Allied Health Professions Australia

Submission on A New Aged Care Act: Exposure Draft (Consultation paper No. 2)

March 2024

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. In aged care AHPA works closely with its Aged Care Working Group which is comprised of representatives of our member professions that provide aged care services.

Note

This submission refers to detail in two of AHPA's previous submissions on the proposed new Aged Care Act: Submission to Consultation on A New Aged Care Act – The foundations (Consultation paper No. 1) [September 2023]; and Submission to Consultation on A New Model for Regulating Aged Care (June 2023).[1]

They are respectively shorthanded in this submission as 'Foundations submission' and Regulatory submission'.

Chapter and question number references are to Consultation paper No. 2, with page references to that paper prefaced by 'CP2'.

Key recommendations

Recommendation 1

Add to the Objects (as per Royal Commission Recommendation 25(a)):

'provide a system of aged care that works to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to live independently as well as possible, for as long as possible'.

Alternatively, an object of the aged care system could be defined as having as a core function:

[1] https://ahpa.com.au/advocacy/submission-consultation-on-a-new-aged-care-act-the-foundations-consultation-paper-no-1/ ; https://ahpa.com.au/advocacy/submission-consultation-for-a-new-model-for-regulating-aged-care/ .

‘To support reablement – rehabilitation and restoring, or at least preserving as much as possible, older people’s capacities so that wellbeing is enhanced and/or maintained, including enabling and encouraging participants to remain in their home for as long as they wish and can do so.’

Recommendation 2

Subject to consultation with First Nations communities and aged care services, the Objects should include:

‘To provide aged care to First Nations peoples that is culturally safe and recognises the importance of their personal connection to community and Country.’

Recommendation 3

The Objects, Statement of Rights and Statement of Principles in the new Act should all clearly embed the concept of needs-based care. The Act should require use of a nationally consistent, evidence-based, assessment and care planning tool, to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care.

Recommendation 4

The Statement of Rights should expressly include:

the right to receive high quality aged care services, including aged care services that promote reablement as defined in the Objects; and

the human right to a standard of food, nutrition and nutritional care that supports health, wellbeing and quality of life.

Recommendation 5

The Statement of Rights should include the rights in:

the International Covenant on Civil and Political Rights;

the Convention on the Elimination of Racial Discrimination;

the UN Declaration on the Rights of Indigenous Peoples; and
the Convention on the Elimination of all forms of Discrimination Against Women.

Recommendation 6

Proposed sections 21 and 92 should be amended so that the rights in the Statement of Rights are legally enforceable via domestic action and there is a positive duty on providers.

Recommendation 7

The Australian Government should consult with the Australian public concerning whether to establish an independent entity to interpret and enforce the rights in the Statement of Rights, as well as providing education and training on those rights.

Recommendation 8

Subsections 22(9)–(11) should be deleted.

Recommendation 9

The Statement of Principles should make clear that it is intended as a non-exhaustive guide of how the Statement of Rights (amended as per our Recommendations 3–6) is intended to operate in the aged care system.

Recommendation 10

The application of the Statement of Principles should be extended to all entities who receive Government funding.

Recommendation 11

The definition of 'high quality care' included in the new Aged Care Act should be consistent with Royal Commission Recommendation 13(2).

Recommendation 12

High quality care, as defined in Recommendation 11, should be embedded in the new Act as the compliance and enforcement standard, aligned with the Statement of Rights and this submission's associated recommendations.

Recommendation 13

The new Aged Care Act must make it clear which entity is responsible for regulating the provision of allied health, and how any issues pertaining to this are to be addressed.

Recommendation 14

The Complaints Commissioner should be established as an independent statutory position appointed by the Minister, with dedicated funding and staffing line items.

General comments

This submission mainly addresses the implications for allied health service provision of the Exposure Draft of the proposed new Aged Care Act. However, because some sections of the Exposure Draft have not yet been drafted or at least released for public comment, and some important elements are planned to be included in the Rules which have not yet been released for consultation, it is difficult for us to comment with full certainty.

The parlous state of allied health in Australia's aged care system

As outlined in AHPA's Foundations submission, allied health is currently significantly underprovided and underfunded, particularly in residential aged care. Since that submission, average allied health minutes in residential aged care have decreased further, to 4.21 minutes.[2] The trend for minutes for some individual allied health professions to be so low that only four professions are individually represented also continues, ranging from 0.06 minutes for speech pathology to 2.75 minutes for physiotherapy, with occupational therapy, allied health assistants and other allied health categories too low to even feature in the data.[3]

[2] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector Quarter 1 2023-24, July to September 2023, 16.
[3] Ibid, 18.

