Proposed Allied Health Aged Care Solutions for Jobs Summit

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

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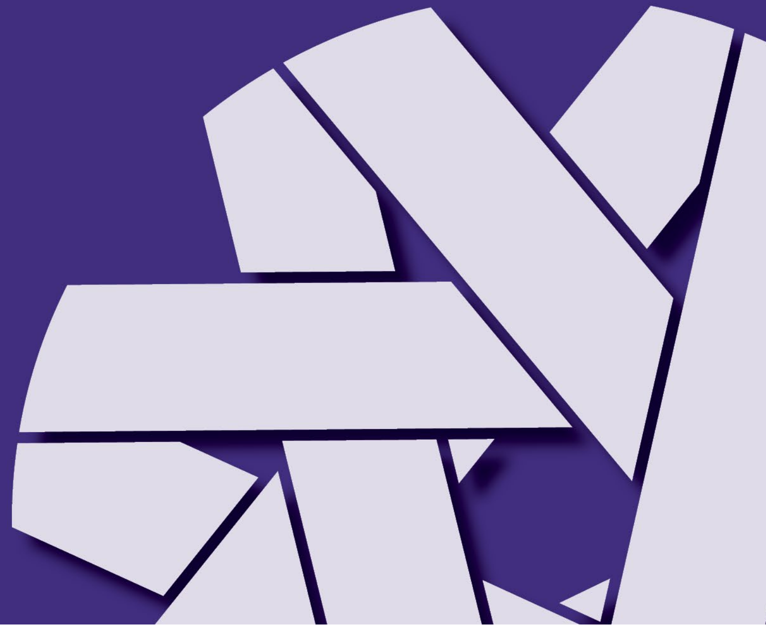

About AHPA and the allied health sector

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 145,000 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.

Overview

The role of allied health in aged care is importantly distinct from that of nursing and personal care. As AHPA conveyed at the Aged Care Workforce Roundtable convened by Minister Wells on 17 August 2022, Government responses to the findings and recommendations of the Royal Commission into Aged Care Quality and Safety have so far not sufficiently addressed the specific challenges and barriers for allied health.[1]

For example, in contrast to recent and ongoing nursing and personal care reforms, there are no current proposals for allied health service provision targets/benchmarks, nor for related accountability mechanisms. In residential aged care, despite the Royal Commission's condemnation of the finding of only 8 minutes' average allied health care being provided per resident per day, allied health spending under the new AN-ACC model is to be left to the discretion of increasingly financially pressured providers.

Alarmingly, the most recent figures show a further decrease in allied health, to 5.3 minutes. Even this extremely low average is mainly contributed to by physiotherapy services, with occupational therapy and podiatry less represented, and other services such as speech pathology, counselling, psychology, exercise physiology, osteopathy and music or art therapy either non-existent or provided so rarely that they do not register in the data. For more detail see our separately attached Policy Brief, *Allied Health Funding in Residential Aged Care*.

More broadly, despite years of advocacy and recommendations from such authorities as the National Rural Health Commissioner, there is still no national allied health workforce planning strategy, nor a minimum dataset to assist that process. Allied health also remains largely disconnected from digital initiatives aiming to enhance service delivery and collaboration, such as

[1] All specific references to recommendations in this document are to those from the Royal Commission that are key to our particular proposed solution.

My Health Record. Again, this is not due to allied health lack of interest and unwillingness, but rather is the result of past Government failure to provide appropriate mechanisms to build system capacity that would facilitate the digital integration of allied health – which in the private sector often consists of small and even sole trader practices – into the broader health system.

We emphasise these urgent broader priorities for reform to provide a context for our proposed allied health workforce solutions. To truly enhance and make the most of the capabilities of the aged care allied health workforce, long-term neglect of the sector must first be addressed.

