Allied Health Professions Australia

Submission to Office of the Inspector-General of Aged Care for 2024 Progress Report on Implementation of Aged Care Royal Commission Recommendations

March 2024

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

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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.

Overview

This submission focuses on the Commonwealth's progress towards implementing the Royal Commission's recommendations relevant to allied health services.

Accordingly, our submission mainly addresses Question 1 of the Office of the Inspector-General of Aged Care (OIGAC) Submission Process document. It refers to reform implementation priorities identified in the July 2023 Office of the Interim Inspector-General of Aged Care Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety ('Progress Report 1'), and to other relevant Royal Commission recommendations as numbered.

For each relevant theme, AHPA's submission focuses on identifying whether there have been any developments in implementation since our previous Response Table for Progress Report 1 ('Response Table').

The submission also refers to various appendices, several of which have previously been provided to the OIGAC but are also provided here for convenience.

Key issues for allied health

To 'set the scene' for our submission on implementation progress, we refer the OIGAC to our submission on the Exposure Draft of the new Aged Care Act (Appendix A).

Progress Report 1 (p 43) observes that implementation of a large number of recommendations are contingent upon commencement of the new Act. AHPA appreciates that the OIGAC's task of reporting on implementation of Recommendation 1 is focused on the process of developing and introducing the new Act, rather than the proposed content of the Act itself. We are aware that public consultation on the latter is coordinated by the Department of Health and Aged Care ('the Department').

Nevertheless, as Recommendation 1(2) and 1(3) and associated Recommendations 2 and 3 show, some assessment of elements of the content of the new Act is critical to any report on the overall progress of Royal Commission recommendations.

Further, the nature of the present issues confronting allied health in the aged care system requires us to address the broad aged care landscape, including changes proposed by the new legislation.

For these reasons, we refer to Appendix A, which outlines the key problems presently facing allied health in aged care: lack of system attention to the concept of reablement and the role of allied health; absence of benchmarks; underfunding; under-provision of services; inconsistent needs assessment; and little or no effective regulation. We direct the OIGAC particularly to our Recommendations and General Comments (pp 2-7).

As we further detail below, AHPA is deeply concerned that despite various ongoing reforms and the continued best efforts of the allied health sector, allied health care is at grave risk of being even further sidelined in the aged care system.

This will result in older consumers having to try to get their needs met via insufficient and often inappropriate processes in the health system or having to pay for allied health themselves as an optional extra, or simply not receiving key services that they need to live a good life as long as they can. Such outcomes would directly contravene Royal Commission findings and recommendations.

Reform implementation priorities (from Progress Report 1)

Priority area 1: Home Care

Progress Report 1 (p 11) reported stakeholder views that there is a need for greater focus and funding for allied health, including more substantial consultations with allied health providers. Although AHPA has had several discussions and other communication with the Department, we have significant concerns about the development of home care policy and the place of allied health.

Appendix B, Questions 8–15 demonstrates some of the unresolved issues where the allied health sector has not been given a sufficient opportunity to provide meaningful input or to express our concerns.

Most strikingly, AHPA understood that while initial work on developing the Support at Home policy intended to incorporate the provision of allied health on a reablement basis for all older people who need it (Royal Commission Recommendations 35–36), this has now been considerably narrowed to a focus on short-term restorative care, with the term simply to be extended from 8 to 12 weeks.

It appears that the Department is no longer committed to Recommendation 36 and that this recommendation was subject to consideration pending the Aged Care Taskforce Report, together with anticipated advice from the Independent Health and Aged Care Pricing Authority (IHACPA).

The Interim Inspector-General of Aged Care considered that a key and central priority should be on ensuring Support at Home is sufficiently funded to meet the care needs of all older people assessed as requiring support and care, in line with Recommendation 41, and that planning be based on need, not rationed (Progress Report 1, p 12). AHPA is profoundly disappointed that the Australian Government has expressly stated that this is not the intention (see our Appendix A, especially pp 8–12).

The final report of the Aged Care Taskforce has also not definitively answered the question of how allied health care for aged care residents should be funded. The Taskforce proposes to exclude from the new Support at Home program services that are already funded, or 'more appropriately funded', under other Commonwealth, state, territory or local government programs (see further our comments on Recommendation 69 below).

We know that even assuming all allied health needs are currently identified – which in the absence of consistent clinical assessment, is highly unlikely – some aged care consumers, whether at home or in a residential facility, end up accessing allied health services via a chronic disease management plan under the Medical Benefits Schedule. Under the MBS they are only eligible for a maximum of five appointments annually across all professions, usually with a gap payment. Alternatively, consumers may end up simply having to pay for allied health care themselves, or – if they have the resources to afford it – they use private insurance, and on top of premiums, again pay in part.

AHPA is also concerned about the impact of the proposed new regulatory framework on the availability of allied health providers in home care. Home aged care providers are proposed to be registered in Category 4 in order to contract or employ allied health professionals ('AHPs'). But there is a risk that aged care providers will consider the regulatory burden too great and therefore either will not engage AHPs, or the registration burden will end up falling on the AHPs themselves. For these reasons, the new regulatory system should include expedited pathways to registration, such as incorporating recognition of pre-existing registration (eg under the Australian Health Practitioner Regulation Agency or via individual self-regulating professions).