We further note that the Independent Health and Aged Care Pricing Authority (IHACPA) 2023 Residential Costing Study appears to have reported an even smaller number of average allied health minutes, particularly as AHPA understands that pharmacy was included in the IHACPA definition of allied health care, whereas Quarterly Financial Reporting does not include pharmacy.[4]

Inadequate funding of allied health services has flow-on effects to the allied health aged care workforce, including deterioration in the quality of care available to residents. For example, our Foundations submission refers to residential aged care providers substituting 'cheaper' workers from outside allied health, such as personal care workers and lifestyle staff, to provide services that considerations of quality and safety require to be delivered by an allied health professional. Similarly, allied health assistants are sometimes being used to carry out essential allied health tasks, which can expose residents to unacceptable risks.

AHPA repeats below the core themes of our previous submissions that ensuring the provision of allied health services to all older people who need them requires the aged care system to address several interrelated issues. These are: a lack of any meaningful, mandatory service provision benchmark; the current flawed approach to allied health needs assessment; and the failure of the present aged care system to incorporate a philosophy of reablement.

In addition, any notion of ringfenced funding for allied health services is not reflected in the Exposure Draft in its current form. As we have previously submitted,[5] costing and Government funding for allied service provision must be guaranteed in the same way that levels of nursing and personal care are now required to be funded via the AN-ACC funding model. We note that ensuring allied health funding is a crucial component of Royal Commission Recommendations 36 and 38.

Assessment of allied health needs

As AHPA's Foundations submission states, the Royal Commission concluded that allied health should be regarded as a fundamental element of the aged care system, and therefore recommended that aged care provided to people at home and in residential facilities include a level of allied health care appropriate to each person's needs.

Our Foundations submission outlines that nationally consistent assessment of allied health needs has not been implemented for residential aged care or home care, and that current Quarterly Financial Reporting does not facilitate analysing whether residents actually receive the amount and types of services that they are clinically assessed as needing – or even whether they have been appropriately clinically assessed.

In order to meet assessed needs, coordinated care planning and sufficient aged care funding must also be guaranteed. However, as we have noted, there is no dedicated funding of allied health services in residential aged care, and no associated mandatory benchmark equivalent to nursing and personal care minutes.

Accordingly, AHPA looks to the new Aged Care Act to address our well-founded concerns about allied health service provision to aged care consumers.

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[4] 'Appears' because the Costing Study as published does not provide raw figures, but only represents allied health minutes in graph form.
[5] In addition to the references at Note 1, see https://ahpa.com.au/advocacy/submission-aged-care-taskforce/ .

Allied health and reablement

The Exposure Draft makes no substantive reference to allied health. For example, section 9(2)(a), despite reference to nursing services, does not include allied health services. There is an associated lack of reference to reablement: for example, the concept is absent from the Objects and is not clearly expressed in the Statement of Rights or the Statement of Principles.

This absence is despite the inclusion, via section 142(a), in the safeguarding functions of the Commissioner:

> 'to uphold the rights under the Statement of Rights, and protect and enhance the safety, health, wellbeing and quality of life, of individuals accessing funded aged care services, *including* [our emphasis] through encouraging the delivery of culturally safe, culturally appropriate, trauma aware and healing informed funded aged care services'.

The failure to refer to a definition of reablement in the new Act is also despite reablement now, following public consultation, being referenced in the 'Strengthened' Quality Standards and associated draft guidance material (although as outlined below, there is still no associated reference in either to allied health).[6]

As a consequence, nowhere in the Exposure Draft elucidates the relationship between reablement and allied health, contra the Royal Commission. This omission is particularly concerning because it sidelines allied health as an 'add on' service or as a health rather than an aged care matter (with associated funding and access implications).

Recommendation 1

Add to the Objects (as per Royal Commission Recommendation 25(a)):

'provide a system of aged care that works to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to live independently as well as possible, for as long as possible'.

Alternatively, an object of the aged care system could be defined as having as a core function:

'To support reablement – rehabilitation and restoring, or at least preserving as much as possible, older people's capacities so that wellbeing is enhanced and/or maintained, including enabling and encouraging participants to remain in their home for as long as they wish and can do so.'

Enhancing system regulation

Given the parlous state of allied health in aged care, AHPA has previously submitted that the current aged care system fails to ensure quality (including sufficient provision) of allied health services, and that this stems from two main regulatory weaknesses: the process for monitoring compliance; and the content of the Quality Standards.