The Royal Commission stressed that reablement, or where this is not possible, at least preserving capacity, is critical to wellbeing and should be a central focus of aged care. The Royal Commission's Final Report makes a strong direct connection between reablement and allied health care:

> 'The aged care system must support the delivery of allied health care in a way that is person-centred and focuses on the whole person, their goals and quality of life. It must focus on wellness, prevention, reablement and rehabilitation and extend beyond physical health to a multidimensional view of wellbeing.'[2]

The Commissioners held that allied health must become 'an intrinsic part of residential care', and that home care should include:

> 'the allied health care that an older person needs to restore their physical and mental health to the highest level possible – and to maintain it at that level for as long as possible – to maximise their independence and autonomy. Throughout our inquiry, many witnesses described the crucial role of allied health in maintaining mobility and functionality and providing restorative care in response to acute events.'[3]

A clear Government commitment to reablement must therefore include guaranteed provision of allied health needs-based assessment and service provision. Royal Commission recommendations emphasise clinically assessing each person, ideally via a coordinated multidisciplinary team, against the full range of potentially available allied health services that could help maintain their wellbeing and assist reablement. These assessed needs must then be met via ringfenced funding and coordinated care planning.

The Government response to date does not embed automatic allied health assessment in residential or home care. In residential care, the assessor workforce only determines the AN-ACC funding classification level, and it is then up to facility staff to identify any perceived allied health needs. Whether the resident then receives allied health services therefore 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.

In home care, an assessor determines the range of total service needs, including potential allied health services, for each person. It is up to the assessor to decide if the person should be referred on to an appropriate allied health professional for a detailed clinical assessment which will then recommend the services they should receive. Whether the older person proceeds on this pathway

[2] Royal Commission into Aged Care Quality and Safety, Final Report Vol 3A, 176. See also Exhibit 20-1, Australian Association of Gerontology Position Paper, Wellness and Reablement for All Australians, 31 July 2020.
[3] Royal Commission Final Report Volume 1, 101. See also Royal Commission, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.

again depends upon whether the assessor has the training and knowledge to decide on referral to an appropriate allied health professional.

In either context, the onus is then on the provider to deliver the right care needs/case mix to meet the person's identified needs. The developers of the AN-ACC recommended implementation of a standardised care planning tool, but this is not currently proposed for residential or home care, and as previously noted, there is no dedicated funding mechanism to ensure provider delivery of any required allied health services. These factors combine to mean that many aged consumers will not receive the allied services best placed to meet their needs.

The current aged care reform agenda therefore also poses a practical difficulty for presenting more finely tuned allied health workforce recommendations. As an illustration, a longstanding issue for training the future allied health workforce is that students on practical placements are not able to provide hands-on treatment to patients if the latter are being treated under Australian Government funding schemes (eg Medical Benefits Scheme, Department of Veterans' Affairs) or via private health insurance (eg Medibank, HCF).

These restrictions make it difficult for students to find placements and fulfil practicum requirements. This problem is exacerbated in most private allied health practices because their casemix significantly incorporates patients under Government-funded or private insurance arrangements, meaning that any potential hands-on experience in private practice for students is limited to private paying patients. Private practice placements in lower socio-economic areas are accordingly even more limited.

A related long-term problem is the scarcity of senior clinicians able to provide supervision, especially in rural and remote areas. This is also a particular problem for students in newer and emerging allied health professions, who have limited access to supervision in the public system, such as for hospital-based placements.

However, given the lack of benchmarks and funding guarantees in aged care, together with the ongoing absence of allied health needs-based assessment, we simply cannot know how many and what kinds of allied health professionals will be required by the new residential and home care systems. We cannot accurately predict shortfalls and ensure a flow of new graduates, nor address areas of particular disadvantage and lack of access, such as where older persons in rural and remote areas cannot obtain particular allied health services (Recommendation 54), in any useful way.

We do know that allied health professionals are already leaving the aged care sector, and that some large providers are disbanding their in-house allied health professional teams, due to the uncertainties around funding for their services.[4]

Equally concerning is an apparent trend for providers to substitute, for cost reasons, allied health assistants or workers from outside allied health such as lifestyle coordinators, to provide services that are within the scope of practice of an allied health professional. Although valuable contributors to the workforce, allied health assistants are less qualified than allied health professionals, and therefore either require supervision or are simply not suited, nor lawfully permitted, to carry out some essential allied health tasks.

