Services for Australian
Rural and Remote Allied Health

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Services for Australian Rural and Remote Allied Health (SARRAH) submission on the new Aged Care Act Exposure Draft

Thank you for the opportunity to contribute to the consultation of the proposed Aged Care Act.

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, aged care, disability, early childhood and other service systems. SARRAH was established in 1995 as a network of rurally based allied health professionals to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. We continue to do that. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAH has a substantial network of members, many of whom provide allied health services to elderly Australians, including those receiving support through Commonwealth aged care support programs in residential and community settings. SARRAH has a longstanding interest in the availability, accessibility and impact of allied health services (or the lack of them) as they impact the health and wellbeing of older Australians.

We note that SARRAH receives no Commonwealth or other government financial assistance to support its representational, advisory, general membership engagement or support, advocacy, or related operational activities. Our members fund this aspect of our work.

SARRAH considers the following points are crucial to improving assurance as to quality of care available to care recipients, including bridging gaps in care. We note that important gaps exist in the provision of and performance information relating to allied health services for aged care recipients,

The Government's aged care reform agenda aims to address serious, systemic problems identified by the Aged Care Royal Commission (ACRC). It is a major, challenging and generally very positive development and beginning to deliver far better results for aged Australians to a level of quality the community expects in many areas of aged care operations. Further, the new, rights-based Aged Care Act should strongly reinforce the continued improvement in standards and quality of aged care. Similarly, a much-strengthened Aged Care Safety and Quality Commission, establishment of the office of the Inspector-General of Aged Care and

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revised performance and reporting measures lay the basis to enable, support and require better standards of care.

The new draft Act includes under ***Statement of Principles*** (page 33) (3) *The Commonwealth aged care system supports individuals to: …(d) maintain or improve the individual's physical, mental, cognitive and communication capabilities to the extent possible, except where it is the individual's choice to access palliative care and end-of-life care*.

The right of a person to maintain and be supported to maintain their "***physical, mental, cognitive and communication capabilities to the extent possible"*** is:

- A fundamental issue of human rights, reinforced through the draft Aged Care Act;
- Frequently will require access to and the provision of services by qualified allied health professionals and/or allied health assistants, working under the direction of the allied health professional; and
- Was identified clearly as an area of aged care reform system performance that was (at a system level) sub-standard and needed to improve substantially.

SARRAH is of the view that the proposed Aged Care Act falls short in addressing the needs of Aboriginal and Torres Strait Islander peoples, and as a minimum should cite the UN Declaration on the Rights of Indigenous Peoples as the basis upon which First Nations peoples should expect culturally responsive, equitable and accessible Aged Care services.

The Aged Care Royal Commission (ACRC) found that allied health services were underused and undervalued across the aged care system. The ACRC Final Recommendations included numerous references to improving access to allied health care, most notably:

- **Recommendation 36: Care at home to include allied health care** – *the detailed recommendation is on pages 233-234 of the ACRC Final Report.*

And

- **Recommendation 38: Residential aged care to include allied health care** – *the detailed recommendation is on page 235 of the ACRC Final Report.*

The ACRC also found:

"*the current system is largely failing those Australians who are identified by the current legislation itself as having 'special needs'. People living in regional, rural and remote areas, for example, have significantly less access to aged care than people living in major cities*[1].

[1] Page 9 of the Final Report of the Aged Care Royal Commission (Volume 1)

"We are particularly concerned about access to aged care services in regional, rural and remote areas. Older people make up a greater share of the population in these areas than in major cities. Furthermore, people in regional, rural and remote areas experience multiple disadvantages, which can magnify the need for support in older age. The data shows that the availability of aged care in outer regional and remote areas is significantly lower than in major cities, and has declined in recent years."[2]

SARRAH recognises and welcomes the resourcing and effort going to improve general access to aged care in rural and remote communities and, importantly, to improving, capacity, access and the cultural safety and responsiveness of aged care services for Aboriginal and Torres Strait Islander Australians.