As we have previously submitted, we would expect a high functioning aged care regulatory system to be capable of addressing the current concerns about allied health quantity, types, and quality in residential aged care.

It is difficult to comment definitively when the 'Strengthened' Quality Standards are to be in the Rules, those Rules are not available for public perusal, and associated guidance material for the Quality Standards is subject to a separate public consultation with a deadline that extends past

[6] For more on reablement, see AHPA's Foundations submission.

the Exposure Draft consultation period. For example, one issue to be resolved is that given that, as noted above, the Quality Standards now refer to reablement more extensively, it is not at all clear how that aspect of the Quality Standards is intended to relate to the new Act.

With respect to allied health, the Quality Standards themselves also continue to have flaws which are not addressed by the draft guidance materials. As just one example, the Guidance for Quality Standard 3.2, like the Exposure Draft, does not recognise the key relationship between reablement and allied health.

For further comment on the proposed regulatory system, see our comments on Chapters 3, 5 and 6 below.

Chapter 1 Introduction (pp 12-30)

While AHPA understands the legal need for the reference to sickness in the eligibility provisions, the framing in section 9(2)(a) of 'by reason of sickness' is too narrow – older people receiving or in need of aged care services are not necessarily sick. This medicalised definition ignores the broader understanding of reablement and thereby also, as submitted above, elides the essential role of allied health services in aged care.

AHPA understands that subsections 10(4) and 10(5) are intended to include allied health professionals in the new definition of aged care worker. Subject to public consultation on the proposed regulatory framework categories, we do not take issue with this.

However, we note that there are necessary implications for policy initiatives concerning the allied health component of the aged care workforce. For example, as our Regulatory submission recommended, allied health assistants should be subject to a nationally consistent delegation and supervision framework. More broadly, allied health workforce data must be collected to inform planning for future workforce need, as to date workforce strategies have focused almost exclusively on personal care workers.

Q1. Are the revised Objects, Statement of Rights and/or Statement of Principles clear and do they achieve their intent? If not, what changes are required?

We reiterate our Foundations submission that the Objects should include (from Royal Commission Recommendation 1(3)(a)) 'provide a system of aged care based on a universal right to high quality, safe and timely support and care.'

See also our Recommendation 1 above.

AHPA also reiterates our Foundations submission recommendation below.

Recommendation 2

Subject to consultation with First Nations communities and aged care services, the Objects should include:

'To provide aged care to First Nations peoples that is culturally safe and recognises the importance of their personal connection to community and Country.'

The Objects also only refer to 'taking into account' needs, and do not even refer to 'assessed needs'. The Statement of Rights does not improve on this, and neither does the Statement of Principles.[7]

Recommendation 3

The Objects, Statement of Rights and Statement of Principles in the new Act should all clearly embed the concept of needs-based care. The Act should require use of a nationally consistent, evidence-based, assessment and care planning tool, to identify, plan for and deliver the allied health needs of individual aged care residents and consumers receiving home care.

Statement of Rights

As flagged in our Foundations and Regulatory submissions, the Exposure Draft's model is weak and does not provide confidence that the relevant human rights of older people receiving aged care will be able to be meaningfully and consistently upheld.

The two essential problems concerning the proposed Statement of Rights are the content of the rights; and the actual operation of the Statement in the legislation and Australian legal system as a whole.

In terms of content, the Statement of Rights is insufficiently focused and lacks detail. For example, nothing in the listed rights provides consumers with a conduit to address current allied health limitations, such as a failure of a provider to assess their clinical needs or to provide (and pay for) necessary allied health services.

Taking this scenario as a test example, there is no proposed enforceable universal right of access to funded aged care services. CP2 (23) rationalises this exclusion on the basis that:

> 'the Royal Commission recognised that the system should be financially sustainable and based on need. Any rights or entitlement to access funded aged care services must be balanced against these considerations.'

But the Royal Commission was clear that older people should be entitled to all forms of support and care which they are assessed to need (Recommendation 25(b)). The Commissioners found that the present aged care system does not deliver allied health services to meet that goal.[8] The Royal Commission's Final Report and associated recommendations also leave no doubt that service provision must attain a reablement standard.[9]

Instead, the nearest applicable content in the proposed Statement of Rights is section 20(1)(a)(ii):

> 'An individual has a right to (a) exercise choice and make decisions that affect the individual's life, including in relation to. . .(ii) how, when and by whom those services are delivered to the individual'.

If a consumer has been assessed to need occupational therapy (or should have been assessed and requests such a service) and the provider tells them that they have no occupational therapy services, it is highly likely that directing the consumer to pay for the service themselves – and even to source it – will be deemed sufficient under the proposed new Act.

