SUBMISSION

Allied Health Professions Australia

Royal Commission into Aged Care Quality and Safety

Supplementary Submission – Hearing 4, Program Redesign

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Allied Health Professions Australia
Level 8, 350 Collins Street, Melbourne VIC 3000
Phone: 03 8676 0634 Email: office@ahpa.com.au
Website: www.ahpa.com.au

Introduction

Allied Health Professions Australia (AHPA) is pleased to provide a brief response to the Royal Commission into Aged Care Quality and Safety Counsel Assisting's Submissions on Program Redesign. We recognise that the upcoming hearing will focus on allied health related issues and will be an opportunity to explore these issues in more detail so we will not seek to provide an overly long response. However, we have identified several points that should be addressed as soon as possible and will seek to highlight those here.

In responding, AHPA reiterates our strong support for the work of the Commission and counsel assisting. We are pleased to see the strong recognition for the need to move away from a rationed funding environment and for the need to focus on wellness, reablement and rehabilitation in the aged care environment. It is incredibly pleasing to see the role of allied health professionals being seriously addressed. We continue to take the view that there is a strong need to begin taking a rights-based approach to services for older people, based on similar principles to those that apply for people with disability.

Allied health interventions are essential to enabling participation, supporting the maintenance and improvement of functionality and compensating for functional loss and mental ill-health. As previously argued, we consider it inappropriate to settle for poorer outcomes for older Australians than other members of the community simply based on their advanced age or an expectation of a shorter lifespan.

We continue to argue that the allied health role is one that should be specifically highlighted alongside the care workforce role, noting that allied health professionals are specific enablers of greater participation in life, whatever the capacity of the individual. Without a strong and central role for allied health services, we remain concerned that we will not achieve the intentions of the new Aged Care standards and refocus our aged care system on creating the basis for greater dignity, control and quality of life for older Australians.

AHPA is the national peak body representing Australia's allied health professions. We have 20 allied health member associations and a further eight affiliate members with close links to allied health. The AHPA membership represents some 130,000 allied health professionals working across a wide range of settings and sectors. A significant proportion of those allied health professionals provide care to older Australians.

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

General comments

- **Needs-based entitlement**
  AHPA strongly supports reforms to the aged care system that uncap the supply of funding packages and places and create confidence for older Australians and providers that the funding required to meet assessed needs can be delivered. In moving to an uncapped supply, we recognise the need to link funding levels to the costs of providing care. However, we counsel caution in setting efficient standardised costs for allied health services due to the wide range of individual needs that may arise and the lack of current data to base this on. We argue both for reviewing the pricing work done by the National Disability Insurance Agency (NDIA), which has sought to benchmark costs for allied health services, and for seeking to build on the data from that Scheme as well as aged care to ensure a more representative and useable foundation. We also note in this context that efficient standardised costs requires the identification and mandating of best practice programs of care for particular areas of need—e.g. if an older person is identified as having particular needs in relation to mobility and falls risk, then appropriate interventions should be identified and mandated for any consumers with that need identified. In this case funding could be relatively standardised though with provisions to ensure access including travel subsidies if appropriate providers are not available onsite.

- **Comprehensive assessment and care planning**
  AHPA strongly supports the need for comprehensive assessments to be undertaken to establish eligibility for funding and the closely related need for detailed care planning to be undertaken in order to identify and fund the individual needs of the older person. We agree that this has the potential to drive a shift to higher quality care. We argue that careful thought should be given to how these assessors are positioned in relation to both the funder and the provider, noting the potential to learn from the current Department of Health trial around assessments under the proposed AN-ACC aged care funding model and the NDIS trial of independent assessors. We argue for the need to establish baseline qualifications for those assessors, with either allied health qualifications or allied health and nursing requirements established as requirements in the aforementioned programs. This baseline has been determined as essential to understand not only care needs but the broader range of factors and complexities that inform the individual care needs of the older person being assessed. In addition, we note the benefit of independence while also noting the challenge of ensuring consistency of expertise and interpretation across a national workforce. The latter in particular has proved difficult in the NDIS planner and local area coordinator context and so we argue for the need to consider the experiences of that program carefully in developing recommendations.

