Victorian Healthcare Association
Vision • Value • Voice

Briefing

5 August 2020

Royal Commission into Aged Care Quality and Safety – Hearings into mental health, oral health and allied health care

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) held hearings from 15-17 July 2020 into how mental health, oral health and allied health care could be improved for people accessing aged care services.

Evidence

The focus of the hearings was on testing potential solutions for mental health, oral health and allied health care. There was broad support for the propositions, but witnesses repeatedly highlighted the need for multidisciplinary care, accountability, and funding reform.

Most of the witnesses provided evidence in these discrete areas; only a few government officials provided feedback on the range of issues discussed at the hearings. The summaries below are separated into the different policy areas. These brief summaries are intended to provide key details and themes for VHA members. The transcripts of the hearings are available here on the Royal Commission website. Further details on the witnesses included in the summaries below can be found in the witness list below.

• Mental healthcare

The Commission focused predominantly on aged mental healthcare for the first day of the hearing (15 July), ascertaining areas of improvement in the system, with a discussion over potential reform.

The Royal Commission has previously heard evidence of issues affecting mental health care in the aged care system, including concern over aged care workers capability and capacity, the inadequate and fragmented nature of funding, and that there is a 'missing middle' that are not receiving care. Staff at the Royal Commission have developed propositions to solve these issues, which were tested with witnesses. These propositions are:

- **Proposition M1**: Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care.
- **Proposition M2**: Fund mental health assessments and mental health treatment plans by a psychiatrist for Australians living in residential aged care.
- **Proposition M3**: Increase funding for psychologists providing psychological services to people living in residential aged care.
- **Proposition M4**: Incentivise psychiatrists and psychologists to attend residential aged care facilities.
- **Proposition M5**: Increase outreach services by state and territory government older person's mental health services to Australians accessing aged care services.
- **Proposition M6**: Increase mental health training for personal care workers.
- **Proposition M7**: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents; The Quality of Care Principles 2014 and any subsequent instrument should include an explicit and measurable requirement to maintain the mental health of residents.
- **Proposition M8**: Peer workforce; The Australian Government should inquire into the potential contribution of the mental health peer workforce in addressing access to mental health services in aged care.

A key theme that emerged from the evidence on the day was the need for a multi-disciplinary approach. Dr Alison Argo highlighted how a multidisciplinary approach to aged care mental health is beneficial, including that it provides training value to the practitioners involved. In terms of funding a multi-disciplinary approach, one suggestion was for Medicare to fund that collaboration and travel expenses, as it currently only supports engagement with the patient.

Victorian Healthcare Association
www.vha.org.au
Level 6, 136 Exhibition Street
Melbourne Victoria 3000
T 03 9094 7777 F 03 9094 7788
E vha@vha.org.au

Inadequate funding was repeatedly highlighted throughout the day. Dr Corser highlighted that the primary health model funding is deficient to ensure equitable access across regional areas, with a lot of variation even between PHNs – Professor McFarlane argued that there is a lack of accountability over the use of funds meant for older persons mental health care. It was highlighted that funding often drives service delivery, whereas it actually requires a collaborative approach to meet needs of clients. The lack of funding has meant that aged care psychiatry has focused on the most acute cases, rationing access, when greater focus is needed on early intervention and prevention.

There was, overall, broad support for the propositions, but workforce shortages were pinpointed as an issue that would impact their effectiveness. For instance, for Proposition M2, there are not enough aged care psychiatrists for this to make a difference; telehealth would help, but it would be hard to currently expand access. This would likely lead to increased timelines and waiting lists; people would then stop referring. Similarly, there was support for extending Proposition M3 to other allied health mental health staff to ensure access to services, as there was concern over there being enough qualified psychologists in the system. Professor Bhar highlighted the Wellbeing Clinic as a potential model to overcome workforce issues, utilising post-graduate student volunteers, arguing that it was effective, scalable and three times cheaper than using registered practitioners. However, Dr McGowan, CEO of SA Health, and Dr Lyons, Deputy Secretary of the New South Wales Ministry of Health, disagreed with Proposition M5, as State and Territory based older person's mental health outreach services are not appropriate to deliver lower-level mental healthcare