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[7] Section 22(4) includes the phrase 'based on the needs' but this only refers to culturally appropriate, trauma informed etc, not clinically assessed needs.
[8] Royal Commission into Aged Care Quality and Safety, *Final Report Volume 3A The new system*, 2021, 176.
[9] Ibid. See also, for example, Recommendations 25 and Recommendations 36–38.

Similarly, subsections 20(2)-(4) say nothing about the individual's right to be clinically assessed for their allied health needs and to have those needs provided via services paid for by the provider.

The Statement also does not incorporate (even by reference) any international conventions except the International Covenant on Economic, Social and Cultural Rights (CESCR) and the Convention on the Rights of Persons with Disabilities (CRPD). The nearest applicable aspects of both incorporated conventions are the CESCR's Article 12 and the CRPD's Article 25 – the right to health. However, in those conventions, essentially the right to health is mainly guaranteed via other obligations to provide equality before the law and non-discrimination. In addition, the CRPD appears to have been incorporated in the Exposure Draft mainly to ensure compatibility with the Constitution with respect to home care.

Other limitations to the content of the rights concern the proposed definition of quality aged care services, which we address under Question 3 below.

In terms of the practical operation of the Statement of Rights, the Objects include giving effect to obligations under the CESCR and CRPD, and 'to provide an aged care system designed to uphold the rights of individuals under the Statement of Rights' (s 5(b)(i)). We have already noted limitations to the content of the rights in the Statement. However, the most striking weakness is that the rights are not enforceable (s 21(3)). It is instead proposed that:

> 'It is the intention of the Parliament that registered providers delivering funded aged care services to individuals must not act in a way that is incompatible with the rights specified in section 20, taking into account that limits on rights may be necessary to balance competing or conflicting rights and the rights and freedoms of other individuals.' (s 21(2))

Upholding the rights therefore relies largely on provider compliance with their obligations under the Quality Standards, and the Aged Care Quality and Safety Commission's regulation of those.[10] As discussed in our Foundations submission and further below, this is not reassuring.[11]

Rights in the Statement cannot be simply left to an assumed dovetailing with the Quality Standards that is then to be interpreted and applied by the Aged Care Quality and Safety Commission (see our comments on Chapters 3, 5 and 6 below). The Act must provide that they are enforceable.

Recommendation 4

The Statement of Rights should expressly include:

the right to receive high quality aged care services, including aged care services that promote reablement as defined in the Objects; and

the human right to a standard of food, nutrition and nutritional care that supports health, wellbeing and quality of life.

Recommendation 5

The Statement of Rights should include the rights in:

the International Covenant on Civil and Political Rights;

[10] See eg CP2, 23-24.
[11] See also the reference to provider actions 'to be *guided* by the Statement of Rights (emphasis added, CP2, 98)'.

the Convention on the Elimination of Racial Discrimination;

the UN Declaration on the Rights of Indigenous Peoples; and

the Convention on the Elimination of all forms of Discrimination Against Women.

Recommendation 6

Proposed sections 21 and 92 should be amended so that the rights in the Statement of Rights are legally enforceable via domestic action and there is a positive duty on providers.

Recommendation 7

The Australian Government should consult with the Australian public concerning whether to establish an independent entity to interpret and enforce the rights in the Statement of Rights, as well as providing education and training on those rights.

Statement of Principles

We repeat our objection concerning subsection 22(9) from our Foundations submission.

Subsections 22(10)-(11) pre-empt the yet to be released recommendations of the Aged Care Taskforce. They also have potentially concerning implications for allied health services. For example, does the unspecified reference to 'services' in subsection 22(10) mean that when read with subsection 22(11), allied healthcare will have to be paid for by the consumer?

If so, as detailed in our Regulatory submission, this is in direct contradiction to Royal Commission Recommendation 69 which includes that allied health care should generally be provided by aged care providers. Commonwealth Government accepted this recommendation and noted 'Careful consideration needs to be given to harmonising funding and quality requirements for allied health, mental health and oral and dental health services.'[12]

Overall, the Statement of Principles is weak. For example, section 22(2)(c) simply states that the Commonwealth aged care system supports the delivery of funded aged care services by registered providers that *recognises* the rights of individuals under the Statement of Rights (emphasis added).

Similarly, section 23 simply requires various entities to 'have regard to' the Principles, and provides that the Statement of Principles is not enforceable in its own right. This leaves the only likely possible legal route to be via a costly and arduous administrative law action which is unlikely to be accessible to the vast majority of aged care consumers.