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[4] See eg (Hansard Proof) Evidence to Senate Community Affairs Legislation Committee, Parliament of Australia, Canberra, 25 August 2022, 20-21 (Scott Willis, National President, Australian Physiotherapy Association).

To put this another way, the neglect of allied health as a crucial third pillar of aged care is in imminent danger of turning the whole aged care sector into a 'thin market' that compromises safety and quality. It will ultimately exacerbate Australia's already considerable health sector burden, via outcomes such as increased hospitalisations and surgeries. In this climate, there are no quick fixes and no point in advocating for strategies such as training, attracting and retaining the allied health workforce, until the current crisis has been addressed.

As part of developing an integrated system for the long-term support and care of older people (Recommendation 4), both residential and home-based care sectors must be made capable of delivering allied health services to a reablement standard. Proposed human rights reforms to the Aged Care Act (Recommendations 1–3) will demand nothing less.

Our solutions

Most of our solutions can be commenced as soon as possible, with #1–#4 able to be achieved within 6 months. Residential aged care crisis response and pathway mapping (#5) is our proposed temporary solution, because there are urgent allied health service needs that cannot wait for the completion of solutions #8–#13.

As an active member of the National Aged Care Alliance, AHPA is also keenly aware that discussions will be needed on the financial sustainability of the aged care sector. The approach in #5, together with the EMBRACE project (#6), will assist Government and key stakeholder deliberations as part of #12 and #14.

To be completed within 6 months

1. *Monitoring of implementation of Royal Commission allied health-related recommendations*

Establish an independent unit for implementation and monitoring of allied health-related Royal Commission recommendations, including those concerning the workforce, funding and the role of allied health in reablement. This unit might be located within the Office of the Inspector-General (Recommendations 12, 148), and should include in its staff, or draw upon in a funded partnership, a diversity of allied health professional knowledge.

2. *Allied Health Assistants*

As part of ongoing regulatory alignment reforms (eg Recommendation 69), the Commonwealth works with States and Territories to nationally embed an Allied Health Assistant Delegation and Supervision Framework.[5]

3. *Best practice allied health workforce ratio*

Amend Quarterly Financial Reporting requirements for allied health service provision by residential aged care facilities to include reporting against a recommended best practice minimum ratio of allied health professionals to allied health assistants.

4. *National Allied Health Workforce Strategy Part 1*

Commence development of a National Allied Health Workforce Strategy in collaboration with the disability, veterans' care and primary health care sectors, beginning by addressing duplication of regulatory systems (Recommendations 69, 75).

[5] As an example see https://www.health.vic.gov.au/publications/supervision-and-delegation-framework-for-allied-health-assistants-and-the-support-0 .

To be completed within one year

5. *Residential aged care crisis response and pathway mapping*

In consultation with the assessment and care planning teams in #8 and #9, assign and fund a provisional allied health service provision benchmark (average in minutes per resident per day). This benchmark will be conservative, because at this stage needs-based assessment and care planning will not be in place, and a more thoroughly investigated standard will result from #8.

In addition to providing immediate systemic 'first aid' in the current crisis, the intention of this ad hoc solution is to supplement the provisional benchmark-associated funding with temporary utilisation of other identified pathways, and to use the resulting data to inform a conversation about funding and sustainability as part of #8.

A representative sample of residential aged care facilities should be incentivised to supplement their existing required reporting with summarised documentation of the pathways used to provide allied health care and associated funding sources. This mapping should begin with identification of how the resident's allied health needs came to the facility's attention eg via AN-ACC assessment, referral to clinical allied health assessment, via nursing staff at the facility, visit by GP etc. Documentation of allied health service provision should include whether this came from employees on staff or contactors, and any use of permanent or temporary Medicare items and/or residents' private insurance for external services. Residents' out of pocket or entire personal payments should be recorded.

Extend existing and recent allied health programs such as the Allied Health Group Therapy Program designed to improve function and mobility and prevent falls in aged care residents,[6] including where appropriate, expanding the list of types of eligible providers; and document the use of such programs.

