Allied Health Professions Australia

Submission to Office of the Inspector-General of Aged Care for 2025 Progress Report on Implementation of Aged Care Royal Commission Recommendations

March 2025

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

Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
www.ahpa.com.au
office@ahpa.com.au

About Allied Health Professions Australia and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association for Australia's allied health professions. AHPA's membership consists of 28 national allied health associations and a further 10 affiliate members, each representing a particular allied health profession. AHPA collectively represents over 185,000 allied health professionals and works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce of around 14,000 professionals.

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.

Overview

This submission focuses on the Commonwealth's progress towards implementing the Royal Commission's recommendations relevant to allied health services.

Our submission identifies whether there have been any developments in implementation since our 2024 submission to the Office of the Inspector-General of Aged Care ('2024 OIGAC submission').

Where relevant, we also refer to the:

- Office of the Interim Inspector-General of Aged Care 'Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety' (June 2024) ['2024 Progress Report'];
- Office of the Interim Inspector-General of Aged Care 'Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety' (July 2023) ('2023 Progress Report'),
- relevant Royal Commission into Aged Care Quality and Safety ('Royal Commission') recommendations ('RC Recommendation [x]'); and
- AHPA's 'Allied health in aged care – The case for systemic review by the Inspector-General of Aged Care' (August 2023) ['Case for systemic review'] and Update (November 2023).

AHPA is deeply concerned that despite various ongoing reforms and the continued best efforts of the allied health sector, allied health care is at risk of being even further sidelined in the aged care system.

This will result in older consumers having to try to get their needs met via insufficient and often inappropriate processes in the health system, or having to pay for allied health themselves as an optional extra, or simply not receiving key services that they need to live a good life as long as they can. Such outcomes would directly contravene Royal Commission findings and recommendations.

Continuing key issues for allied health: residential aged care

Our 2024 OIGAC submission framed the discussion of the issues confronting allied health in the aged care system within the broad aged care landscape, including changes proposed by the new legislation.

Overall, the key problems facing allied health in aged care continue, including lack of system attention to the concept of reablement and the role of allied health; absence of benchmarks; underfunding; under-provision of services; inconsistent needs assessment; and little or no effective regulation to ensure allied health is provided to all older persons who need it.[1]

As detailed in our 2024 OIGAC submission, the Royal Commission identified 'reablement' as critical to older people's physical and mental health and wellbeing, and allied health care as key to reablement. Royal Commission recommendations therefore included 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.[2] In this way the Royal Commission called for embedding the concept of needs-based care, including allied health care, in the aged care system.[3]

More recently, the Inspector-General of Aged Care has also called for the Commonwealth Government to more broadly implement the needs-based approach that the Royal Commission envisaged.[4] However, despite considerable aged care reforms since the Royal Commission's Final Report, allied health service provision, particularly in residential aged care, remains in a parlous state.

Grossly insufficient provision

The Quarterly Financial Snapshot Table overleaf shows that allied health service provision in residential aged care is now just over half the eight minutes per resident per day criticised as grossly insufficient by the Royal Commission.

Other than the four professions specified in the Table, until Quarter 3 2023-24, between 70 and 80 per cent of residential aged care respondents did not report any minutes or expenditure for the categories of occupational therapy, allied health assistance and other allied health categories specified in the Quarterly Financial Reporting ('QFR') framework.

From Quarter 3 2023-24 until the most recent Quarterly Financial Snapshot – Quarter 1 2024-25 – despite over 98% of surveyed providers delivering some kind of allied health care, results for occupational therapy, allied health assistance and other QFR allied health categories were not included. This was because more than half of respondents did not report any expenditure for these categories.

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[1] For more detail, see 'Case for systemic review'.
[2] RC Recommendations 25(b)), 36 and 38.
[3] RC Recommendation 41.
[4] Office of the Inspector-General of Aged Care, *2024 Progress Report on Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*, 7.

In other words, although these are other categories of allied health services that should be reported on – including psychology, social work, counselling, exercise physiology and art and music therapy – the numbers are, at best, too small to be meaningful.