It is therefore unclear how non-adherence to the Statement of Principles would be practically addressed, and what the consequences might be. As with the Statement of Rights, we are left to rely on the existing regulatory system of incident reports, complaints and audits.

A further profound limitation is that the Statement of Principles only applies to Government agencies.

[12] Department of Health, Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety (May 2021), 46. The recent Joint Statement to clarify the roles and responsibilities for the delivery of health care for people receiving aged care services does not resolve this issue.

Recommendation 8

Subsections 22(9)–(11) should be deleted.

Recommendation 9

The Statement of Principles should make clear that it is intended as a non-exhaustive guide of how the Statement of Rights (amended as per our Recommendations 3–6) is intended to operate in the aged care system.

Recommendation 10

The application of the Statement of Principles should be extended to all entities who receive Government funding.

Q3. Do you consider the revised definition of high quality care will encourage providers to aim higher? Does it align with your future vision for aged care?

No, and no. While section 19's definition of high quality care includes many elements that AHPA supports, it does not address the glaring issues of under-provision of allied health, nor the lack of consistent allied health needs assessment. In comparison, the Royal Commission definition of high quality care is that it includes consistent, system-wide skilled assessment of care needs.

Further, we repeat our Foundations submission's critique of the proposed approach to high quality care, on the basis that it is only aspirational. This runs counter to the Royal Commission's finding that high quality care must be the foundation – and hence the enforceable benchmark – of aged care.

The proposed distinction between what is enforceable – 'quality' care – and aspirational 'high quality' care is also unconvincing. Much of what is listed under section 19 should be expected as part of 'quality', particularly if the Statements of Rights and of Principles are to be meaningful.[13]

In contrast to (aspirational) high quality care, (enforceable) quality care is not clearly defined in the Exposure Draft but is instead to be interpreted via the Objects, Statement of Rights, Statement of Principles and the Quality Standards.

Due to the absence of public consultation material, it is not possible to comment in detail on how provider obligations and regulatory enforcement under the Quality Standards are intended to relate to the definition of quality care and actual provider performance outcomes. However, in terms of allied health provision, and given the limitations of the proposed Statement of Rights and Statement of Principles (see above), it is highly likely that most providers will only do what is actually required of them by law, and hence there will be little in the way of a meaningful minimum standard.

Recommendation 11

The definition of 'high quality care' included in the new Aged Care Act should be consistent with Royal Commission Recommendation 13(2).

[13] See also CP2, 20-21. As a further illustration of the confusion between the two categories, see Department of Health and Aged Care, *A New Model for Regulating Aged Care Consultation: Summary Report* 2023, 59.

Recommendation 12

High quality care, as defined in Recommendation 11, should be embedded in the new Act as the compliance and enforcement standard, aligned with the Statement of Rights and this submission's associated recommendations.

Q4. Do you think a single service list will increase clarity of the services that the Commonwealth aged care system provides to older people?

Yes. However, it is also important that there is coordination and consistency with other government-funded schemes for service provision, such as the National Disability Insurance Scheme (NDIS) and Veterans' Affairs.

Chapter 2 Entry to the Commonwealth aged care system (pp 31-44)

AHPA is extremely disappointed that the Exposure Draft has no automatic right to access service provision. As we discuss above with regard to the Statement of Rights, the new Act must include an enforceable universal right of access to funded aged care services. Provisions concerning eligibility for services must be consistent with the Statement of Rights and Statement of Principles, in a manner that guarantees not just equitable access to assessment, but also to services.

AHPA also supports the submission to this consultation from our member Speech Pathology Australia (SPA), that more clarity is needed concerning supports for people with disability who are aged over 65. In particular, the new Act must ensure that those older people are able to access the services they need in a timely manner, and at a level and quality that is consistent, regardless of the scheme under which they are provided.

With respect to First Nations aged care services, AHPA supports the submission to this consultation from the National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) that the removal of eligibility criteria for people aged 45–49, along with proposed changes to criteria for people aged over 50, are of concern.

We concur with NATSIAACC that these and associated changes may reduce provider flexibility to provide services. This will have detrimental impacts on provider sustainability and engagement with the aged care sector by First Nations older people.

We note that any additional steps or pathways in the entry process must not produce unnecessary delays in older people receiving services.

Q13. Is there anything else you would like to see specified in the legislation regarding the needs assessment process?

AHPA supports the notion of reassessment 'on the papers' where appropriate, but we remain concerned that the initial assessment is merely a screening, not a clinical assessment (see our General Comments above and our Recommendation 3).