- **Pathways for access to services**
  AHPA strongly endorses the need to have a ‘no wrong door’ approach to service access and note that in addition to general practice, a range of allied health services with primary contact roles are potential connectors for people. For example, an optometrist may well be involved in identifying vision issues that mean an older person requires additional home

supports, or a speech pathologist, physiotherapist or occupational therapist may be involved in providing privately-funded support or post-acute support after an older person has been discharged and in that capacity identify functional support needs best provided by the aged care system.

- **Data collection and analytics**
  AHPA argues strongly for the need to improve data collection and analytics across aged care and the related primary and acute health systems. For data to drive effective policy, it will be important to support the development of minimum datasets and the linking of data across health and aged care, and to support access to the tools needed for data extraction for allied health providers, specialists and aged care providers. Current systems used by most of these providers do not have the capacity to extract appropriate data currently.

- **Key functions for the aged care system**
  AHPA argues that the need for specific identification and updating of best practice care standards for older people should be included in the key functions of an aged care system. The failures in the current system and the lack of consistency across community and residential care settings show that there is a need to better understand and mandate appropriate care. We do not believe that this is sufficiently encompassed under either policy development, or the setting and regulation of quality and safety. Counsel-assisting does note that defining and measuring high quality care is an important area of inquiry. We strongly agree and note the need to continue the allied health role carefully as part of this process, both in terms of the direct engagement of the older person by the allied health professional and in terms of an effective multidisciplinary team where the allied health professional potentially supports, trains and guides the care team in how best to support that older person.

- **Funding for preventative, rehabilitative and restorative interventions**
  AHPA argues that preventative, rehabilitative and restorative interventions should be funded through a separate pool to ongoing care. We argue that there should be a mechanism to identify both the care required and the cost of that care with some capacity for adjustment according to local conditions. This could be based on an assessment and care planning tool that identifies different types of need and the appropriate interventions hat would be triggered by that need. These could be separated out into specific areas—e.g. an older person experiencing a stroke may have a range of interrelated but separate issues including swallowing and communication support needs as well as physical rehabilitation needs, and needs in relation to the assessment for and fitting of assistive technology. Each of these could be areas could be assessed and funded (or not) based on the individual's need and a separate funding pool for that person triggered.
  We note in this context our very strong concerns about the proposal that funding of preventative, rehabilitative and restorative interventions would only be available "on the basis that they represent a justifiable 'investment' of public funds, likely to delay or prevent the progression of the person receiving care to require higher levels of more costly ongoing care." (42, p. 14). While we very much recognise the need to have a sustainable scheme, we are deeply concerned about applying economic principles rather than a rights-based

approach that focuses on the needs and wishes of the older person. We question how this would be achieved, imagining a scenario in which the health team is called upon to determine how much the cost of care would be if the person was confined to their bed versus the cost of supporting them to remain mobile through the use of appropriate assistive technology. We have significant concerns that the cheaper option in such a scenario would be that in which the person in confined and that this represents the current status quo. We note in this context our view that the Australian public would not accept such an outcome.

- **Casemix adjusted staffing ratios**
  AHPA notes our previous submission on workforce and our concerns about staffing ratios in relation to allied health. We refer the Commission to our most recent submission.

Responses to the Proposals

In responding to the Program Redesign proposals by counsel assisting, AHPA has sought to focus only on those areas of the greatest relevance to the allied health sector. This submission should be considered in conjunction with the previous submissions we have made to the Commission.

1. Life planning

AHPA strongly supports the proposal to increase the role of the health system in supporting planning for ageing and aged care. We recognise the essential role of GP health assessments for older people and the potential to improve outcomes for older people through appropriate early interventions and other supports. We note in this context that older people and the GP-led primary care team are hampered significantly in realising this opportunity by the limitations of the Medicare Benefits Schedule in relation to referred allied health services. Annual limits of five sessions, low rebates and short session durations all mean that when a GP identifies the need for additional services related to conditions like chronic pain, type 2 diabetes, or other chronic conditions, those allied health services may still require significant out-of-pocket expenditure. We also note that while GPs are experts in some aspects of ageing, allied health practitioners such as social workers or occupational therapists working in the aged care system are likely to be better placed to provide effective guidance.