TABLE Allied health profession minutes (median) per resident per day[5]

Quarterly Financial Snapshot	Total allied health	Physiotherapy	Speech Pathology	Podiatry	Dietetics
Oct–Dec 2022 (Q2 2022-23)	4.6	2.97	0.04	0.20	0.10
Jan–Mar 2023 (Q3 2022-23)	4.55	2.96	0.05	0.21	0.12
Apr–Jun 2023 (Q4 2022-23)	4.26	2.73	0.06	0.23	0.12
Jul–Sep 2023 (Q1 2023-24)	4.21	2.75	0.06	0.21	0.13
Oct–Dec 2023 (Q2 2023-24)	4.11	2.66	0.06	0.24	0.14
Jan–Mar 2024 (Q3 2023-24)	4.05	2.63	0.06	0.22	0.13
Apr–Jun 2024 (Q4 2023-24)	4.16	2.66	0.07	0.22	0.15
Jul–Sep 2024 (Q1 2024-25)	4.25	2.68	0.07	0.24	0.15

Another measure of allied health provision can be obtained from the Australian Institute of Health and Welfare 2023 Aged Care Provider Workforce Survey ('AIHW Workforce Survey'). The Survey results show that between 2020 and 2023 the number of allied health professionals and assistants working in aged care homes decreased by 42 per cent.[6] It is clear from both the overall recorded decline and individual AIHW Workforce Survey data tables that allied health is significantly under provided. Just one example is the total national headcount of 64 psychologists, especially when one considers that it is unlikely that most of those psychologists are working fulltime in aged care.

AHPA's own 2023 survey of allied health professionals (AHPs) working in residential aged care found that just over half of respondents said their role had changed since introduction of the AN-

[5] Department of Health and Aged Care, Quarterly Financial Snapshots of the Aged Care Sector: Quarter 2 2022-23 (October to December 2022), 13-14; Quarter 3 2022-23 (January to March 2023), 15; Quarter 4 2022-23 (April to June 2023), 16-18; Quarter 1 2023-24 (July to September 2023), 15-18; Quarter 2 2023-24 (October to December 2023), 18, 22-23; Quarter 3 2023-24 (January to March 2024), 15, 19; Quarter 4 2023-24 (April to June 2024), 18, 19; Quarter 1 2024-25 (July to September 2024), 19, 22.

[6] Australian Institute of Health and Welfare (2024) *2023 Aged Care Provider Workforce Survey: Summary Report*, Australian Government https://www.gen-agedcaredata.gov.au/topics/aged-care-workforce/2023-aged-care-provider-workforce-survey .

ACC funding model.[7] Almost one in five of those respondents had lost their role, and 48% had their hours decreased. Others were leaving the sector or considering doing so, due to concerns about declining service quality. This exodus then exacerbates the problem, leaving fewer professionals to provide essential services.

Aged care residents and their families have reported to AHPA their experiences of trying to obtain allied health services, including being told that the facility does not have these available and that they will have to find care themselves. At best, if they can afford to do so, consumers are then left out of pocket trying to access services via private health, or they may receive a maximum of five Medicare-subsidised treatments per year – or they simply have to pay for it entirely out of their own pocket or go without. The impact of the current Schedule of Residential Care and Services on allied health service provision and consumer cost, and the failure of proposed reforms to address this, is discussed further below.

Lack of dedicated funding and the impact of AN-ACC

AHPA's 2024 OIGAC submission discussed the lack of dedicated funding for allied health services in residential aged care, with providers being expected to pay for allied health services out of overall federal Government funding to providers under the new AN-ACC model. However, the AN-ACC is not designed for allied health funding needs, and a further limitation on allied health provision has developed via the interrelationship of AN-ACC funding and the introduction of mandatory minutes for personal and nursing care.[8] These 'care minutes' have, in effect, set benchmarks via which providers have begun to allocate portions of the overall AN-ACC funding that the Commonwealth Government provides to them to spend on direct care.

In the absence of a comparable benchmark and ringfenced funding for allied health care provision, there is no guarantee that AN-ACC funds will be spent on allied health – or indeed, on any direct form of care, despite Government intention.

For example, the latest *Aged Care Sector Mid-Year Report* concludes:

> 'it appears that, on average, homes are generating surpluses from direct care services (primarily taxpayer-funded) to cross-subsidise losses from everyday living and accommodation.'[9]

This situation is likely to continue when, as the Inspector-General of Aged Care has observed, despite Royal Commission Recommendation 69 that allied health care should generally be provided by aged care providers, there is still no clarification of the various funding responsibilities for aged care.[10]

The Inspector-General has also noted the effects on residents' access to allied health, and supports the Department of Health and Aged Care ('Department') initiating a review of the impact

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[7] https://www.ahpa.com.au/news-updates/summary-of-results-from-survey-of-allied-health-workforce-in-residential-aged-care-2023 .

[8] Diane Gibson and Stephen Isbel, 'Reform and reverberation: Australian aged care policy changes and the unintended consequences for allied health' *Australian Occupational Therapy Journal* 2024 June, 71(3): 392-407 https://doi.org/10.1111/1440-1630.12953 .

