, including its relationship to the regulatory framework, is not clear in the proposed new Act.

#### Legal status

Despite the proposed inclusion in the Objects that the Act gives effect to Australia's obligations under the Convention on the Rights of Persons with Disabilities ('CRPD'), the International Covenant on Economic, Social and Cultural Rights ('ICESCR'), and 'other relevant instruments' (CP, 11), nowhere in the Consultation paper are rights described as human rights.

An outline of the proposed Statement of Principles as providing 'an additional level of surety' proposes consistency with the Objects, the Purpose Statement and operational provisions under the Act, so that aged care consumers' 'interests, needs and personal circumstances will be recognised and respected when actions are taken under the new Act' (CP, 21). However, this role description does not even mention the Statement of Rights, or even 'rights'.

Treaties such as the CRPD and the ICESCR are embedded in an international regulatory system designed to uphold human rights. In contrast, although the consultation material sometimes refers to rights, the language is more tentative and vague. For example, in a discussion of achieving high quality care:

> 'The new system needs to be *constructed and managed to ensure registered providers are funded, supported and incentivised* to continually improve their services, and *take into account, and balance* the diverse needs of older people accessing aged care services *and the challenges facing the sector*, particularly in remote and regional Australia (CP, 28, emphasis added).'

#### Place in the regulatory framework

When the proposed aspirational status of 'high quality' care and services (see our response to Question 13) is combined with the narrow application of the proposed new duty of care (see our

response to Question 15), there will be a large gulf in the proposed new regulatory approach between 'substandard care', and care that is not high quality.

As far as AHPA can ascertain from the Consultation paper, under the proposed new Act, regulation of compliance is primarily intended to entail, as currently, application of the Quality Standards by the ACQSC. In the absence of any indication that the Quality Standards will be further revised to meaningfully incorporate the Statement of Rights, this regulatory approach is not likely to bridge the 'quality gap'.

This is because apart from the new duty, enforcement options will mainly still rely on current mechanisms of complaints, incident reporting and provider assessment, with a few possible additional remedies. As our submission outlines in 'Aged care regulation and allied health' above, present regulatory mechanisms, together with the Quality Standards themselves, are not up to the task.

AHPA is therefore very concerned that there are significant obstacles to realising the potential of the Statement of Rights within the existing regulatory framework. For other relevant commentary, we refer to our June 2023 submission to the Consultation on A New Model for Regulating Aged Care.[50]

### Recommended changes

Rights in the Statement must be enforceable. Consequently, and given that conventional legal interpretation ascribes more authoritative weight to the objects and purpose of legislation, we recommend that both should clearly reference the Statement of Rights (see our responses to Questions 3 and 5).

Upholding the various rights should be central to operation of the new Act. Accordingly, the Statement of Rights should list the rights of people seeking and receiving aged care, using a level of generality adapted from Royal Commission Recommendation 2 (for more detail, see our response to Question 7).

AHPA is also concerned that – perhaps associated with the equivocal approach to the status of aged care consumers' human rights – the consultation material gives no consideration to how those rights will be adjudicated, with the implication that somehow they will dovetail with the Quality Standards and be interpreted and applied by the ACQSC.

This task is made all the more difficult by the absence of overarching federal human rights legislation. Consideration should be given to establishing an independent entity to interpret and enforce the rights in the Statement of Rights, as well as providing education and training.

**Recommendation 9**

The Statement of Rights should list the rights of people seeking and receiving aged care, using a level of generality adapted from Royal Commission Recommendation 2 (for detail, see our response to Question 7).

**Recommendation 10**

Government should consult with the Australian public concerning whether to establish an independent entity to interpret and enforce the rights in the Statement of Rights, as well as providing education and training on those rights.

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

### 7. Are there any rights that you think we have missed that should be included?

Provided the Statement of Rights is legally enforceable, it should include the right to receive high quality aged care services (see our response to Question 13).

The Statement of Rights should also expressly include the International Covenant on Civil and Political Rights, the Convention on the Elimination of Racial Discrimination, the Declaration on the Rights of Indigenous Peoples and the Convention on the Elimination of all forms of Discrimination Against Women, in addition to the others currently proposed.

AHPA also supports the submission to this Consultation from our member Dietitians Australia, that the Statement of Rights includes the human right to a standard of food, nutrition and nutritional care that supports health, wellbeing and quality of life.

Otherwise, as indicated in our responses to Questions 1 and 3, AHPA prefers the level of generality in the Statement of Rights expressed in Royal Commission Recommendation 2. Consequently, many aspects of the rights proposed in the Consultation Paper (CP, 16-17) would be better in the Objects or the Principles. Other aspects retained in the proposed Statement of Rights should clearly use the language of the international conventions where relevant, as these have a particular legal nuance.