We do not support the proposed formalisation of the use of algorithms and computer-generated care plans, without public consultation based on more detail of what is currently undertaken and what is proposed for the future. Such consultation must include considerations of transparency and accountability.

Chapter 3 Registered providers, aged care workers and digital platform operators (pp 45-63)

Q17 Do you consider that the proposed draft statutory duties on registered providers and responsible persons achieve the proposed policy intent?

Registration

We note and approve in principle the proposal that separate obligations apply to aged care providers, responsible persons of registered providers, aged care workers (including allied health professionals when they are employees or contractors), and the operators of digital platforms that facilitate access to funded aged care services.

We cannot make detailed comment on the proposed registration categories because they have not been included in the Exposure Draft material. However, AHPA understands that obligations for provision of allied health in the home are likely to fall under Category 4, with allied health in residential care being part of Category 5 and/or Category 6.

AHPA agrees that it is appropriate that the highest onus, including most of the burden of the statutory duty discussed below, should fall on the aged care provider rather than the individual worker. We therefore understand that at this stage of the reforms at least, individual allied health professionals will not be required to register but will be subject to aged care worker regulation, including via the Code of Conduct and worker screening.

It is difficult to comment in depth on the practical impact of aged care worker obligations, particularly because the Guidance on the Quality Standards has not been finalised. Nevertheless, it is important that regulation of allied health professionals does not require administratively onerous and costly processes.

The aged care regulatory system must take into account the fact that allied health professionals are already either regulated by the Australian Health Practitioner Regulation Agency or are, through their particular profession, self-regulated to an equivalent standard. The new aged care regulatory system must also recognise that many allied health professionals are subject to regulatory frameworks in other care and support sectors such as the NDIS, and so existing regulation requirements outside the aged care system should not be unnecessarily duplicated.

A continuing vexed issue is whether the registration categories will be effective in making the relevant providers responsible not simply for unsafe and risky practices, but for ensuring sufficient and appropriate types of allied health. This takes us back to unresolved questions about the regulatory system and its relationship to the Objects, Statement of Rights and Statement of Principles.

For example, the requirement that, as a condition of registration, providers demonstrate that they 'understand' the Statement of Rights (s 92(1)(a)) is too weak. Certainly, it appears that a breach of a condition of registration is unlikely to result in addressing problems with allied health service provision (see more broadly our comments on Chapter 6 below).

We also note the statement in CP2 (57) that reporting requirements for registered providers under the new Act will be streamlined, removing some of the complexities of current arrangements, and that the Rules will prescribe requirements about reporting information relating to various matters. It is not clear what those proposed changes might mean for public transparency, nor what providers will be required to report under processes such as Quarterly Financial Reporting. This

clarity is especially important given the Government's stated commitment to improving transparency (eg CP2, 82).

On a similar note, AHPA has been advocating for better pathways and public information concerning Schedule 1 of the Quality Principles. It appears that whatever becomes of Schedule 1 will be in the Rules, together with the Quality Standards. At this stage we do not know what will happen to the current distinction in Schedule 1 between items that the provider must provide (pay for) and items to which they must simply provide access. This is important given the risk identified above that responsibility for allied health provision to aged care consumers will be diverted to health rather than required under aged care.

More generally, public accountability requires better data collection and public reporting, as recommended by the Royal Commission (eg Recommendation 38(d)).

Statutory duty

As outlined in our Foundations submission, the new statutory duty for providers sets the threshold too high (and hence likewise the compensation pathway).

When this restricted cause of action is considered in the light of the proposed regulatory definition of quality (as opposed to the merely aspirational level of high quality), there will remain a large number of older people whose allied health-based needs will not be guaranteed to be met.

This group includes people receiving care that is substandard but does not pass the two-step test for breach of duty of care (let alone the third step required for a penalty). Those people, like those consumers receiving care that does not reach the proposed 'quality' standard, will have to rely on enforcement of the Quality Standards by the Aged Care Quality and Safety Commission (further discussed below).

There will also continue to be many older people who do not receive high quality care but whose care meets the proposed 'quality' definition, and so there will be no enforcement pathway available at all. That is likely to be the experience of the vast majority of older people not receiving sufficient or appropriate allied health services.

Chapter 4 Fees, payments and subsidies (pp 64-67)

Q21. How does the proposed structure of Chapter 4 read to you?

Given the scarcity of details in the Exposure Draft and the fact that the Aged Care Taskforce recommendations have not yet been publicly released, there is insufficient detail to comment on some of the relevant issues in this Chapter.