[9] UTS Ageing Research Collaborative, *Australia's Aged Care Sector: Mid-Year Report (2023–24)*, 21; and see more generally, 11-12, 21-29.

[10] Office of the Inspector-General of Aged Care, *2024 Progress Report on Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*, 41. The need to ensure allied health funding is a crucial component of Royal Commission Recommendations 36 and 38.

of the interrelationship of the AN-ACC and care minutes on the provision of allied health in residential care.[11]

The Inspector-General suggests that the Department consider:

> 'whether other policies, such as legislating a requirement for providers to spend all their care subsidy on the provision of enablement-focused care, could offer an effective means of realising the Royal Commission's intent. . . It is timely to reconsider whether the AN-ACC remains responsive to the needs and pressures associated with delivering high-quality residential aged care with a reablement focus.'[12]

AHPA was recently informed that the Department is contemplating undertaking an evaluation of the strategic effectiveness of care minutes in 2025-26. This would appear to be a response to the Inspector-General's comments, but as yet we have no other information.

Inconsistent needs assessment

Our comments in our 2024 OIGAC submission concerning RC Recommendations 28, 31 and 32 still stand.

Implications for quality and safety

AIHW Workforce Survey data tables provide a total headcount of AHPs and allied health assistants ('AHAs') in residential aged care of 6447, of which 1974 are AHAs.[13] The AHA total exceeds the headcount for any single allied health profession in aged care – even for physiotherapy which has the largest individual headcount of 1671. It means that AHAs are 31% of the allied health workforce in residential aged care.

There is evidence that aged care providers are sometimes inappropriately substituting AHAs to provide services that considerations of quality and safety require to be delivered by an allied health professional.[14] While AHAs are a valuable part of the workforce, it can be inappropriate and dangerous to substitute them as a supposedly 'cheaper' option, especially if they are not supervised by an allied health professional.

Similarly, 'cheaper' workers from outside allied health, such as personal care workers and lifestyle staff, are known to be used to undertake tasks that should only be carried out by AHPs.[15]

In our 2024 submission we noted the lack of mechanisms to ensure quality with respect to allied health service provision. The new Aged Care Act does not improve this, particularly given the lack of genuine implementation of RC Recommendations 13 and 14. We refer the Inspector-General to the Appendix to this submission, which lists AHPA's recommendations to the Senate Community Affairs Legislation Committee on the Aged Care Bill 2024 (October 2024).

However, relevant to RC Recommendations 22-23, we welcome the development of new Mandatory Allied Health Quality Indicators ('QIs') in residential aged care, particularly the indicator of percentage of recommended allied health services received. Although there is still no

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[11] Office of the Inspector-General of Aged Care, *2024 Progress Report on Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*, 42.
[12] Ibid.
[13] https://www.gen-agedcaredata.gov.au/topics/aged-care-workforce/2023-aged-care-provider-workforce-survey .
[14] https://www.ahpa.com.au/news-updates/summary-of-results-from-survey-of-allied-health-workforce-in-residential-aged-care-2023 .
[15] Ibid.

consistent process for clinical assessment of allied health needs, AHPA regards this QI as a step in the right direction.

Continuing key issues for allied health: Home and community aged care

When we turn to allied health care provided to aged care consumers living at home, current data tells us little. The only allied health data for home aged care reported via QFR is simply reported as an aggregate category of 'allied health', with an average of 1.78 minutes of care per recipient per day provided in Quarter 1 2024-25.[16]

In home and community care, while the AIHW Workforce Survey found a 90 per cent increase in allied health workers since 2020, the ageing population is continuing to grow, and with many older people preferring and being encouraged by Government to remain living at home rather than moving into residential care, more Home Care Packages have been released by Government.

This will require more services and more AHPs, but provision of allied health to older people in the community is starting from a low base, with the Royal Commission finding that only 2% of Home Care Package funding was being used on allied health services. AHPA is aware from our allied health professionals' experience and from consumers' reports to us that there remain consistent themes of unmet allied health needs in home care that are similar to those for aged care residents.

As we outline below, current uncertainties about price cap setting and the list of home support service types proposed in the draft Aged Care Rules also raise doubts about whether consumers will have sufficient access to the allied health services they need.

New challenges in implementing the reforms

As implementation of the reforms has been planned and rolled out, various other issues have arisen for the provision of allied health.

The overall reform process

Although the allied health sector has been a part of consultation processes, the 1 July 2025 deadline has meant that often there is little time for under-resourced organisations to effectively engage with draft documents and proposed program arrangements.

