Allied Health Professions Australia

The state of allied health in residential aged care – Survey Results

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

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Introduction

The allied health sector is actively working with Government and other key stakeholders in the development and implementation of aged care reforms.[1]

AHPA and its members welcomed the finding by the Royal Commission into Aged Care Quality and Safety that allied health is essential to what might be shorthanded as 'reablement/restorative care' – helping to maintain older people's wellbeing and function for as long as possible (see 'Appendix: Background to the Australian National Aged Care Classification (AN-ACC) funding model').

The Royal Commission found that despite this key role, provision of allied health services in residential aged care averaged only 8 minutes per day per person. The Royal Commission therefore recommended that allied health care must be provided at a level and range that meets people's needs.

AHPA has consistently expressed our strong concern to Government that despite these recommendations and those of the architects of the AN-ACC model, there is no allied health benchmark comparable to nursing and personal care minutes, and no targeted funding for allied health care. We are also aware that recent data indicates that the average amount of allied health in residential aged care has decreased to just over 5 minutes per day.

While AHPA welcomed the replacement of the Australian Classification Funding Instrument by the AN-ACC, we know that simply leaving it to providers to allocate spending on allied health from their total AN-ACC allocation will continue to result in an extremely poor level of allied health provision.

Recent and proposed aged care reforms also do not embed automatic allied health assessment, and use of a standardised care planning tool and delivery via multidisciplinary teams, in either residential or home care. These processes are essential for allied health to be able to perform its reablement/restorative role.

Due to our concerns, AHPA's Aged Care Working Group conducted a survey of 279 allied health professionals in residential aged care to ascertain whether they had experienced any changes in their work and in the provision of allied health services in the six weeks since AN-ACC commenced on 1 October 2022. The survey results should be regarded as a preliminary snapshot, and the Working Group plans to repeat the survey once the AN-ACC model has been in place for a longer period.

Survey results

Results from the survey demonstrate that there are already serious impacts on both the allied health residential aged care workforce and aged care residents, including more than one in eight allied health professionals losing their jobs.

[1] See eg AHPA's Policy Brief, Allied Health Funding in Residential Aged Care (July 2022) and Proposed Allied Health Aged Care Solutions for Jobs Summit (August 2022) at https://ahpa.com.au/policy-statements-and-submissions/page/2/ ; Submission on Aged Care Pricing Framework Consultation Paper (October 2022) and Submission to the Department of Health and Aged Care on Revised Aged Care Quality Standards (November 2022) at https://ahpa.com.au/policy-statements-and-submissions/ .

37% of all respondents have had their clinical role or employment change, generally for the worse, including reduced hours of work and experiencing cuts to overall allied health services in their workplaces.

Job insecurity, deterioration in roles and concerns about the impacts on quality of care also contribute to the decision of a further 30% of respondents to stop working in aged care.

The effects are being felt particularly in physiotherapy and occupational therapy.

Respondents were particularly concerned – and often greatly distressed – about the resulting impacts on the quality of care they are able to provide. Negative impacts on quality include the replacement of individual care by (cheaper) group sessions, and the inability of remaining professionals to provide in-depth care, including via care planning and reablement/restorative approaches.

Our early snapshot therefore suggests that regardless of whether insufficient funding under the AN-ACC model is already having a direct influence, providers are anticipating a fiscal crisis and so are cutting allied health, due to it being the only key workforce that does not have mandated staffing levels.

The result is the beginning of a downward spiral in which, as working conditions for remaining allied health professionals deteriorate and quality of care for residents decreases from an already low base level, more experienced professionals choose to depart from aged care.

The key survey themes are presented in more detail below, illustrated by some of the numerous comments from respondents.[2]

Job losses

13% of respondents have lost their jobs.

> *Unfortunately my job will be made redundant within 4 weeks. No other companies are hiring allied health professionals as most facilities have cut hours for allied health professionals on site.*
>
> *I had no option but to discontinue work at my facility as there were no longer any shifts allocated by my agency and aged care provider.*

Reduced hours

43% of respondents whose role has changed have had their hours reduced.

> *Hours have been reduced significantly so I now work part time across two different sites. I was working full time at one site prior to AN-ACC. I have been told the hours will be further reduced after 12 months.*
>
> *It is hard for 1 allied health practitioner to deal with 70 residents. With only 4 days to work.*

Cuts to overall allied health

41% of all respondents said their clinical team structure had changed, with 84% of those (a third of all respondents) saying there had been a decrease in the number of allied health professionals.