We further support the recognition of the key role of health literacy and the proposal to have care

2. Information and contact points

AHPA strongly supports change to the aged care system that accommodate a range of referral processes for older people. We further support the proposal that the Australian Government should fund and support education and information strategies to improve knowledge about aged care amongst health professionals and understanding of the role a health professional can play in supporting an older person to understand their needs and opportunities in relation to aged care. This must appropriately incorporate allied health services in addition to general practice and other health system interfaces—we have previously noted that a range of allied health professions have

primary contact roles and may in some cases be the key health provider in an older person's life, spending comparatively significantly more time with the older person than their GP.

In developing recommendations, AHPA argues it will be necessary to begin more carefully defining the interaction between the primary care system and aged care. Depending on how both our primary care and aged care system reforms are undertaken, it is likely that older people living in the community and in residential homes will look to a combination of heath and aged care services to meet their needs. This will require both systems, and those with 'connector' roles within them, such as GPs, nurses and allied health practitioners, to understand those systems and to have the necessary referral pathways to support consumers gaining access where needed.

While AHPA supports greater transparency in relation to the potential for residential homes to be assigned star ratings, and the intention to ensure that people are aware of staffing levels in residential homes, we reiterate our concerns about the limits of taking a collective approach to reporting allied health staffing. Given the very high volumes of mental health, communication, behaviour, dementia, and mobility-related issues, we very strongly recommend seeking to define key areas and the staffing associated with those to allow consumers to better understand if a residential home has the capacity to support their needs or those of their family members.

3. Care finding and case management

AHPA strongly supports the need to provide support to people seeking support to navigate and utilise the aged care system. We support the proposal for care finders to provide an ongoing case management role and the further proposal that they do not have decision-making responsibility for care planning. We note however that their role is likely to be a significant influence in relation to care planning, both in their close interaction with the older person and their family, and in their interaction with service providers. As such we argue that it will be essential to think carefully about the expertise and experience of those recruited to these roles and to ensure that appropriate standards are set both in relation to commencement in these roles and in terms of ongoing learning and development. We argue that the experience gained in the NDIS in relation to Local Area Coordinator and Support Coordinator roles should be taken into consideration.

In relation to employment responsibility for care finders, AHPA argues that it is likely to be more effective to utilise a model whereby government is responsible for employing and managing this workforce. We argue this on the basis of the need to ensure strong consistency nationally, the need to ensure independence from community and other providers, and the ability to derive data and support policy-making through the work of this organisation.

While AHPA argues that the care finders will need to work effectively with the assessment workforce, we argue that there is likely to be a benefit for consumers if there is some distance between the two roles. We argue this on the basis that care finders should be wholly concerned with working on behalf of the older person and seeking the best possible options for that person. That role includes advocating strongly for eligibility for appropriate services. The assessment workforce on the other hand is likely to face at least some degree of pressure to manage the difficult question of who is in and who is out. While AHPA would love to see a system where any older

person is eligible and the only determination is funding, experience elsewhere suggests that there will naturally be tension between the two roles in terms of their focus. By separating them, consumers are likely to have greater confidence in the care finder role.

We note that counsel-assisting has proposed that care finders would not have an advocacy role. AHPA argues that an advocacy role is essential and that if care finders are not supported to provide that service, then other alternatives should be established/maintained. In this latter case, the above argument for separation is unnecessary.

4. Assessment

AHPA supports the broad proposals for assessment put forward by counsel assisting. The recommended processes seem reasonable and the use of a single network of assessment teams supported and funded by a single organisation an effective way to deal with some of the fragmentation and inconsistency experienced in aged care and other sectors. We further support the need for this to be independent of service provision. From our perspective, it is clear that the current, fragmented system is ineffective and has a significant detrimental impact on older people and works against a more streamlined, consistent approach to meeting the needs of the older person throughout the ageing process. As the submissions by counsel assisting note, the assessment process has been subject to significant review as well as being the subject of current trials by the Department of Health as part of a move to test a shift from the Aged Care Funding Instrument (ACFI) to the proposed Australian National Aged Care Classification (AN-ACC). We see the proposals as building constructively on the findings of those other processes thus far and as such, they have our support.