To illustrate, so far there have been seven different tranches of the Aged Care Rules released for consultation.[17] As another example, while AHPA appreciates our membership of the Aged Care Transition Sector Working Group, we are the sole allied health representative, and the Working Group meets fortnightly, often with extremely short turnaround times for comments on draft material.

We have various significant concerns about elements of the rollout of both the new Support at Home program and the approach to residential aged care services. Unfortunately, at the Working Group level the Department informs us that policy decisions have already been made and that our input is to be limited to communicating those changes to stakeholders. This is despite the fact that much of the material, including key elements of the aged care system in practice, was not evident in the Aged Care Act itself.

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[16] Department of Health and Aged Care, Quarterly Financial Snapshot of the Aged Care Sector: Quarter 1 2024-25 (July to September 2024), 29.

[17] https://www.health.gov.au/our-work/aged-care-act/consultation#aged-care-rules-consultation-topics-by-release .

This is especially the case in the draft subordinate legislation (Aged Care Rules), and in relation to aspects of the regulatory framework, as we detail below. The situation has not been assisted by elements of the draft Rules publicly released and subsequently described by the Department as 'mistakes', and some apparent confusion between the Department and the Aged Care Quality and Safety Commission concerning allied health professional regulatory obligations (see below). The limited time frame also does not give us confidence that our submissions have been heeded.

Support at Home (RC Recommendations 35 and 36)

This section of our submission builds on our comments in our 2024 OIGAC submission on Priority area 1: Home Care, from the 2023 Progress Report.

As they stand, the draft Aged Care Rules 2024 ('Rules') will not enable the delivery of allied health services to all older people in the community who need them.

Problematic definitions

It is a positive development that the Restorative Care pathway and other pathways under Support at Home allow for the provision of allied health services. However, to be funded by Government, services must be specified in the Rules. AHPA is therefore concerned about the Rules' proposed definition of allied health, which results in 'allied health profession' and 'allied health professional' referring only to Ahpra-regulated allied health professions, thereby omitting self-regulating professions such as speech pathology, dietetics, exercise physiology, social work, orthotics/prosthetics and music therapy.

At a meeting with the Department on 28 October 2024 we were informed that this definition was an error and that it would be rectified. However, this does not appear to have happened, and AHPA was recently informed that it would be necessary to engage in a long process of reaching State and Territory agreement to change the Health Practitioner Regulation National Law. We disagree that this is the only way to make the definition inclusive of all allied health.

The draft Rules do not demonstrate an understanding of the diversity of allied health professions, each with specific training and qualification requirements and different scopes of evidence-based practice.

Allied health and clinical care

AHPA welcomes the Australian Government's commitment to fund 100% of clinical care in aged care (relevant to RC Recommendation 125).[18] However, the draft Rules split the allied health professions delineated into, first, 'Allied health and therapy' (regarded as clinical for funding purposes) and, second, 'Therapeutic services for independent living' which may require a consumer co-contribution.

In the first category, 'therapy' appears to have been included to accommodate the self-regulating professions, but the use of 'allied health' then implies that allied health professions are not part of the 'independent' category. This is not only confusing – the second category includes two Ahpra-regulated professions – but is also in our view simply wrong, because we regard aspects of all types of allied health as including clinical care. The division also means that funding for some allied health services – osteopathy, art therapy and chiropractic – would inappropriately require a consumer co-contribution.

[18] See eg (Hansard Proof) Commonwealth, Parliamentary Debates (Second Reading Speech), House of Representatives, 12 September 2024, 70 (Anika Wells, Minister for Aged Care).

Further, some allied health services, such as audiology and optometry, are not referred to at all in the draft Rules. Although they are presently subject to other funding arrangements, it is important that the new legislation and associated programs acknowledge the critical importance of these services in maintaining the independence and physical and cognitive abilities of older people.

There can also be challenges for allied health professionals such as audiologists in delivering the services needed, and existing funding mechanisms can be restricted for some services and consumers. The Department should consult peak bodies such as our members Audiology Australia and Optometry Australia to determine the best avenue for ensuring needs-based delivery and 100% Government funding of these services.

Other allied health professions such as orthoptics and orthotics/prosthetics should also be included, and we refer the Inspector-General to AHPA's website for a more comprehensive list.[19]

Pricing caps

Consistent with RC Recommendation 6, the Independent Health and Aged Care Pricing Authority ('IHACPA') is now required to provide annual pricing advice to the Minister for unit-based services on the Support at Home service list.