The Royal Commission also looked into the ineffectiveness of current attempts to increase access to mental health support for those in residential aged care. The Royal Commission heard that the Commonwealth Government's own figures show that only 3,605 people in residential aged care have received mental health support in the last 18 months as part of the Better Access Program, which was meant to support mental health care in residential facilities to substitute for access to MBS-subsidised mental health support. This is despite 49 per cent of aged care residents being diagnosed as having depression, according to the Australian Institute of Health and Wellbeing. Commonwealth Government officials noted the impact of COVID-19 and the time required to establish programs, but agreed that there was wide variation between PHNs in their delivery of services so far.

• Oral health

The Commission focused on oral health on the first two days of the hearing (15-16 July). The Commission had previously heard evidence on oral health, including the poor access to oral healthcare and the poor delivery of oral care in aged care settings. The focus, for the hearings, was on testing potential solutions, which are:

- **Proposition D1**: Fund public dental services to provide outreach services to Australians accessing aged care services in their place of residence.
- **Proposition D2**: Increase oral health care training for personal care workers.
- **Proposition D3**: Greater clarity on the role and responsibilities of residential aged care providers to maintain the oral health of residents.
- **Proposition D4**: Fund services delivered by oral hygienists and dental and oral health therapists in residential aged care facilities.

The Commissioned heard from Dr Wallace, who presented on the Senior Smiles program, which places a qualified oral health practitioner, an oral health therapist or a dental hygienist into aged care facilities. A cost and benefit analysis found many benefits, including improved nutrition, lower risk of pneumonia, decreased GP visits, fewer avoidable admissions to hospital, better quality of life, better denture care, and less anxiety costs. Dr Wallace highlighted the benefits of an embedded model to support oral health, noting that if the funding does not come from the facility and if the facility does not have that practitioner on site, then established processes, policies and procedures will disappear when that practitioner leaves the facility. To support this, Dr Wallace called for an accreditation requirement on having a qualified preventative oral health practitioner, as well as establishing documentation for oral health practices, similar to those already established for toileting, showering, feeding and medication. There was support from other witnesses for embedded care, including Dr Matthews, who noted the need for embedded

expertise to help support propositions D1 and D4. Others, such as Dr Dooland, supported a dental outreach approach, with aged care staff trained to support prevention and assessment to augment this capability.

There was broad support from the witnesses on most of the oral health propositions, particularly on increasing the oral health capabilities of the aged care workforce and funding public health services to deliver outreach care. Similar to the evidence on mental health care, there was also support for oral health being part of a multidisciplinary approach. Ms Stormon stressed the need for multidisciplinary teams, while Professor Wright called for dental specialists to be part of broader multidisciplinary teams.

There was also evidence on the need to reform oral health funding. Ms Stormon agreed with the review of the funding model, noting that the gold standard of care is hard to achieve under current parameters, which leads to people missing out. Dr Matthews pointed to confusion over the dual aged care funding system, which leads to a gap, and needs to be simplified. Both expressed support for a Seniors Dental Benefit Scheme, although noting its potential limitations. Dr Lyons, presenting on behalf of the NSW Ministry of Health, agreed with the proposal, as the state would prefer an older persons equivalent of the Child Dental Benefits Scheme. However, Dr Lyons also set out that the NSW Government didn't support Proposition D1 due to its connection with the National Partnership Agreement on Public Dental Services for Adults (NPA), which usually last 5 years – NSW would prefer a more long-term funding arrangement, as there is no certainty of maintenance funding in NPAs.