> *Restructure of RAC allied health staff to merge with community team operated by the same organisation. So staff who were working exclusively in RAC now have dramatically fewer hours*

[2] RAC = residential aged care; RACF = residential aged care facility (aged care home).

in RACFs and are required to spend majority of hours in community / NDIS. For example, I would spend up to 22 hours per week servicing one particular facility but this has now dropped to that facility receiving only eight hours per fortnight.

The home has reduced our allied health services and some of my colleges have been made redundant. We no longer have enough hours provided to provide suitable amount of care for residents.

A lot of facilities have reduced their allied health services by quite a bit. They only pay for base hours, to cover falls reviews and patient mobility assessments.

Others anticipate further cuts to allied health services:

Facilities have cut hours for allied health by 75%.

Have been told the scope of work moving forward will be 1 therapist per 280 residents. Prior to AN-ACC the 150 bed (100-120 resident capacity) home had 3.5 fulltime.

Replacement of individual care by group sessions

45% said services provided by their profession had changed. 58% of those respondents said available services have decreased and 60% said individual treatment sessions have decreased, with residents often only having the option of attending group sessions, which cost less for the facility to provide.

The contract the aged care provider has set up with the allied health team now means less individual support for residents which means minimal focus on reablement and restorative services.

I have noted that in each facility I work in there has been a decrease in physiotherapy and occupational therapy services for residents, who have complained to me that they no longer are receiving one on one support and it is about now having to do group exercise. Importantly the support was weekly for this person so she has now missed out on any individual support unless she pays for this. She uses a walker and came in to care after a fall, so this has implications for her ongoing independence. For another resident who had a fall and cannot walk unassisted and needs ongoing intensive physiotherapy, this has now decreased which has all sorts of implications on her mental health, her lack of independence with all aspects of her life.

When residents learn that this service is no longer available to them they feel like nobody cares for them as they age. The decision power for their healthcare does not effectively lie with them but in the hands of the management.

Reactive rather than in-depth care

Many professionals said that the changes meant that they now could only react to referrals, rather than collaborating in multidisciplinary care and providing more in-depth support to the facility through reviews and staff education.

Have been told that the only scope of work for allied health will be referral based only.

There is no imperative for a holistic multidisciplinary team discussion to be able to really provide an integrated and person-centred response to the individuals who we are there to support.

Still involved but staff under pressure due to reduced hours. Not enough time to effectively complete reviews for every resident as well as therapy.

The allied health activities are ad hoc and designed according to the practitioner available and not what the residents actually need. There is no strategy to identify what the residents need and want.

60% were not involved in care planning at their facility, and other respondents felt that allied health was not sufficiently involved in care plans:

As allied health contractors we have limited assessment input into care and behaviour support plans, which previously we did have. Due to less individual services provided.

Residents' mobility and health will decline without individual treatment plans – non-ambulant and non- weight bearing residents will increase contractures without treatment.

Allied health are involved in care planning but they are restricted by what they can do and provide. It doesn't take a genius to figure out what's going on. Providers budget less and restrict services hence care plans are not truly reflective of what the residents need.

Without holistic diverse care models how will it be possible to live and practice the new aged care standards?

Deteriorating quality of care

One of the most significant themes is the deterioration in the quality of allied health care able to be provided to residents. 79% of allied health professionals were concerned about safety or quality of care for residents, and a similar proportion of respondents were also worried about the future for allied health in residential aged care.

Increase in pain, falls and decreased care for residents due to lack of allocated hours for allied health.

It is often the case that an allied health professional identifies that a person could and would benefit from an intervention or therapy that they simply aren't afforded the opportunity to provide ultimately leading to deconditioning, loss of function, deterioration and increased direct care needs.

The high likelihood that allied health professionals will see their hours reduced to consultancy and oversight time. The actual clinical work will be left to personal care workers or lifestyle people to implement.

Residents returning from hospital, post surgery, post decline, post stroke, post fall, post infection etc – will have no chance at individual rehabilitation and treatment resulting in extremely poor outcomes and probably fatal. Residents who need individual treatment such as chest physio, BPPV exercises etc that is prescribed by the facility GPs will not receive their treatment with the abolishment of 1:1 treatment.

It's not enough to have therapists flit in to work through few referrals, things will be missed and what happens to an individual that has complex needs? The lack of onsite therapists can only make everyone less safe.

No requirements for facilities to access the full range of allied health professionals. Huge variability across the sector which will result in different outcomes for residents depending upon the facility they live in.

Who will assess their care and manual handling needs? Who will keep them as strong and mobile as they can be? Who will consider their quality of life and reducing loss of function as they age?