In addition to the above issues about how the service list is to be defined, AHPA is concerned that the transition to set unit prices may not take sufficient account of the diversity of types of allied health services providing these services and which affect provider costs and are hence relevant to pricing. Failure to reflect this diversity will produce inadequate prices and so are likely to reduce and narrow the types of services available to consumers, with for example, small or sole trader providers being driven out of the home care market.

In addition, pricing may not be based on the appropriate evidence and comparators. AHPA has considerable experience of the present National Disability Insurance Scheme pricing approach, which for the past five years has not raised price caps, even by indexation to wages or the cost of living, for most allied health services.

Costing and pricing must take sufficient account of the often unique nature of the demands on allied health professionals providing aged care services in diverse contexts. It is therefore inappropriate to 'harmonise' pricing across care and support sectors in any simple way. For allied health service provision, costing must also consider costs associated with quality improvement, human resources, training and placements, professional development, supervision, and any registration and compliance under the proposed new aged care regulatory system (see further below).

Costing must also address the gaps identified in IHACPA's 21 March 2024 Support at Home Costing Study – Study Report ('Support at Home Costing Study'), so that the pricing advice structure includes additional adjustments for costs associated with the service delivery setting and method (eg individual or group), and any significant travel requirements.

IHACPA must additionally consider that allied health services provided via a third party provider, such as an allied health professional subcontractor to a home care provider, require a different approach to costing. In these circumstances, the home care provider is likely to charge for administration of the third party arrangement, but the allied health provider will also have their own administration, business and other costs. The pricing of the allied health service must be

[19] https://ahpa.com.au/our-members/.

capable of taking both sets of costs into account. Otherwise, the price to the consumer is likely to be insufficient for many allied health providers to make a living, and therefore for aged care consumers to receive the support they need.

Allied health subcontractors clearly operate within a different employment model to allied health professionals who are direct employees of the home care provider. Costs may also be differently spread when the allied health provider is a large entity, compared to small or sole traders.

AHPA's experience to date of IHACPA's residential aged care costing of allied health has been that IHACPA's approach simply reflects the available data.[20] That costing produces a quite different result to that obtained from estimating the cost of the allied health care people might be clinically assessed to need, with consequent impacts on what market pricing is proposed. As discussed above, current data also tells us little about allied health care provided to aged care consumers living at home.

Further, the 2023 Support at Home Costing Study noted significant cost variations within allied health and therapy subcategories, but did not delineate these. It is important that costing and pricing is undertaken at the individual profession level, because allocations to different cost subcategories may vary among different types of allied health services, affected by factors such as the mix within a particular profession of direct employment compared to subcontracted services.

After receiving submissions from stakeholders, IHACPA has now provided pricing advice to Government, with the setting of caps being deferred until 2026. This fosters a climate of uncertainty for allied health providers, who will not be permitted to 'top up' prices by charging the consumer but will have to provide the service under the cap if consumers are to be able to use Government funding.

AHPA therefore has serious concerns that IHACPA's advice and the Government response will result in inadequate pricing for allied health aged care services, which will in turn negatively impact the allied health workforce and market.

Assistive Technology and Home Modifications ('AT-HM')

The allied health sector supports the creation of a new national scheme to enable older people to have more equitable access to AT-HM across different locations across Australia, as a fundamental element of the new Support at Home Program. However, AHPA and its members have significant concerns about the proposed $15,000 lifetime cap and associated funding tiers being proposed for the Home Modifications scheme.

In particular, we are very concerned that the funding approach, particularly the $15,000 lifetime cap:

- is inadequate;
- will make access to major modifications more difficult than under the current Home Care Packages program;
- will have significant unintended consequences; and
- fails to consider the financial position of many older Australians.

[20] See eg https://ahpa.com.au/advocacy/submission-independent-health-and-aged-care-pricing-authority-on-consultation-paper-on-the-pricing-framework-for-australian-residential-aged-care-services-2025-26/ .

We refer the Inspector-General to the separately attached 'Briefing Note: Home Modifications in the Support at Home Program'.

Residential Care Service List (relevant to RC Recommendations 37 and 38)

As for Support at Home, the residential service list should be clearly interpretable and require providers to pay fully for, from Government funds, allied health services based on clinical assessment of residents' needs.

However, proposed changes to the service list perpetuate the problems in the current list of residential care and services (Parts 2 and 3, Schedule 1, *Quality of Care Principles 2014* ['Schedule 1']. The proposed approach fails to encompass the diversity of allied health disciplines that assist residents' reablement, and as with Support at Home, does not appreciate that 'clinical care' encompasses many aspects of the range of allied health disciplines.

This results in the sidelining of allied health as an 'add on' service, contradicts Government commitment to pay 100% of residents' clinical care costs, and continues the lack of guaranteed funding, with associated access implications for aged care residents.