Q24. Do you support registered providers being given access to specific additional Commonwealth funding which must be used for a particular purpose, rather than to deliver specific aged care services?

In principle yes, but we are very disappointed that there is nothing new proposed with regard to person-centred and provider-based subsidies in terms of any ringfenced funding for allied health (CP2, 65-66), as we discuss under General Comments above.

Chapter 5 Governance of the aged care system (pp 68-74)

Q25. Do you think there are any additional functions missing from the role of the Commissioner?

Q26. Is it clear how the roles of the System Governor and Commissioner differ, but also fit together, as regulators of the aged care system?

AHPA understands via CP2 (69) that section 132 of the Exposure Draft provides that the System Governor's functions include 'facilitating equitable access to funded aged care services for older people in need irrespective of their location or diverse characteristics' and 'monitoring and encouraging the training and development of aged care workers [which now include allied health professionals]'.

However, of the two roles of System Governor and Commissioner, it is still not clear which entity is proposed to take responsibility for ensuring provision of allied health according to need.

CP2 (70) interprets the Exposure Draft as reframing the Commissioner's functions in a way which has a greater focus on the rights of older persons, ensuring safe and quality care to older Australians in the performance of these functions. In practice, this boils down to ensuring provider compliance with obligations and addressing incident reports and complaints (the latter two which relate to obligations and the Statement of Rights).

However, section 142(a) of the Exposure Draft includes in the safeguarding functions of the Commissioner:

> 'to uphold the rights under the Statement of Rights, and *protect and enhance the safety, health, wellbeing and quality of life*, of individuals accessing funded aged care services, *including* [my emphasis – 'including' is omitted in CP2's (71) characterisation of this section] through encouraging the delivery of culturally safe, culturally appropriate, trauma aware and healing informed funded aged care services'.

This broader conceptualisation of the Commissioner's functions appears to have potential for ensuring that the provision of allied health services enhances the health, wellbeing and quality of life of aged care consumers.

Recommendation 13

The new Aged Care Act must make it clear which entity is responsible for regulating the provision of allied health, and how any issues pertaining to this are to be addressed.

Q 27. Do you think the proposed arrangements for the Complaints Commissioner clearly demonstrate their role in the aged care system?

No. AHPA submits that the best way to achieve robustness and accountability of the complaints system is to ensure that the Complaints Commissioner is independent of the Commission.

Recommendation 14

The Complaints Commissioner should be established as an independent statutory position appointed by the Minister, with dedicated funding and staffing line items.

Chapter 6 Regulatory mechanisms (pp 75-81)

Q29. Do you consider the expanded powers made available to the Commissioner will ensure they can take a pro-active and risk-proportionate approach to the regulation of the sector?

It is difficult to provide definitive comments on how the proposed improved regulatory system will work, because 'the devil will be in the detail' of either the Rules or how the Aged Care Quality and Safety Commission (the Commission) will perform its functions. For example, the details of the service delivery -related obligations condition in section 105 of the Exposure Draft are to be in the Rules and will be consulted on separately (CP2, 54).

However, broadly our response to Q29 is 'no'. We support a risk-proportionate approach, but that hinges on the understanding of risk, which so far has not served the allied health needs of older people. There are also too many steps and 'let offs' under the proposed new Act before the possibility of any meaningful enforcement.

This submission has rejected the notion that 'high quality' care should be simply aspirational. Section 99 of the Exposure Draft and associated Quality Standards require registered providers in certain registration categories to demonstrate the capability for, and commitment to continuous improvement and to have a continuous improvement plan. CP2 (54) states that this condition 'is designed to ensure providers work with the Commission to improve their delivery of funded aged care services, and towards delivering high quality care.' But this is purely voluntary.

The Exposure Draft continues the aged care system's strong reliance on complaints having to come from the consumer or their family, or perhaps issues raised via incident reporting, rather than non-compliance being picked up through routine monitoring by the Commission. At the same time, the whole system, particularly the purely aspirational status of high quality aged care, is underpinned by an assumption that aged care consumers are practically able to take the initiative via the star ratings system (and now too, Dollars for Care reporting) to 'ensure market standards' by 'choosing' services and residential facilities.

As outlined previously in AHPA's Regulatory submission, under the proposed new Act much of the burden of regulation will therefore fall on aged care consumers, many of whom, particularly in residential aged care, are not in a position to effectively advocate for their rights without external assistance. This is not the approach of a human-rights based aged care system.