Not just caring *for* residents

Allied health professionals' passion to achieve the best possible outcomes for residents is key to their motivation to work in the sector. Our respondents care not only for older people, but also about the impacts of decreased services upon their lives.

The value of allied health in RAC has been completely overlooked. The loss of quality of life without regular assessment, exercise, and mobilising for aged care residents is heartbreaking.

Allied health is woefully underfunded and not available to those most in need. Residents are told by RACF management to fund the service themselves. . .The gaps in service are huge. Feel like RAC is happy to reduce hours which is impacting care. . . I really feel sorry for the residents who were getting services for last 12 years now suddenly been advised that this service exists no more. This will lead to poor outcomes for the elderly. Really sad.

Residents are depressed as they miss the quality time they spent with allied health staff.

Our role is not valued currently and residents are disappointed about the decreased amount of time that we can spend with them.

Very sad for the residents. I believe a lot will decline without access to allied health for pain management and functional mobility. Care staff and nursing teams are constantly understaffed so have no time to spend with the residents, nor do they have the expertise.

Leaving the sector

When professionals' distress at the impacts on residents is combined with the deterioration in working conditions, it is probably not surprising that an alarming 30% of those surveyed expect to cease working in residential aged care in the foreseeable future.

Within the company that I work for, positions have been made redundant. I feel like other staff are leaving voluntarily and don't want to return to aged care. There is a lot of uncertainty about the future of our roles in residential aged care.

I like many of my allied health colleagues have been made redundant! Unless model of funding changed and actual sites allow allied health to fully utilise their skills for the best outcome for residents I am hesitant to return to working in a RACF.

I am leaving within the month. Job uncertainty and also a desire to change industry has led me to this decision. I feel that allied health teams will no longer be employed and will attend site on referral basis- this does not allow for a holistic approach and takes away from the homely and warm approach that can be delivered by on-site professionals

12-24 months. No security/stability as facilities will still decide whether to increase or decrease the hours for allied health professionals.

I would continue at the current aged care facility, but I have been given the option to work at a significantly lower pay rate, which would make it hard to cover my staffing costs, to the point it is not economical for me to commit to continue working there.

We had so much hope for AN-ACC and we're frustrated by this outcome. I will forever have my heart in RACF but I'm leaving due to burnout from the system.

Solutions

Government needs to act quickly to address the growing crisis in allied health care and to implement the Royal Commission's view of allied health as an intrinsic part of residential aged care that should be delivered to a reablement standard.

AHPA has previously provided the Minister for Aged Care with an extensive document, 'Proposed Allied Health Aged Care Solutions for Jobs Summit', following the Aged Care Workforce Roundtable in August 2022.[3] Those solutions remain pertinent, but to halt further deterioration in the quality of residential aged care, a modified version of our proposed Solution 5, 'Residential aged care crisis response and pathway mapping', should be implemented as soon as possible.

1. Set a provisional benchmark

A provisional allied health service provision benchmark (average minutes per resident per day) should be set and mandated. AHPA suggests that 22 minutes is an appropriate measure, as this is informed by AN-ACC-related secondary research (see Appendix).

2. Fund it

Although AHPA has been assured by the Department of Health and Aged Care that existing funding is sufficient for an acceptable level of allied health care, we continue to dispute this claim, and the survey results support our concerns.

AHPA and our members therefore seek to discuss with the Minister and the Department, as a matter of urgency, how temporary additional funding might be best provided. For example, because our proposed solution is an ad hoc one which provides immediate systemic 'first aid', it may be appropriate to combine some short-term funding allocation for allied health with the temporary utilisation of other identified pathways, such as use of Medicare-funded allied health services, in order for facilities to achieve the provisional benchmark.

3. Establish provider obligations and incentives

It will be important that providers document the pathways used to provide allied health care and associated funding sources, including any residents' out of pocket or entire personal payments. AHPA further proposes that within two years an evidence-based benchmark and associated nationally consistent, needs-based assessment and care planning tool be developed.[4] In the interim, providers should be required to document their allied health care planning, including how the resident's allied health needs came to the facility's attention and what professionals were responsible for planning and delivering the care to meet those needs.

An aspect of the temporary funding supplement could therefore be aimed at incentivising providers to supplement their existing reporting obligations with documentation of their use of the pathways and care planning.

[3] https://ahpa.com.au/policy-statements-and-submissions/page/2/ .
[4] Proposed Solutions 8 and 9, https://ahpa.com.au/policy-statements-and-submissions/page/2/ .

4. Ensure longer-term allied health provision

As outlined in our 'Proposed Allied Health Aged Care Solutions for Jobs Summit', AHPA proposes that over the next two years, the Encompassing Multidisciplinary Block-funded Reablement in Aged Care Evaluation (EMBRACE) project be developed, completed and evaluated. The EMBRACE project will test 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.

