Allied Health Professions Australia

Submission to Capability Review of the Aged Care Quality and Safety Commission

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

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About Allied Health Professions Australia and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing Australia's allied health professions across all disciplines and settings. AHPA's membership collectively represents some 180,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners.

With over 200,000 allied health professionals, including 14,000 working in rural and remote areas, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, including providing diagnostic and first-contact services, and preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses.

Allied health practitioners also support pre- and post-surgical rehabilitation and enable participation and independence for people experiencing temporary or long-term functional limitations. Allied health therefore provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

Working with a wide range of working groups and experts across the individual allied health professions, AHPA advocates to and supports Australian governments in the development of policies and programs relevant to allied health.

Introduction

AHPA welcomes the opportunity to make a submission to the Capability Review of the Aged Care Quality and Safety Commission ('Commission'). As consultation on the in-home aged care reforms is still proceeding, we focus on residential aged care.

Our submission focuses on the question of whether the Commission currently facilitates the delivery of safe and high-quality allied health care for older Australians. We explain why this is not the case, and indicate directions that must be taken if Australia is to ensure quality of allied health care for older Australians in the future.

The provision of allied health services in residential aged care is in a parlous state. The reasons for this might be represented by a three-cornered stool in which poor Aged Care Quality Standards ('Quality Standards'), lack of Government commitment to any enforceable targets for allied health provision, and failure of the Commission to act as a strong and effective quality regulator, all combine to prevent accountability for the quality of allied health care.

Given this triangulation, we are concerned that review of the Quality Standards appears to have taken place in an earlier, separate process rather than in tandem with the Capability Review. As outlined below, the functions of the Commission and the content of the Quality Standards are 'pieces of the puzzle' that need to be addressed together in public consultation and policy development if aged care quality is to be assured.

Due to the central relevance of AHPA's earlier submission to the Department of Health and Aged Care on the proposed revised Quality Standards, we attach that document as a separate appendix to this submission.

As another corner of the triangle, it is equally important to set the regulation of allied health quality in the context of the Government approach to aged care reforms. Our submission therefore

begins by placing quality issues for allied health in the context of relevant recommendations from the Royal Commission into Aged Care Quality and Safety ('Royal Commission'), and associated Government responses. We then consider the role of the Commission and the Quality Standards in regulating aged care quality, before considering the Quality Standards' content with specific regard to allied health. Finally, we consider the actual practice of the Commission in the regulation of allied health quality.

Allied health, the Royal Commission and Government response

The Royal Commission found that although allied health services are a fundamental component of aged care, and are particularly critical in helping to maintain residents' wellbeing and facilitating restoration of function, allied health services are underused and undervalued across the aged care system.[1]

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.[2]

The Commissioners therefore called for 'a change in culture in the aged care sector, to view allied health services as valuable rather than a burden on funding',[3] and for allied health to become 'an intrinsic part of residential care'.[4]

The Royal Commission further recommended that the aged care system should focus on wellness, prevention, reablement (restoration) and rehabilitation, and extend beyond physical health to a multidimensional view of wellbeing.[5] Recommendation 38 focused on residential aged care and supported this more holistic approach through requiring the provision of a level of allied health care appropriate to each person's needs.

AHPA has regularly communicated with the Minister for Aged Care and the Department of Health and Aged Care regarding the undervaluing of allied health in residential aged care, and the barriers that must be overcome to implement the relevant Royal Commission recommendations. These issues are fundamentally about quality and safety for aged care residents.

Lack of mandated minutes for allied health

AHPA strongly supports the Government commitment to raising the wages of aged care workers, and we welcomed the recent reforms in residential aged care nursing and personal care. However, we are extremely concerned about the absence of articulated plans to ensure sufficient allied health provision in residential aged care.

Unlike nursing and personal care, allied health care still has no minimum mandated minutes. Research undertaken for the Royal Commission found that aged care residents received, on average, only 8 minutes per person per day of allied health care.[6] The architects of the Australian National Aged Care Classification (AN-ACC) recommended that to meet the allied health needs of

[1] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 83.
[2] See eg Royal Commission into Aged Care Quality and Safety, 'Hospitalisations in Australian Aged Care: 2014/15-2018/19', 2021.
[3] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[4] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 1 Summary and recommendations*, 2021, 101.
[5] 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 and Recommendations 35 and 36.
[6] 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.

residents, an average of 22 minutes' allied health care would be required, and that accordingly, funding for allied health service provision should be built in to the AN-ACC model.[7]

This recommendation has not been implemented, and instead identification of allied health needs and related necessary spending is to be left to the discretion of increasingly financially pressured providers, without any mandated minimum allocation of funds. Nevertheless, the Department insists that allied health expenditure will be sufficient.[8]

AHPA's analysis makes clear that even the most sanguine estimates of provider spending on allied health will be grossly insufficient.[9] Departmental calculations rely on past provider expenditure of 4% of total care funding, which translates into between 4.6 and 8.8 minutes per day – a far cry from 22 minutes a day. The proportion of provider allied health spending has also recently decreased from 4%, resulting in 5.07 minutes per day[10] – worse than the Royal Commission finding.