**Recommendation 11**

In addition to Recommendation 9, the Statement of Rights should expressly include:

- the right to receive high quality aged care services; and
- the human right to a standard of food, nutrition and nutritional care that supports health, wellbeing and quality of life.

**Recommendation 12**

In addition to Recommendations 9 and 11, and the human rights conventions currently proposed in the Consultation paper, the Statement of Rights should include the rights in:

- the International Covenant on Civil and Political Rights;
- the Convention on the Elimination of Racial Discrimination;
- the Declaration on the Rights of Indigenous Peoples; and
- the Convention on the Elimination of all forms of Discrimination Against Women.

### 8. Are there any rights that you think should be worded differently?

Yes – see our response to Question 7.

### 9. We consider it critical that person-centred complaints pathways are available for older people to seek early resolution of concerns about their rights. This is because the ideal scenario is where the registered provider or if necessary, the Commission can address risks early, instead of using enforcement mechanisms after harm has already occurred. Do you think we have the balance right?

No. AHPA has previously detailed our disagreement with the risk-based approach as conceptualised in the Department's Consultation Paper No. 2 *A new model for regulating aged care* (April 2023).[51]

[51] Ibid.

This approach risks supporting a system where strategies to maintain and promote high quality are confused with quality assessment for legislative compliance. The likely result will be that compliance requirements are located more at the voluntary end rather than the enforcement pole of the spectrum of regulatory mechanisms – to the detriment of high quality care, including allied health provision.

See also our response to Question 13.

## Statement of Principles

### 10. Do you support a Statement of Principles being included in the new Act as well as a Statement of Rights?

### 11. Are there any principles that you think we have missed that should be included?

### 12. Are there any principles that you think should be worded differently?

As submitted in our response to Question 1, the legal status of the Statement of Principles needs to be made clear. AHPA's preference is for the Statement of Principles to provide 'lower level' indications of the implications of the Statement of Rights for aged care service provision and associated matters.

Proposed Principle 9 states:

> 'The aged care system should fund aged care services, which are not unlimited, for older people most in need - taking into account the individual needs of older people, and with individuals expected to meet some of the costs of services they use where they have the financial means to do so.' (CP, 23).

AHPA submits that this is inappropriate to include in the new Act, given that the Aged Care Taskforce is currently deliberating. In particular, the phrase 'which are not unlimited' is commentary and does not belong in legislation. It is also incompatible with Royal Commission Recommendation 3(b)(xix), and may be potentially inconsistent with the Statement of Rights.

### Recommendation 13

The Statement of Principles should make clear that it is intended as a non-exhaustive, guiding list of how the Statement of Rights is intended to operate in the aged care system.

### Recommendation 14

Proposed Principle 9 should not be included in the Statement of Principles.

## Definition of high quality care

### 13. Are there any changes you would make to the proposed definition of high quality care?

In the aged care system proposed by the new Act, high quality care is expected to 'grow over time' and to be differentiated from 'the "standard" delivery of quality and safe aged care services in line with specific legislative requirements' (CP, 26). Consequently, in this approach, high quality care is aspirational, and it is only the delivery of 'quality and safe' aged care services that will be enforced.

The Royal Commission said that high quality care must be the foundation of aged care. Recommendation 1 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, and Recommendation 13 refers to 'embedding high quality aged care'.

Even if it were not merely aspirational, the proposed new Act's definition of high quality is also not as strong as the Royal Commission's. Recommendation 13 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).

In comparison, the Consultation paper (27) simply proposes supporting the person to enhance their physical and cognitive capacities and mental health, and only 'prioritises' various aspects, which AHPA submits should be a core aspect of care and services that are deemed to meet regulatory standards.

Even in these prioritised aspects there are missing elements; for example, 'providing funded aged care services that are trauma aware and healing informed' makes no reference to those services being required to be delivered by those who are suitably trained and qualified to do so.

Similarly, the proposed definition of high quality care refers to 'aged care services that are *responsive* to the person's *expressed* personal needs' (emphasis added). Unlike Royal Commission Recommendation 13, this does not include the consistent, system-wide skilled assessment of those needs, as outlined in our response to Question 5.

Royal Commission Recommendation 13 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 much more strongly aligned with what is required for the provision of high quality allied health services.

Perhaps the biggest question mark in the Consultation Paper is how the proposed aspirational status of 'high quality' will align with the proposed Statement of Rights (see our responses to Questions 1 and 6).

Consistent with Royal Commission recommendations, providers should be mandated to comply with a 'high quality' standard, not simply a 'quality' one (see our response to Question 7).

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.

**Recommendation 15**

The definition of 'high quality care' included in the new Aged Care Act should be consistent with Royal Commission Recommendation 13(2).