Problematic definitions

As with the draft Rules for Support at Home, the Department's Residential Care Service List Consultation Discussion Paper (December 2024) ['Discussion Paper'] does not recognise allied health as consisting of many distinct professions with different scopes of practice, and therefore as often not interchangeable.

Allied health is inappropriately corralled into a confusing concept of 'Rehabilitation, allied health, speech and fitness therapy programs' which ignores the fact that speech therapy is an allied health discipline, and the integral relationship between allied health and reablement outlined above. It is also unclear: for example, what are fitness therapies? The emphasis is inappropriately only on allied health treatment of physical functioning, and even there, services appear limited to physiotherapy rather than also occupational therapy or other professions such as osteopathy, chiropractic and exercise physiology.

Otherwise, allied health services are largely invisible in other aspects of the proposed Residential Care Service List, except for an 'access-only' item discussed below. We are at a loss concerning why 'dementia and cognition management' is treated separately from 'Rehabilitation, allied health, speech and fitness therapy programs' when reablement is also about prevention or slowing down loss of function. It is also not clear if and how specific non-physical therapies such as psychology, counselling and social work will be required to be included in this category.

Allied health and clinical care

The proposed Residential Care Service List often does not treat allied health as clinical care, and/or fails to clearly specify if some allied health disciplines are to be excluded from this category, and if so, what kinds of allied health are to be regarded as clinical care.

Part of the problem is that the Discussion Paper does not define 'clinical' or 'non-clinical' care. It also does not acknowledge that 'clinical care' encompasses many aspects of the range of allied health services. For example, 'emotional support', 'mobility and movement needs' and 'communication' are treated as non-clinical care, when at least some aspects of these are in fact clinical care. For example, 'assistance with eating', 'communication' and 'mobility and movement needs' involve dietitians, speech pathologists, occupational therapists and physiotherapists.

There is also no acknowledgment that assessment and prescription of goods and equipment is often (and should be) a part of clinical care, and that they require a specific type of allied or other health professional to be involved.

The proposed service list retains the 'access only' category

Rather than allocating allied health to a category of clinical care, the proposed approach limits 100% Government-funded services to allied health provided in the category of 'Rehabilitation, allied health, speech and fitness therapy programs'. In this way the draft service list repeats the problems of the current Schedule 1.

AHPA has for some time sought to understand from the Department the minimum obligations on providers to provide allied health care and services, flowing from Schedule 1. We have also tried to clarify the extent to which, under the Quality Principles, providers are required to pay for these services, rather than simply providing access to them via, for example, transporting the resident to an appointment.

We were able to ascertain that various Items in Schedule 1 may pertain to particular allied health services, depending on the circumstances, and that whether providers are required to pay for the actual delivery of an allied health service and/or associated costs also varies.

However, it is still not clear to us how Schedule 1 should be interpreted, including where different types of allied health sit in relation to the different Items below (our emphasis underlined):

- ***Item 2.6 (Rehabilitation Support)*** *- aged care homes must ensure residents have an appropriate therapy program developed for them which is designed to maintain or restore physical functioning so they can undertake daily activities as independently as possible. The aged care home is required to organise for development of the program, including organising and paying for the initial assessment appointment/s, booking any necessary transport. The resident cannot be charged for cost of designing and developing this program.*
- ***Item 3.11 (Therapy Services)*** *- once a rehabilitation support program has been designed and developed for a resident under Item 2.6, the delivery of the program itself falls under Item 3.11. This item will generally include physiotherapy, podiatry and/or occupational therapy, but can include other therapies as needed to address the assessed therapy need. In line with this, the aged care home is responsible for delivery of the treatment/services, including appointment costs and any transport.*
- ***Item 2.7 (Health practitioner services) -*** *aged care homes must provide access to general health services (such as GPs, dentists, and hearing tests) which meet the resident's particular care needs. Whilst the home is responsible for any arrangements, the actual appointment fee, and any transport/escort costs, can be passed to the resident. Usual Medicare Benefits Schedule (MBS) arrangements apply for those services covered by Medicare, with the resident expected to cover any co-payments.*
- ***Item 2.8 (Specialised therapy services)*** *- aged care homes must provide access to the health practitioner services resident's need, including allied health services (such as physiotherapy or occupational therapy). Whilst the home is responsible for any arrangements, the actual appointment fee, and any transport/escort costs, can be passed to the resident. This item is for services that are outside of a tailored therapy program (Item 3.11). In these instances, if residents require supports, they may be eligible for Medicare benefits of up to 5 individual allied health services each calendar year.*
- ***Item 2.9 (Support for cognitive impairment)*** *– aged care home must ensure the delivery of therapy services/activities and programs which are specifically tailored to residents*

with a cognitive impairment and are aimed at enhancing their quality of life. Aged care homes cannot charge a resident for the development and delivery of these programs.