Unfortunately, **to date the reforms have not prioritised or resulted in improvements at a system-wide level to allied health care or access**. The new AN-ACC funding model removed prescriptive requirements on the provision of allied health services that incentivised certain services being delivered (regardless of an individuals' actual care need) while not allowing for provision of other allied health services that would improve the person's health, well-being and capacity. The additional resources provided to the sector (including through the AN-ACC) should have enabled providers to – as a minimum - maintain levels of allied health service provision identified by the ACRC. The approach in the reforms to date has been to not require minimum standards of allied health service provision through the AN-ACC or otherwise, instead relying on broader indicator performance and reporting. **The evidence to date is very concerning, with much of the data and feedback suggesting allied health access has worsened since the ACRC reported.** The allied health sector has raised concerns repeatedly about reports of allied health services being cut and discontinued and sector data (detailed below) indicating allied health services being delivered far below the levels considered insufficient by the ACRC.

In light of allied health workforce shortages, maldistribution and strong increases in demand and competition for the available workforce, it is difficult to determine the extent to which workforce shortages and provider decisions contribute to the shortfall. Workforce shortages almost certainly contribute to and exacerbate the problem.

In October 2023, the Government released the *Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety Office of the Interim Inspector-General of Aged Care*[3]. The report repeatedly refers to stakeholder feedback and concerns about the level of allied health care being provided. For instance

[2] Ibid, page 66.

[3] The Interim Inspector General's Report provides an extensive and measured assessment of progress against ACRC Recommendations. However, it is evident throughout the report that stakeholder feedback includes substantial concern at the comparative lack of attention and progress across on allied health assessment and service issues.

Other aspects of stakeholders' feedback focussed on implementation gaps within specific recommendations, including whether the Royal Commission's underlying intent would be achieved. Specific areas of focus include

- *a need for greater focus and funding for allied health, including more substantial consultations with allied health providers*[4].

These issues are further discussed (on pages 16-17, for example) with the report noting;

Increased delivery of allied health care in residential care is central to pursuing a preventative approach for all residents and improving quality of care outcomes. Stakeholders identified the adequacy of allied health care provision as an area of significant concern.

With regard to allied health in home care (important for maintaining quality of life and independence and avoiding premature entry to residential and more intensive service supports), the Report notes:

Responses to this recommendation centred on the exclusion of allied health in present reforms, and expressed concerns this exclusion will continue in the Support at Home policy design currently being developed. …and … The IIG considers this 'Subject to further consideration', 'Ongoing' and 'Not implemented'. The IIG does not have information indicating the Government has accepted or rejected 36, nor does it have evidence demonstrating implementation of any subcomponent of 36. Future progress reports will investigate further[5].

The available data on residential care allied health provision suggests **system-wide service access may not have met the ACRC reported level of 8 minutes per person per day average at all since the report was released**. There is substantial evidence to indicate that for extensive periods of time, provision has fallen to below half that reported by the ACRC.

The Aged Care reform process (including, the new AN-ACC funding arrangements) faces substantial long-term, practical, and logistical challenges to deliver the volume and quality of allied health care envisaged in the Aged Care Royal Commission recommendations.

The following is a summary of reported aged care minutes as issued in reports by two aged care consulting firms StewartBrown and Mirus Australia.

- Stewart Brown data on allied health provision has consistently shown provision at around 6 minutes per person per day over several years[6]; and
- Mirus (which provides general industry reporting based on provider information) has shown more erratic levels of provision, for significant periods

[4] Page 11 – this is the first point listed.
[5] Ibid, page 57.
[6] An example report is available here.

at around 2 minutes per resident per day, with very large spikes (and largely unexplained) in recent months[7].

The variations may be attributable to range of factors, including different cohorts and/or a) stark differences in the allied health service practices of the aged care providers who report to them b) substantial differences in the classification of allied health and/or other services in reporting c) inaccuracies in the information provided to and reported by these firms or d) a mix of these factors.

Given the importance of allied health services to the health and wellbeing of aged care recipients, there is a strong argument for the anomalous information to be investigated and to identify remedial action, including workforce capacity-building measures. This may be a role for the Aged Care Safety and Quality Commission to consider, noting the recommendations of the Independent Capability Review of the Aged Care Quality and Safety Commission.

Further evidence indicates concerns about allied health workforce and service capacity should be investigated and acted on as a priority.