Even a recent scoping study commissioned by the Department concludes – in somewhat contradiction to the 4% 'reassurance' – that the level and breadth of allied health involvement in Australian residential aged care homes is limited.[11]

Most recently, a survey of allied health professionals working in residential aged care undertaken by AHPA's Aged Care Working Group has shown there are already serious impacts on both the allied health residential aged care workforce and aged care residents. These trends include more than one in eight allied health professionals losing their jobs and another 30% planning to leave the sector.[12]

Lack of public reporting of allied health service provision

Any effective aged care system must be able to provide measures of public accountability so that it can be ascertained whether people are receiving allied health services according to assessment of their clinical needs, care is appropriately delivered and coordinated, and impacts are documented. In turn, consumers can use that data to inform their choices about aged care services or facilities, and future improvements can be identified and supported by evidence.

Outside of the Commission's formal role, there is no real accountability such as public reporting of allied health services in residential aged care. Although some data on allied health costs and time spent will be included in the Quarterly Financial Report for residential aged care,[13] in the absence of any benchmarks or ringfenced funding, the purpose of this reporting is unclear.

The Department has simply stated:

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[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 , 33-35; Eagar K, McNamee J, Gordon R, Snoek M, Kobel C, Westera A, Duncan C, Samsa P, Loggie C, Rankin N & K Quinsey, *ANACC: A national classification and funding model for residential aged care: Synthesis and consolidated recommendations. The Resource Utilisation and Classification Study: Report 6*, Australian Health Services Research Institute, University of Wollongong, 2019, 8-10. See also https://www.australianageingagenda.com.au/clinical/allied-health/allied-health-a-real-loser-in-budget/ .

[8] See eg https://www.health.gov.au/resources/publications/how-allied-health-care-is-supported-under-an-acc .

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

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

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

[12] https://ahpa.com.au/news-events/ .

[13] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers ; https://health.formsadministration.com.au/dss.nsf/DSSForms.xsp .

> 'This information is important because it will allow the Department to understand how allied health is delivered in residential aged care facilities. The reporting of allied health care minutes will help the Department to monitor the overall cost of care to aged care facilities.'[14]

However, the allied health care provided will not be publicly reported against each of the 13 AN-ACC classes, so it will not be possible to know whether, for example, older people with high needs received more allied health services on average than high functioning residents.

There also appears to be no way under the current model for the public to use the basic allied health data reported to assess whether allied health care is being provided via appropriate allied health needs assessments, care planning, and the involvement of multidisciplinary teams to clinically assess residents and match them with the right types and levels of allied health care.

This knowledge is important because to date, despite recommendations from both the AN-ACC team and the Royal Commission,[15] the aged care reforms 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. For example, 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.

The role of the Commission

When questioned about allied health service provision, the Department has placed all accountability squarely on the regulator. For example, the Department stated in Evidence to the Senate Community Affairs Legislation Committee Inquiry into the Aged Care Amendment (Implementing Care Reform) Bill 2022 that the Aged Care Quality and Safety Commission will identify any instances of insufficient allied health provision.[16]

The Department has similarly insisted that allied health will be adequately provided, by citing providers' obligations under the *Aged Care Act 1997* ('the Act'), and in particular as defined by the Aged Care Quality Standards in the *Quality of Care Principles 2014* ('Quality Principles'). The Commission regulates providers according to these obligations.[17]

Providers' legal responsibilities in relation to the quality of the aged care that they provide include:

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[14] https://www.health.gov.au/resources/videos/qfr-guide-allied-health-reporting-for-residential-aged-care-providers .
[15] 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.
[16] (Hansard Proof) Evidence to Senate Community Affairs Legislation Committee Inquiry into Aged Care Amendment (Implementing Care Reform) Bill 2022, Parliament of Australia, Canberra, 25 August 2022, 34-35 (Michael Lye and Mark Richardson, Department of Health and Aged Care). See also the Aged Care Quality and Safety Commissioner's response in the same transcript, and the Commission's Compliance and Enforcement Policy (14 July 2021), pp7-9.
[17] *Aged Care Act 1997*, Part 4.1, Division 54; *Quality of Care Principles 2014*, Part 5 and Schedules 1 and 2. See also the Regulatory Impact Statement for the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 which notes 'there is a risk that providers reduce allied care services within residential aged care when the requirement to provide certain treatments to access additional funding is removed. This risk is minimised by the Aged Care Quality Standards requiring the delivery of clinical care in accordance with the consumer's needs, goals and preferences to optimise health and well-being' (p198).

to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;[18]

to comply with the Aged Care Quality Standards;[19] and

such other responsibilities as are specified in the Quality Principles.[20]

For the provision of allied health services in residential aged care, the Quality Principles specify the care and services that an approved provider must provide in Parts 2 and 3 of Schedule 1 and Part 1 of Schedule 5, and must be provided in a way that complies with the Standards in Schedule 2.[21]

As an example, one of the most directly relevant allied health items in Schedule 1 is Item 3.11 in Part 3. Item 3.11 is defined as:

> Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services.