We concluded that it is not evident how providers actually decide which Item is relevant to a particular potential instance of allied health service provision, and how they understand the nature and extent of their obligations.[21]

Nevertheless, it is evident that if an item of allied health care is deemed to fall under Item 2.8 (or Item 2.7, which is less problematic because here allied health care, such as hearing services, is funded differently), the aged care provider is not required to pay for delivery of that service, nor for any transport/escort costs. We refer to this from here on as the 'access only' provision. This has left these allied health services to be paid for privately by aged care consumers, or provided through Medicare, Veterans' Care, private insurance, or State and Territory health services.

Spending via these pathways external to the aged care system is highly unlikely to come close to meeting residents' allied health care needs, in part because of limited access to the various avenues, and also due to restrictions on the amount and type of care that can be obtained. Many consumers are also increasingly out-of-pocket due to gap fees and limited rebates – and so may simply not pursue recommended treatment.

For these reasons, AHPA has consistently advocated for reform of Schedule 1. Schedule 1 reform was also raised in the 2024 Progress Report (85). However, the overall scope of what providers are expected to deliver will broadly remain unchanged in the proposed new service list. Allied health care will be 'access only' (Item 7 'General access to allied health services', which replaces Item 2.8 Specialised therapy services), unless it is deemed to be approved as part of Item 2 'Rehabilitation, allied health, speech and fitness therapy programs' (replacing Items 2.6 and 3.11 in the list above).

It is therefore highly likely that the experience for many consumers will be inconsistent with both Government commitments to fully fund clinical care, and RC Recommendation 69.

There are also important related data questions which are not at all addressed in the Discussion Paper. The Department has informed AHPA that aged care homes are not required under Schedule 1 to specifically record what has been delivered under each Item and the corresponding source of payment. We therefore do not know the quantity and types of allied health services to which Item 2.8 currently pertains and how much these cost consumers – and this does not seem likely to be improved for the proposed new Item 7.

The residential service list is therefore a good example of why RC Recommendation 148 – evaluation and monitoring of implementation of the reforms – must be implemented.

New regulatory framework

This section of our submission builds on our comments in our 2024 OIGAC submission on Priority area 1: Home Care, from the 2023 Progress Report.

AHPA remains concerned about the impact of the proposed new regulatory framework on the availability of allied health providers in home care.

[21] The Department has simply stated that the legislative references in the Schedule itself communicate the obligations of aged care homes, and that this legislation is supported by guidance material that is available on the Department of Health and Aged Care website – but this does not resolve the uncertainties.

Unclear for allied health

From consultations in 2024, AHPA understood that with respect to allied health service provision when the new Aged Care Act commences together with the strengthened Aged Care Quality Standards, the main regulatory onus would fall on providers of both residential and home care. We interpreted this decision as a sensible response to our advocacy that our professionals are already extensively regulated via either Ahpra or self-regulation, and so are to be regarded as associated providers.

However, following discussion with the Aged Care Quality and Safety Commission, we are now unsure whether all allied health providers, including small or sole traders, will be exempt from the requirement to register. AHPA awaits a joint meeting with the Department and the Commission later this month.

Further, from 2027 we understand that consumers will be able to engage more than one aged care provider, and therefore at least in theory some allied health professionals may be deemed to be aged care providers and therefore required to register. Again it is unclear what circumstances will give rise to this requirement, and we are particularly concerned about the size of potential fees and audit requirements this might entail, especially given the shift to price caps.

A further complication is that if despite being required to register, allied health professionals have only 'light touch' obligations as we advocated, this seems likely to only apply to Ahpra-regulated professionals given the limitations to the definition of allied health we critique above.

Clinical care

Aged care providers in residential care will be allocated to registration category 6, and accordingly the whole of Quality Standard 5 (Clinical care) will apply. However, allied health professionals providing Support at Home services are allocated to registration category 4. Although it is proposed that aged care providers have the responsibility to uphold the obligations under the Quality Standards, only Outcome 5.1 of Quality Standard 5 is proposed to apply to them. This leaves a problematic gap in terms of who is to take responsibility for other aspects of the Clinical care standard, including for comprehensive clinical care of consumers who live at home.

Other impacts on allied health provision

First, AHPA is concerned that the tiered way in which the registration categories are proposed to be organised risks consumers not receiving allied health that they may or should have been assessed to need.