The EMBRACE project evaluation will also help to determine the costing of allied health care and hence the value of the National Weighted Activity Unit so that the AN-ACC funding model can genuinely build in allied health into future iterations.

As indicated above, the project will also result in the setting of an evidence-based allied health care benchmark and a nationally consistent assessment and care planning tool. Within three years, allied health care quality and associated public reporting could then be embedded in the aged care system.

Appendix: Background to the Australian National Aged Care Classification (AN-ACC) funding model

Royal Commission into Aged Care Quality and Safety

The Royal Commission found that allied health services are a fundamental component of aged care and are particularly critical to what might be shorthanded as 'reablement' or 'restoration' – helping to maintain older people's wellbeing and facilitating restoration of function, or at least maintaining existing function for as long as possible.[5]

Nevertheless, the Commissioners found that allied health services are underused and undervalued across the aged care system,[6] and that aged care residents received, on average, only 8 minutes per person per day of allied health care.[7]

The Royal Commission concluded that this significant under-provision of allied health care produces morbidity, mortality and quality of life impacts, including those associated with dementia, mental health, malnutrition and falls.[8]

The Royal Commission therefore recommended that the aged care system should focus on wellness, prevention, reablement and rehabilitation, and extend beyond physical health to a multidimensional view of wellbeing.[9] The Commissioners called for 'a change in culture in the aged care sector, to view allied health services as valuable rather than a burden on funding',[10] and for allied health to become 'an intrinsic part of residential care'.[11]

With regard to the provision of aged care for people living at home, Recommendations 35–38 support this more holistic approach through requiring a level of allied health care appropriate to each person's needs. Recommendation 13 also requires all care to be high quality, which is defined as care which is 'personal and designed to respond to the person's expressed personal needs, aspirations, and their preferences regarding the manner by which their care is delivered'.

Government response to Royal Commission allied health recommendations

Government accepted Recommendations 13 and 36–37; and gave in-principle support to Recommendations 35 and 38.[12]

The architects of the AN-ACC recommended that to meet the allied health needs of residents, an average of 22 minutes' allied health care per person per day would be required, and that accordingly, funding for allied health service provision should be built in to the AN-ACC model.[13]

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[5] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83; and Recommendations 35–38.
[6] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83.
[7] 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 , 2.
[8] See eg Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.
[9] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021; 101; Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 176.
[10] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[11] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101.
[12] Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021.
[13] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & R Gordon, 'How Australian residential aged care staffing levels compare with international and national benchmarks', Centre for Health Service Development, AHSRI, University of Wollongong, 2019 https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-1.pdf , 33-35; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey,

However, Government has not mandated any minimum average minutes for allied health care – in contrast to nursing and personal care. Identification of allied health needs and related necessary spending is to be left to the discretion of increasingly financially pressured providers, without any targeted allocation of funds. AHPA's analysis makes it clear that even the most sanguine estimates of provider spending on allied health will be grossly insufficient.[14]

The most recent provider allied health care data is 5.07 minutes per day – worse than the Royal Commission finding.[15] A recent scoping study commissioned by the Department also concludes that the level and breadth of allied health involvement in Australian residential aged care homes is limited.[16]

Despite recommendations from both the AN-ACC team and the Royal Commission,[17] current and proposed aged care reforms also do not embed automatic allied health assessment, and use of a standardised care planning tool and delivery via multidisciplinary teams, in either residential or home care. These processes are essential to a reablement/restorative approach.

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/ .

[14] https://ahpa.com.au/advocacy/ahpa-policy-brief-residential-aged-care-july-2022/ .

[15] https://www.stewartbrown.com.au/news-articles/26-aged-care/266-2022-10-stewartbrown-aged-care-financial-performance-survey-sector-report-june-2022 .

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

[17] 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; 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; https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ ; Royal Commission Recommendations 28, 31, 37 and 38.

About AHPA and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing Australia's allied health professions and is the only organisation with representation across all disciplines and settings. We have 26 allied health member organisations and a further 12 affiliates with close links to allied health. A full list of our members is available at https://ahpa.com.au/our-members/ . The scope of allied health encompasses preventive and primary care (including chronic illness), aged care, disability (including the NDIS) and veterans' care.

This breadth makes allied health Australia's second largest health workforce, with over 200,000 allied health professionals. AHPA provides representation for the allied health sector, working with a wide range of working groups and experts across the individual allied health professions to advocate to and support all Australian governments in the development of policies and programs relating to allied health.