In supporting these proposals though, we strongly argue for the need for the assessment teams to have more stringently listed minimum qualification and experience requirements. We note that both the AN-ACC trial and the current NDIS independent assessor trials are seeking to address some of the issues around assessment and both have specified that the assessor workforce must either consist exclusively of allied health, or allied health professionals and nurses. We argue that the same must apply here, noting that allied health professionals are likely to have the best foundation for understanding the broad range of potential needs of the older people they are assessing, particularly outside of a residential setting. We also note that allied health professionals are the most likely to have a strong understanding of the range of preventative and reabling care opportunities that the older person might benefit from.

We agree that assessment teams should be able to rely on current assessments by treating clinicians and, given that access to such assessments may be dependent on the older person's ability to privately fund those, further argue that the assessment process should have provisions to fund additional assessments by relevant other professionals. This might include additional mental health and capacity assessments, communication assessments and more.

In focusing on assessment, AHPA strongly notes our support for better integrating the work of informal carers through a focused assessment and a recognition of the need to support those carers to be able to maintain their roles. We support the broad provisions that have been made and further

argue that this should include the capacity to draw on advice and guidance from appropriate treating practitioners—for example, the informal carer should be able to draw on the advice of a falls prevention expert such as an occupational therapist or physiotherapist where they are having difficulties supporting the older person to safely manage their mobility, or where a person has dementia and challenging behaviours, the ability to draw on advice and guidance from an appropriate behavioural specialist such as a psychologist.

In relation to reassessment, AHPA argues that the potential disincentive for reablement and improved functionality should be carefully considered before mandating reassessment in all situations. This issue has been raised previously as part of the recommendations relating to the AN-ACC and ACFI funding tools with it being noted that the latter, with its system of requiring immediate reassessment if the older person gained functionality and/or had a reduced need for care, effectively financially penalised providers who had made an investment in improved outcomes for older people. On this basis, we argue that providers should be incentivised to invest in reablement, noting that this might be most effective with investment at a rate that may be higher than the daily income, and that reassessment for increased need should be only be mandatory when a person's needs are growing. In such a case, the reassessment process should be agile enough to respond to rapidly changing needs, either through a rapid reassessment process, a remote 'desktop audit' of assessments submitted by appropriate health professionals, or by provisional access to increased funding subject to reassessment. While we note the intention to have assessment teams resourced sufficiently to be prompt in their assessments, we argue these provisions would ensure a smoother transition for older people and the providers that are supporting them.

As a final note in relation to reassessment, we have some questions about the outcomes that counsel assisting notes are to be continuously measured and monitored. AHPA has concerns about the types of outcomes that would be considered signs of success, and the range of different views on what success looks like. The goals of government funders are likely to differ from those of providers, which may further differ from families and informal carers, all of which may be different from the individual outcomes sought by the older person. We argue for the need to expand on the proposals in relation to reassessment outcome measures and to specifically identify the key drivers for this. In doing so we note our view that a rights-based, consumer directed approach is needed.

5. Wellness, reablement and rehabilitation

AHPA welcomes the recognition in the submissions by counsel assisting of funding and supporting wellness, reablement and rehabilitation services for older Australians by the aged care system and we agree with how these have been defined. We have argued extensively that the Australian aged care system requires fundamental reforms that acknowledge and support the need to treat older people with dignity and in a way that seeks to maximise health and personal outcomes at every life stage. Our view is that investment in wellness, reablement and rehabilitation will support an aged care system that will provide better support for older people, will support the attraction and retention of a qualified workforce, and reduce demand for acute services. In some cases, this may result in a more cost-effective system, though we argue that cost shouldn't be the main driver when designing an improved and sustainable aged care system.