The content of the care or services is defined as:

(a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain care recipients' levels of independence in activities of daily living;

(b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow care recipients to reach a level of independence at which maintenance therapy will meet their needs.[22]

Care and services, including allied health as above, must be provided in a way that complies with the Quality Standards.[23]

The Quality Standards are therefore the key tool used by the Commission to ascertain provider compliance with regard to allied health provision. The submission now turns to the content of the Quality Standards to examine whether they might be applied to ensure consistency with the Royal Commission's allied health recommendations.

The Quality Standards

The Quality Standards have long been criticised for their lack of detail and objective measurement.[24] It seems counter-intuitive that public consultation on the Quality Standards ended on 25 November 2022 when the Capability Review has just commenced.

It is also not evident that proposed reforms to the Quality Standards are intended to in any way address fundamental allied health concerns. It is similarly unclear if and whether there is any

[18] *Aged Care Act 1997*, s 54-1(1)(b).
[19] *Aged Care Act 1997*, s 54-1(1)(d).
[20] *Aged Care Act 1997*, s 54-1(1)(h).
[21] *Quality of Care Principles 2014*, ss 6-7. Note too that recent changes to Part 3 include removal of a distinction between the different Parts of Schedule 1, so that additional fees are no longer payable by any care recipient for the provision of any of the care and services in Part 3 (Quality of Care Principles 2014, Part 2 ss 6 &7 and Schedule 1, Part 3 (amended by Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022; see also Aged Care Legislation Amendment (Residential Aged Care Funding) Instrument 2022, Schedule 3, Item 25)). This change means that any allied health service required by the resident other than in short-term restorative care is now even more likely to be required to be paid for by the provider from their overall AN-ACC funding.
[22] The content excludes intensive, long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.
[23] *Quality of Care Principles 2014*, ss 6-7.
[24] See eg Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 87-100; 121-134.

Government intention to reform the Quality Indicators for residential care to align with strengthening regulation of quality allied health care.[25]

Nevertheless, given the Quality Standards consultation, rather than interpreting the present Quality Standards, we refer to our appended earlier submission which examines the Department's proposed revised Quality Standards. Our earlier submission considers not only the words on their face, but also draws on the Commission's existing guidance material on the current Quality Standards to attempt to ascertain how the proposed new Standards might be applied by the Commission to effectively regulate the quality of allied health care.

The earlier submission outlines numerous changes required to the proposed new Quality Standards, and, in some cases, to associated guidance material.

The Commission's operation in practice

The Royal Commission found that the Aged Care Quality and Safety Commission had not shown strong and effective regulation, with the regulatory framework not focused enough on outcomes, and the regulator being too ready to accept the assurances of providers and to manage every provider back to compliance.[26] This appears to have continued.[27]

AHPA is not aware of whether the Commission currently engages in specific routine monitoring of allied health provision in aged care, whether non-compliance in relation to the provision of allied health services has ever been found, and what type of regulatory or enforceable actions have been undertaken.

We understand that in future, information on the provision of allied health services under AN-ACC will be shared with the Commission, but AHPA is not aware of whether and how the Commission intends to monitor allied health provision in residential aged care.

The fact that both the Commission and the Quality Standards pre-date the Royal Commission's finding of only eight allied health minutes also strongly suggests that the Commission's role is not working as intended. Some of this responsibility lies with the present Quality Standards, from which it is difficult to extract specific obligations pertaining to allied health service provision in residential aged care.[28]

The main Commission mechanisms for ensuring that providers meet their responsibilities under the Quality Standards are via accreditation assessments and performance assessments through site audits, review audits, quality audits and assessment contacts. However, even monitoring allied health service provision via these processes requires translating the relevant Quality Standards into a measurable instrument – as does enforcement in any systematic manner.

As detailed above, such an instrument is lacking, because despite Government in-principle acceptance of allied health-related Royal Commission recommendations such as Recommendation 38, it has set no real standard for allied health service provision.

[25] See eg Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 126-130.
[26] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 2 The current system*, 2021, 226-230.
[27] (Hansard Proof) Senate Community Affairs Legislation Committee Estimates, Parliament of Australia, Canberra, 10 November 2022, 111-118.
[28] See eg Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 126-130.

Conclusion

One of the ongoing difficulties AHPA experiences in advocating for allied health care to meet older people's needs is the way in which different aspects of the aged care reform process operate in a siloed manner. If the Commission is to be capable of ensuring allied health service quality, it is essential that all relevant entities – the Commission, the different teams in the Department engaging with issues of quality, service provision, regulatory and legislative reform (including human rights), and key aged care stakeholders – are able to come together via the Capability Review to confirm the Government's response to the allied health-related Royal Commission recommendations and assess the role of the Commission in future implementation.

However, even with greatly improved Quality Standards and a proactive and well-resourced Commission, the present Government lack of commitment to any funded benchmark for allied health care provision will make compliance more difficult to measure, and any enforcement will likewise be hampered.