For example, an aged care provider may be engaged by a consumer only to provide domestic assistance and meals. As these services are their focus, the provider may accordingly be registered in Category 1. If over time it emerges that the consumer also needs an allied health service, while the provider could broker this provision, under the regulatory framework they would then have to vary their registration to Category 4 – with an associated increase in fees and perhaps a new requirement to be regularly audited. In our view it then becomes unlikely that the provider would be prepared to provide allied health to the consumer.

Second, relevant to RC Recommendations 13, 14 and 19, we remain concerned that the regulatory framework will not pinpoint the types of failures illustrated by the above example. While initial work on developing the Support at Home policy intended to incorporate the provision of allied health on a reablement basis for all older people who need it (RC Recommendations 35–36),

despite more reference to ‘reablement’ in the ‘Strengthened’ Quality Standards and associated draft guidance material, it is not clear how this will be monitored and enforced.

Other relevant Royal Commission recommendations

Recommendation 8

AHPA still has concerns that the role of Commonwealth Chief Allied Health Officer is not sufficiently senior or resourced, to enable meaningful engagement with all relevant aged care issues.

Recommendation 24 Star Ratings

Our comments in our 2024 OIGAC submission still stand.

Recommendation 58 Access to specialists and other health practitioners through Multidisciplinary Outreach Services

Our comments in our 2024 OIGAC submission still stand.

Recommendation 59 Increase access to Older Persons Mental Health Services

Our comments in our 2024 OIGAC submission still stand.

Recommendations 72-73 Equity for people with disability receiving aged care; Annual reporting to Parliament by the Disability Discrimination Commissioner and the Age Discrimination Commissioner

Our comments in our 2024 OIGAC submission still stand.

Recommendation 75 Aged Care Workforce planning

AHPA supports the recent release of the National Allied Health Workforce Strategy but notes its high level of generality and the associated need for a detailed implementation plan, including a focus on the allied health aged care workforce. See also our comments on Recommendation 8.

Appendix

Recommendations from AHPA's submission to Senate Community Affairs Legislation Committee on the Aged Care Bill 2024 (October 2024)

Amendment Recommendation 1

The Objects, Statement of Rights and Statement of Principles in the Bill should clearly embed the concept of needs-based care consistent with the recommendations of the Royal Commission into Aged Care Quality and Safety.

Amendment Recommendation 2

The Bill should require use of a nationally consistent, evidence-based, identification, assessment and care planning process, to ensure delivery of the allied health needs of individual aged care residents and consumers receiving home care.

Systemic Recommendation 1

Government funding for allied health care should be based on individually assessed allied health needs as per Amendment Recommendation 2.

Systemic Recommendation 2

Government funding for allied health care, as clinical care, must be considered and applied under an overarching principle of reablement consistent with Amendment Recommendation 3, and with associated commitment to multidisciplinary team care.

At a minimum, provision should be made for the delivery of care by the suite of allied health professions listed in Royal Commission Recommendation 38(b), including mental health practitioners, podiatrists, physiotherapists, occupational therapists, speech pathologists, dietitians, exercise physiologists, music therapists, art therapists, optometrists and audiologists.

Amendment Recommendation 3

The Objects of the Bill should include, consistent with 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.'

Amendment Recommendation 4

The definition of 'high quality care' in the Bill should be consistent with Royal Commission Recommendation 13(2).

Amendment Recommendation 5

High quality care, as defined in Amendment Recommendation 4, should be embedded in the new Act as the compliance and enforcement standard, aligned with the Statement of Rights and this submission's other associated recommendations.

Amendment Recommendation 6

The Statement of Rights should list the rights of people seeking and receiving aged care, ensuring that the content is consistent with Royal Commission Recommendation 2.

Amendment Recommendation 7

In addition to Amendment Recommendation 6, 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 (Amendment Recommendation 3); and

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

Amendment Recommendation 8

In addition to Amendment Recommendations 6 and 7, the Statement of Rights should incorporate by reference 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.

Amendment Recommendation 9

Clause 24 of the Bill should be amended so that the rights in the Statement of Rights are legally enforceable via a court or tribunal.

Systemic Recommendation 3

The Australian Government should establish an independent entity to review the operation and impact of the Statement of Rights.

Amendment Recommendation 10

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

Amendment Recommendation 11

The Bill 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.

Systemic Recommendation 4

The Australian Government should commit to open consultation processes with aged care stakeholder peak organisations on all draft Rules associated with the Bill. These processes should facilitate full discussion between peak organisations, Government and other relevant aged care system entities, as well as written submissions.