**Recommendation 16**

High quality care, as defined in Recommendation 15, should be embedded in the new Act as the compliance and enforcement standard, aligned with the Statement of Rights.

### 14. Outside of the new regulatory model, are there any other initiatives that you would like to see addressed in the new Act to encourage registered providers to aim higher and deliver high quality care?

Provision of high quality care must be the compliance standard, not simply be aspirational – see our response to Question 13. The ACQSC already has the required functions to assist in promoting

compliance and educating providers on their obligations. Our Recommendation 10 proposes consideration of a separate entity for adjudicating issues arising under the Statement of Rights, which might collaborate with the ACQSC on training and education.

## Approach to penalties and compensation pathway

### 15. Do you support inclusion of the new statutory duty of care in the new Act?

AHPA supports the concept of a statutory duty, but the proposed threshold for a breach is too high.

The suggested test for a potential breach already requires registered providers to be shown not to have taken reasonable steps to avoid their actions adversely affecting the health and safety of persons in their care. This might be expected to address provider failures to attain the quality threshold. But failures will only amount to a breach of the duty if they are 'serious'. Even then, penalties will only apply where a failure to take reasonable steps results in a risk to, or actual serious illness, injury or death of, an aged care consumer. A new remedy of compensation is similarly restricted to criminal breaches.

When this restricted cause of action is considered in the light of the proposed regulatory definition of quality (as opposed to the merely aspirational level of high quality), there will remain a large number of older people whose rights are not being upheld (eg the right to health when needs-based allied health is not sufficiently guaranteed).

This group includes people receiving care that is substandard but does not pass the two-step test for breach of duty of care (let alone the third step required for a penalty). Those people will have to rely on enforcement of the Quality Standards by the ACQSC, which is discussed in our response to Question 6.

Other examples will be where care may not be deemed 'substandard' but still falls under the proposed 'quality' regulatory bar, and hence will rely on the same processes. There will also continue to be many older people who do not receive high quality care but whose care meets the proposed 'quality' definition, and so there will be no enforcement pathway available at all. To date, that is likely to have been the experience of the vast majority of older people not receiving sufficient allied health services.

### 17. Do you support related duties being placed on responsible and governing persons of aged care providers?

Yes. This would be akin to obligations in other systems, and would seem to follow from standards of governance. See also Royal Commission Recommendation 14.

### 18. Do you think a related duty should be placed on aged care workers?

No, probably not. Unless they have been criminally negligent, they should be covered under employer/principal relationships, as for other similar occupations.

### 19. Do you think a separate duty should be placed on organisations that provide enabling services and/or facilitate access to aged care workers? What should be the extent of such a duty?

Yes. Again, this would seem to be akin to obligations in other systems. It is important to address the impact of factors such as funding shortfalls, if the provider has tried their best and through no fault of their own has not been able to deliver appropriate services.

### 20. Do you have any further feedback on the proposed approach to compensation?

There is insufficient detail in the Consultation paper to comment, and apart from the limited scenario under the proposed general duty, it is unclear when else compensation might be available as a remedy. As we note in our response to Question 6, the ACQSC is not the appropriate adjudicator.

## Approach to disclosure protections for whistleblowers

AHPA leaves comment on this theme to others who are more qualified.

## Approach to embedding supported decision making

AHPA leaves comment on this theme to others who are more qualified.

## Proposed access and eligibility arrangements and requirements

### 30. Do you support the proposed eligibility requirements under the new Act?

### 31. Do you have any concerns about people under 65, unless homeless or First Nations and over 50, being excluded from entering funded aged care services?

### 32. Are there other things you would like to see changed about entry arrangements for the aged care system?

AHPA supports the submission to this consultation from our member, Speech Pathology Australia (SPA), which raises significant concerns regarding the proposed eligibility criteria and associated definitions and processes.

Issues include:

- The new Act must expressly refer to, and provide for, cognitive and communication needs when people are attempting to access aged care.
- Currently proposed processes required to access aged care services are discriminatory.
- The proposed requirement that older people identify their issues and make an application for assessment to justify their 'care need' is problematic.
- While we generally support the principle of younger people under 65 years accessing services and supports outside the aged care system, there should be flexibility of access to aged care system supports for people under the age of 65 who have ageing-related conditions, and where no other supports exist.

We particularly endorse SPA's comments that the proposed eligibility components of the new Act do not incorporate an understanding of holistic care and reablement (see also our response to Question 5). One example is the current narrow definition of care needs. As SPA also submits, another illustration is proposed eligibility criteria which will only enable access to allied health services when the older person already needs assistance from someone else. This is antithetical to the concepts of prevention and early intervention which not only enhance wellbeing and function, but are cost efficient.

As SPA submits, if these issues of concern are not addressed, they are likely to produce barriers to access, and adverse outcomes for older people.