In noting our support, AHPA voices our concern that the list of services that will be included as part of a wellness reablement and rehabilitation stream is incomplete and quite varied. While we understand that further hearings will seek to further define these services, previous experience suggests that if the broad focus areas are not defined early, this can inadvertently lead to key areas of need being neglected at a later stage. In arguing for a more complete outline, we suggest that rather than flagging individual professions (e.g. occupational therapy or physiotherapy), it would be more effective and appropriate if instead the area of intervention is defined. This would have the effect of focusing more on the need than the specific profession as there can be crossover (such as both speech pathologists and dietitians potentially being able to provide support with swallowing and feeding issues). We argue that these areas of intervention must include communications support, falls and physical mobility support (with and without assistive technology), mental health support (encompassing loneliness and grief), and chronic illness support in addition to the other areas listed such as nursing, personal care, medication, and nutritional interventions. As a broad principle, we should seek in providing services to focus on supporting older people to achieve particular individual goals that they may have—e.g. to have sufficient mobility to be able to leave their home or prepare a meal.

We note the need to address chronic illness support as part of a focus on better aligning the work of the primary care system with that of the aged care system. In doing so, we highlight recent work undertaken by Australian governments through the Disability Reform Council to address the health needs of people with disability arising from gaps in access and service provision for some cohorts. We argue that there is a similar need to identify scenarios where the health system is not able to meet the unique needs of older people and for the aged care system to have systems in place to meet these needs.

In addressing wellness, reablement and rehabilitation, counsel assisting has noted the need to explore the provision of such services for all older Australians, regardless of their cognitive status or prognosis. AHPA strongly supports the need for this and reiterates our previous argument for closer alignment with, and learning from, the NDIS. We argue that those living in the community should have the same individual plan arrangements as NDIS participants, with the capacity to similarly set goals, define personal outcomes, and access the services they genuinely need to meet their individual requirements. For those living in residential care, it may be most effective to progress the proposed model of splitting the funding of day-to-day, consistent care needs, from individualised supports focused on wellness, reablement and rehabilitation.

In considering new models for older Australians, we strongly argue for the need to consider a more equitable approach that ensures that older Australians have similar supports and opportunities as someone accessing the NDIS.

6. Diverse needs in aged care

AHPA supports the principles outlined in relation to recognising and responding to the diverse needs of older Australians. We also cautiously recognise the need to continue with a market-based approach and strongly support the need for careful monitoring of the adequacy of those markets. To do so effectively will require a careful and thorough approach to developing the right systems for

data collection and analysis. Other systems such as the NDIS continue to struggle to accurately identify thin markets and areas of unmet need and this is hampering the capacity to develop appropriate policy and market support approaches that address those gaps.

AHPA also argues for the need to consider alternatives to a purely market-based system for areas that cannot sustain appropriate services in a free market.

7. Home support and care

AHPA has previously noted a range of issues and opportunities in relation to home supports and we reiterate those here—an effective home support system depends on a range of factors:

- Consumers with sufficient health literacy and, potentially advocacy support, to be able to make genuine and informed choices about their care.
- Coordinators employed by providers need to have better and more consistent knowledge about the range of services an older person may need, particularly in relation to wellness and reablement. It may be most effective to provide consistent guidance in the form of best practice guidelines to help coordinators understand the services they should be encouraging consumers to take up. This might include a falls prevention program if the older person has shown increased mobility issues and falls or identified concerns about their mobility.
- Providers and those coordinating services may have a conflict of interest in relation to which services they offer, noting both the administrative burden and differing incomes for the provider between utilising an external service and one owned or employed by that provider.

AHPA is uncertain about the role of the aged care provider coordinator versus that of the care finder. The care finder role does provide an opportunity for some independent oversight and case management support resulting in better outcomes for the older person.

8. Standardised data collection and analysis

AHPA strongly supports the need for standardised data collection and analysis and the proposals for linkage of existing datasets across government funding programs. AHPA particularly argues for the need to connect the primary care, aged care and acute systems to better understand system utilisation by older Australians and where better outcomes are achieved or not achieved as a means of informing policy. This will need to involve specific work in the primary care and aged care sectors to ensure that the systems and processes are in place to allow data extraction from the clinical systems used by providers. Primary care system integration (including private specialist providers) is essential as aged care provider systems are likely to only provide a small part of the overall picture of the care and treatment an older person receives.