In November 2022 Allied Health Professions Australia (AHPA) conducted a survey of 279 allied health professionals in residential aged care to ascertain whether they had experienced changes in their work and in the provision of allied health services since AN-ACC commenced on 1 October 2022[8]. The results were that, **in the initial six weeks following the introduction of the AN-ACC** (which does not require provision of AH services explicitly):

- 13% of survey respondents had lost their jobs
- 43% of respondents whose role had changed and had their hours reduced
- 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.

These impacts come on top of a longer-term decline in the direct employment of allied health professional staff in aged care facilities. The Financial Report on the Australian Aged Care Sector: 2020–21[9] included evidence of allied health service decline within facilities since 2003, reinforcing concerns SARRAH and others have repeatedly raised, including:

- The proportion of the aged care workforce delivering allied health care is reducing – as a percentage and, evidence strongly indicates, on a per care-recipient basis;

[7] For example – go here. Recent spikes in AH numbers appear at odds with underlying AH workforce capacity and availability.

[8] https://ahpa.com.au/advocacy/3489-2/.

[9] For detail refer to Figure 3: Full- time equivalent (FTE) direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2016 and 2020 (estimated FTE and percent). Source: Financial Report on the Australian Aged Care Sector

- Both AHPs and AHAs are employed, however, it is unknown whether the allied health assistants have a defined scope of practice or are being supervised by an AHP;
- The average age of aged care recipients has increased over this time, as has the complexity of their care needs.

There are indications the Government intends to address allied heath access and provision at some future point in the reform process. That is positive, however does not address the very immediate health and wellbeing needs of the aged care population and the avoidable decline they are and will experience if they do are unable to access time and appropriate allied health services. Further, at whatever time allied health access is prioritised and providers will be required in practice to meet the levels of service delivery and care required by the new Aged Care Act and community expectations, there will need to be a workforce available to deliver that specialised care. The recent experience in relation to Registered Nurses (another workforce widely known to have been in shortage for more than a decade) demonstrates the need for forward-looking and sustained workforce capacity building.

To underline the point, modelling commissioned by the Australian Council of Deans of Health Sciences[10] projects **a deficit of 25,000 allied health professionals to meet aged care service need by 2033.** Solid research-based modelling is an invaluable resource for policy-makers if they choose to use it. On face value the findings are broadly consistent with the current demand, shortages and projections (prepared by Jobs and Skills Australia) detailed in Section 2 of the submission.

The Aged Care Act and associated reforms should increase the priority on allied health service provision. As with all service systems and sectors requiring allied health professional input and care, the risk of people not accessing that care is greatest in rural and remote Australia, where workforce shortages and constrained service capacity are widespread and entrenched. The draft Aged Care Act is silent on these issues and the risk if they not clearly articulated is that the opportunity to addressing them is lost.

In addressing the specifics of the Aged Care Act exposure draft, SARRAH members have two key concerns that relate to the implementation of the aged care standards and Act in practice:

Concern 1: Registration Categories and Regulation requirements

During the webinar (New Aged Care Act and Support at Home program update | Australian Government Department of Health and Aged Care), it was presented that within the new provider registration categories, Allied Health would be considered to belong to *Category 4- Personal and Social Care in the Home*, rather than *Category*

[10] Reported in an article in the Australian Ageing Agenda (8 November 2023)

5- Nursing and complex Care. Presenter Simon Christopher then articulated that an application to register as a provider for Category 4, would not require organisations to meet *Standard 5: Clinical Care* (information can be found at 31-35 minutes into the webinar recording).

Aged and Community Care Providers Association (ACCPA) provide the following information for Standard 5: Clinical Care. SARRAH and its members believe that Allied Health sits in this standard.