To further enable solution #5, direct referrals to allied health professionals through My Aged Care should be enabled. Similarly, gateways to Medicare programs such as Better Access should be facilitated so that prior GP referral is not required.[7]

6. *Aged care data*

Fully integrate allied health services into National Minimum Datasets linking health and aged care that enable identification of whether a person has received aged care services, and of the type of those services. Include allied health services in the National Aged Care Data Asset (Recommendations 67, 108).

7. *Digital systems and interoperability*

As an integral part of implementing a new service-wide client relationship management system interoperable with My Health Record for care management, case monitoring and reporting systems built around older people's care, the Australian Digital Health Agency must prioritise giving practical support to allied health providers of aged care services so that they can adopt My Health Record (Recommendations 68, 109).

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[6] This 12-week, evidence-based, restorative program was introduced in specific COVID-affected residential aged care facilities in response to COVID-19, but perversely, its implementation was hindered by the pandemic.

[7] Recent research shows the current Better Access model is not working in residential aged care: https://www.australianageingagenda.com.au/clinical/aged-care-residents-underusing-mental-health-services/ .

To be completed within two years

8. *Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project*

Develop and complete the project, including real-time evaluation, which tests at 1-2 residential aged care trial sites the efficacy of a block-funded multidisciplinary approach to assessment, care planning and delivery of needs-based allied health care, founded on best practice reablement.

The project will provide core allied health professions (dietetics, physiotherapy/exercise physiology, occupational therapy, speech pathology, podiatry, psychology/counselling, music therapy) on site, and identify and use secure pathways to other allied health disciplines as required. Allied health clinicians will be funded to supervise allied health assistants, together with students who will undertake practical placements at the trial site(s) in partnership with their training university.[8]

Impact outcome measures will include resident health and wellbeing, Emergency Department presentation, staff retention and satisfaction, Serious Incident Response Scheme reporting and management, and use of restraints. Totals of each type of allied health service assessed and provided will be reported by minutes and by cost.

(Recommendations 25, 28, 31, 37-38, 54, 58-59)

9. *Needs assessment and care planning tool for residential aged care*

To be undertaken in tandem with #8. Develop a national best practice needs assessment and care planning tool for residential aged care as recommended in *AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations, The Resource Utilisation and Classification Study: Report 6* (Recommendations 25, 28, 31, 37-38).

10. *Needs assessment and care planning tool for home care*

Develop a national best practice needs assessment and care planning tool for home care, if deemed necessary (Recommendations 25, 35-36).

To be completed within three years

Refining the model(s)

11. Build in to the EMBRACE project in #8, through partnering with appropriate university research teams, a cost and efficiency analysis which measures the total value of the model and compares it to reporting from residential aged care facilities in #5.[9]

12. Use findings in #5, #8 and #11 to determine appropriate national residential aged care model(s) to roll out.

13. Draw on #12 and other findings to, for residential aged care:

a) legislate mandatory minutes or a similar benchmark for allied health;
b) increase allied health reporting requirements and accountability so that levels and standards are equivalent to those for nursing and personal care, allied health is reported by profession, and relevant information can contribute to star ratings; and

[8] See eg https://www.tandfonline.com/doi/abs/10.1080/17549507.2020.1779346 .
[9] Cost and efficiency to be assessed on a holistic basis. For an example of full costing, see Access Economics, *The Cost of Domestic Violence to the Australian Economy*, and KPMG's updated report at https://www.dss.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/economic-cost-of-violence-against-women-and-their-children?HTML#1 .

c) enhance quality standards and indicators by introduction of specific allied health measures.

(Recommendations 13-14, 20-24)

14. Utilise the residential aged care findings and associated reforms to consider potential reforms to home care in addition to #10 (Recommendations 35-36, 41, 54, 58-59).[10]

15. *National Allied Health Workforce Strategy Part 2*

Complete the aged care sector's contribution to the co-development of a National Allied Health Workforce Strategy (begun in #4), utilising findings from #5, #8 and #14 to establish the numbers and distribution of allied health professionals required in aged care as part of national broader workforce planning. Use that information to identify and roll out strategies to address potentially relevant factors such as inter-sector competition for allied health professionals, student placements and supervision (Recommendations 54, 67, 75, 82-83).

[10] As the Support at Home reforms are currently being developed, including through consultation, it is not yet appropriate to provide detail.