With respect to multidisciplinary team care as recommended in Recommendations 35-36, see Appendix B, Questions 6-8 and associated comments.

Priority area 2: Improving quality of residential care through funding and minimum care requirements

With regard to implementation of Recommendation 38, Progress Report 1 (pp 16-17) observed that the majority of stakeholders commented on allied health being excluded from sector-wide reforms such as care minute requirements, and from the provision of direct care in the AN-ACC funding model.

This situation has not improved. Indeed, the state of provision of allied health in residential aged care has further declined, to an average daily allied health figure of 4.21 minutes – less than half the average criticised by the Royal Commission. The Department continues to insist that there is no cause for alarm, and has claimed in each of the five Quarterly Financial Snapshots since Quarterly Financial Reporting (QFR) commenced that providers under-report allied health.

The Interim Inspector-General's observation that questions remain about the sufficiency of funding for allied health in residential care settings (Progress Report 1, p 20) is also even more relevant at the present time. Although the Aged Care Taskforce final report recommends that government funding continue to focus on care costs (Taskforce Recommendation 9), it fails to acknowledge the current lack of any designated funding for allied health, unlike care minutes for nursing and personal care.

At present, residential aged care providers do not necessarily have to provide and pay for some kinds of allied health services – they are simply required to provide 'access' to them. As with home care, this results in consumers often having to pay for allied health care themselves, or at best

they have to make a part payment under Medicare and receive only five treatments a year, or they use private insurance if they have the resources to afford it and can pay a gap fee.

We do not actually know how much of the current allied health services provided to residents are paid for outside AN-ACC (or paid for outside Government home care funding), because this data is neither collected nor monitored as part of ensuring provider compliance with quality care obligations. Implementation of Recommendation 38(d) therefore also remains a vexed issue: see Appendix B, Questions 2–5.

With respect to multidisciplinary team care as recommended in Recommendations 37-38, see Appendix B, Questions 6-7 and associated comments.

Other relevant Royal Commission recommendations

Recommendation 6 (and Recommendations 11, 115 and 116)

AHPA's Response Table submitted that IHACPA's approach to allied health costing is deeply problematic. This issue has become even more pressing: see Appendix C.

Recommendation 8

Not satisfactory. Further to our Response table comment, we note that at present there is no Commonwealth Chief Allied Health Officer (CAHO), and there has not been for some months. This means allied health has no one at a sufficiently senior level in the Department to incorporate the views of the allied health sector, or even communicate relevant information and initiatives.

To illustrate, AHPA belatedly discovered the Office of CAHO is developing a National Allied Health Workforce Strategy – an initiative for which we have advocated for some time. However, governance arrangements do not include any industry representation, despite the strategy scope including primary, disability and aged care sectors.

AHPA also repeats our concern about the continuing trend for the Department to outsource key aspects of the reforms and ensuing mechanisms to private consulting firms (see eg Appendix C). In our experience this has often resulted in poor outcomes.

Recommendations 13-14

Not implemented or not satisfactory – see Appendix A.

Recommendation 19

Our comment in the Response Table stands. See also Appendix A, pp 6-7.

Recommendations 22-23

Still in progress (public consultation).

Recommendation 24

Our comments in the Response Table stand.

Recommendation 28

Problematic – see Appendix B, Questions 9-12.

Recommendations 31-32

Our comments in the Response Table stand. See also Appendix B, Questions 6-8 and associated comments.

Recommendation 37

See Appendix B, Questions 3-4 and preceding comments.

Recommendation 58

Not implemented. See also Appendix B, Questions 6-8 and associated comments.

Recommendation 59

Our comments in the Response Table stand (and also with reference to the mental health aspects of Recommendation 61).

Recommendation 67

As far as AHPA is aware, not implemented (see also our comments below on Recommendation 69).

Recommendation 69

Not implemented – see Appendix D and Appendix B, Questions 1-4.

Recommendation 71

As far as AHPA is aware, not implemented (see also our comments above on Recommendation 69).

Recommendation 72

With respect to the response from the Department and the Aged Care Quality and Safety Commission for Progress Report 1, see Appendix B, Question 8. Otherwise, as far as AHPA is aware, not implemented.

Recommendation 75

With respect to allied health, not implemented. See Appendix B, Question 16; and our comments concerning Recommendation 8 above.

Recommendation 122

With respect to allied health, not implemented due to problematic QFR processes (see Priority Area 2 above and Appendix A, p 4).

Recommendation 125

Not implemented. AHPA looked to the Taskforce report for some certainty on recommended funding directions, but most detail has been left to Government (see Priority 1 and Priority 2 above).

Recommendations 127-129

Partly implemented. AHPA looked to the Taskforce report for some certainty on recommended funding directions, but most detail has been left to Government (see Priority 1 and Priority 2 above).