Standard 5 - Clinical Care

"This Standard applies to all residential care providers but only those home care providers that under the proposed new regulatory model are registered to provide nursing and complex care management. It is aligned to various parts of the current Standards 2, 3 and 8, but contains new and enhanced actions which mirror many of the requirements in the National Safety and Quality Health Service Standards. These include:

- *specific obligations relating to clinical governance including the role of the Governing Body, workforce capability and new actions to implement a digital clinical information system*
- *detailed and specific actions that focus on managing key risk areas of swallowing, continence, mobility, nutrition and hydration, mental health, pain, oral health, pressure injuries and wounds, sensory loss, cognitive impairment and palliative and end of life care; and*
- *detailed actions to ensure care is comprehensive and coordinated."*

Therapeutic interventions delivered by allied health professionals are imperative to reducing risk and improving the quality of care in each of the listed "key risk areas" under Standard 5-Clinical Care:

- Swallowing (Speech Pathology/Dietetics)
- Continence (Occupational Therapy/Dietetics)
- Mobility (Physiotherapy/Occupational Therapy/Podiatry/Exercise Physiology)
- Nutrition and hydration (Dietetics/Speech Pathology)
- Mental health (Social Work/Psychology/Occupational Therapy/Exercise Physiology)
- Pain (Physiotherapy/Exercise Physiology/Occupational Therapy/Podiatry)
- Oral health (Dentist/Speech Pathology)
- Pressure injuries and wounds (Podiatry/Occupational Therapy)
- Sensory loss (Podiatry/Occupational Therapy/Physiotherapy)
- Cognitive impairment (Occupational Therapy/Social Work)
- Palliative and end of life care (all Allied Health).

SARRAH members who are also CHSP/HCP registered providers have concerns around the future regulation of Allied Health services in Aged Care and advocate for:

1. Allied Health be escalated into Category 5, and/or
2. Category 4 providers required to meet Standard 5-Clinical Care for registration.

Concern 2: Support at Home Classification- Clinical Review of Personas

Members advise that in the past two years during webinars on the Support at Home Program in which classifications, personas and prescribed care plans were discussed, it was explained that Aged Care participants are assessed and classified into 1 of the 11 classes listed below. A prescribed care plan determined by an algorithm from the assessment findings would then be provided for the client, with the example given being "an hour a month of allied health"

An example of a care plan for an Aged Care client may include:

- Dietetics (monthly): weight loss management, dietary supplement prescription, meals on wheels involvement
- Exercise Physiology group (weekly): re-strengthening program, cardiac rehab, falls prevention
- Podiatry (6 weekly): routine general foot care, neurovascular assessment, skin integrity, pressure management
- Physiotherapy (Monthly): mobility aids, pain management
- Occupational Therapy (As required): home modifications, equipment prescription, cognitive assessment, pressure management
- Speech Pathology (as required): swallowing assessment, diet modification, meals on wheels involvement.

We consider that "an hour a month of allied health" to address the listed interventions is grossly inadequate. Such minimal levels of service have been shown to lead to clinical deterioration of many care recipients, leading to avoidable hospitalisation, early entry into residential care and failure to meet the objectives of the Support at Home, Commonwealth Home Support Programme (CHSP) and Home Care Package (HCP) to keep "…elderly clients in their homes, accessing community and on country for longer".

Under-estimation of the care needs for recipients are often encountered where decisions about allied health interventions are made by health professionals who are not themselves allied health professionals and may not fully appreciate the time required to deliver therapeutic interventions.

SARRAH has long advocated for multidisciplinary assessment of care needs at the point of entry to aged care to avoid such pitfalls.

From the Aged Care Royal Commission's Final Report:

A survey found that in 2018–19, only 2% of Home Care Package funding was spent on allied health. Under the Commonwealth Home Support Programme in 2018–19, while 29% of people received services categorised as allied health and therapy services, more than half of the people received fewer than five allied health services per year. Allied health care in residential aged care is also insufficient and we are concerned that the type of service provided may be influenced by funding arrangements.

And to further illustrate the point:

Mobility is closely linked with people's health and their quality of life. However, we heard numerous examples of aged care providers not supporting people to maintain and improve their mobility—including limited access to allied health professionals critical to promoting mobility, such as physiotherapists. Poor mobility increases the risk of falls and fall-related injuries due to deconditioning and reduced muscle strength.

We are concerned that self-determination, client-centred care, client choice and control, thin markets in rural and remote areas and rural multidisciplinary team scope of practice are not adequately addressed in the draft Aged Care Act.

There are indications the Government intends to address allied health access and provision at some future point in the reform process. Aged Care reform, underpinned by the Aged Care Act, should increase the priority on allied health service provision.

If you would like to discuss issues raised in SARRAHs response or require further information, please contact [redacted]

Yours sincerely

[redacted]

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