AHPA is also not convinced that the stronger powers proposed for the Commissioner are likely to make any genuine difference for allied health because that partly depends on the practical outcomes of the recommendations from the Capability Review, combined with continuing problems in how the Quality Standards are likely to be interpreted and applied by the Commission.[14]

As an illustration of the problematic current context, recent research on Australian residential aged care found that residents only receive appropriate care half of the time, and this result is

[14] See: AHPA's Foundations and Regulatory submissions; AHPA's Submission to Capability Review of the Aged Care Quality and Safety Commission (December 2022) https://ahpa.com.au/advocacy/submission-to-capability-review-of-the-aged-care-quality-and-safety-commission/ ; AHPA's Submission to Department of Health and Aged Care on Revised Aged Care Quality Standards (November 2022) https://ahpa.com.au/advocacy/ahpa-submission-to-the-department-of-health-and-aged-care-on-revised-aged-care-quality-standards/ .

associated with significant provider failures to adopt evidence-based clinical practice and to meet personal and clinical care standards.[15]

Such failures need to be set against the factors identified in this submission:

- the absence of reablement from the Exposure Draft
- no mandated benchmark for allied health care minutes or associated designated funding; and
- variable allied health needs assessment processes and inadequate monitoring.

When all of this is combined with a lack of concrete quality outcome measures and associated guidance, it suggests that these failures are unlikely to be addressed once the new Act commences, particularly given that high quality care will not be enforced as the standard.

Q31. Does the new Act provide sufficient clarity regarding the role of the Department in managing the integrity of the aged care program? Is there anything you would like to see included in the new framework to ensure program assurance is maintained?

No, and yes – see our comments and recommendations above, including Recommendations 13 and 14.

Q32. What are the advantages and disadvantages of the proposed new critical failures powers? Are these powers necessary to ensure urgent and decisive action can be taken to protect older persons in residential care and maintain service continuity?

Q33. Are the conditions identified to trigger the critical failures powers reasonable, or are there other conditions that could be considered?

It is not possible to comment usefully here without more detail, except to reiterate that defining 'risk' is key.

Chapter 8 Miscellaneous (pp 89-94)

AHPA does not support the use of algorithms or analogous computer programs for classification or decision making. At the least, public consultation on detailed proposals is needed.

We would prefer that the new Act was subject to independent review in less than the proposed five-year timeframe. If the gaps and lack of clarity in the Exposure Draft, including the current absence of draft Rules, is not sufficiently addressed via public consultation before a new Act commences, AHPA recommends that independent review be conducted within 6 months after the third anniversary of the Act's commencement.

[15] Peter Hibbert et al, 'Unsafe care in residential settings for older adults: a content analysis of accreditation reports', *International Journal for Quality in Health Care* 2023 35(4) 1-8; Peter Hibbert et al, 'The quality of care delivered to residents in long-term care in Australia: an indicator-based review of resident records (CareTrack Aged study)', *BMC Medicine* 2024 22: 22.

Chapter 9 The reform timeline and readiness support (pp 95-100)

Q42. Do you have any views on the best approach to schedule the implementation of these important reforms to help ensure a smooth transition and compliance with the new legislative framework?

Q44. What type of activities will you need to do to transition to the new aged care system (e.g. structural changes, staff training etc) and how much time will you need for these activities prior to the new system taking effect?

The scale and complexity of aged care reforms over the past few years has presented considerable challenges to an under-resourced sector, particularly for not for profit and unfunded stakeholders. In addition, allied health peak bodies have not always been sufficiently consulted, despite organisations such as AHPA regularly raising issues and concerns.

In this submission we have alerted the Department to some significant lacunae in the Exposure Draft, together with some key 'unknowns'. The first step in ensuring successful implementation of the new legislation should be to address these, including necessary stakeholder consultation, before introducing the Bill to Parliament.

The Department and other relevant entities must then collaborate with stakeholders, including the allied health sector, in development and rollout of the integrated readiness plan and an implementation strategy. The plan and subsequent implementation must address all issues of concern to consumers and providers, including deadlines, registration procedures and workforce requirements.

It is then important for Government to continue to engage with aged care stakeholders in the ensuing policy and program design.

Lastly, given the breadth and complexity of the matters covered in the new Act, we submit that Government should improve upon the process of implementation of the Royal Commission's recommendations. This should be done by establishing an implementation monitoring group that includes key stakeholders and considers the most appropriate strategies to evaluate the impacts of the aged care reforms.

This monitoring group may also be the appropriate forum to ensure ongoing collaboration with other sectors of the care and support economy such as the NDIS, so that best practices can be adopted and service consistency for consumers assured.