• Allied health

The Commission discussed allied health during the final two days of the hearings (16-17 July). Similar to oral health, the Commission had previously heard evidence on gaps in allied health care, particularly due to the funding mechanism. The focus of the hearings was primarily on testing one of the funding propositions that had been developed by Counsel Assisting:

- **Proposition A5**: Implement a new funding model to support the delivery of allied health care to aged care recipients. Two funding mechanisms should be used to achieve a sustainable funding model to support high-quality allied health for aged care:
    - Fund residential aged care and home care providers to deliver 'frequent and ongoing' allied health services; and
    - Increase funding for 'infrequent or episodic' allied health services through a new MBS benefit structure for people accessing aged care services under an 'Aged Care Plan'

There was broad support for proposed funding mechanism, including the splitting of funding for episodic and ongoing allied health care. Only Ms Hewat, CEO of Allied Health Professions Australia, argued there should be one funding stream held by providers which would deliver all types of care. Dr McGowan, CEO of SA Health, and Dr Lyons, Deputy Secretary of the NSW Ministry of Health, both supported the proposed funding mechanism in principle, although Dr Lyons noted that there needs to be nationally consistent approach to reduce unwarranted care variation.

However, witnesses did set out how the mechanism needs to operate to support care. Similar to the other policy areas discussed during the hearings, there was support from witnesses for establishing a multidisciplinary approach. Ms Hill and Dr Ward emphasised the need for a multidisciplinary approach, highlighting that the funding mechanism has to be adaptable to the needs of the patients; currently practitioners try to adapt the needs of patients to fit into the funding available. The hospital model was highlighted as an example of where this works and something that should be expanded into aged care.

There was also some support for establishing embedded allied health teams. Ms Hewat supported having embedded multidisciplinary teams, although noting that rural and regional services would need to contract teams, but this could be aligned with other organisations, such as a local hospital, that would need similar services. The success of existing embedded approaches was also presented to the Royal Commission; Southern Cross Care, who have 17 residential aged care facilities, highlighted their success with a wider health promotion approach, leading to a 67 per cent reduction in hospital transfers. Similarly, the Life Care facility in Adelaide set out their use of multidisciplinary teams to support allied health outcomes.

The Commission also heard that the funding mechanism must support care delivery which benefits patients. Two aged care allied health providers identified issues such as a lack of funding for certain areas of allied health in aged care settings, with this failing particularly acute with ACFI, which was deemed too prescriptive to give the care that older people need. This was agreed to by the two private residential aged care facilities, who were concerned about perverse incentives due to deficit funding – providers get more money if a client is less independent. In terms of the proposed funding scheme, the NDIS was highlighted as a potential model to copy, with multidisciplinary assessment on what services should be episodic or ongoing.

A major area of disagreement in evidence was in regards to where the funding would be held. Concerns were raised by aged care allied health providers about funding aged care providers directly due to potential accountability and cost-cutting issues. This was echoed by Dr McGowan, who expressed concern over an aged care provider coordinating allied healthcare due to the potential for poor care to not be challenged. However, both aged care providers that gave evidence argued that providers were best placed to hold allied health funding, while Ms Hewat argued that the aged care system needs to be responsible for establishing programs of care due to the multidisciplinary approach required.

Witness list

Witnesses called to give evidence to the Commission at the health interface hearings are set out below.

Witnesses	**Details**
UX	Direct evidence
Dr Alison Argo	Clinical Geropsychologist
Dr Diane Corser	Clinical Geropsychologist
Associate Professor Stephen Macfarlane	Geriatric Psychiatrist
Professor Sunil Bhar	Clinical Psychologist and Professor of Psychology, Swinburne University of Technology
Mark Silver	Social Worker and Coordinator of the Wellbeing Clinic for Older Adults at Swinburne University of Technology
Dr Leanne Beagley	CEO, Mental Health Australia
Dr Janet Wallace	Associate Professor in Oral Health, School of Health Sciences, Faculty of Health and Medicine, University of Newcastle
Dr Kathleen Matthews	President, Australian Dental Association, NSW
Nicole Stormon	Vice President, Australian Dental and Oral Health Therapists' Association
Beryl Hawkins	Direct evidence
Professor Fredrick Allan Clive Wright AM	Clinical Professor, Centre for Education and Research on Ageing at the Concord Clinical School, University of Sydney
Dr Martin Dooland AM	Adjunct Associate Professor at the University of Adelaide
Dr Stephanie Ward	Consultant Geriatrician
Dr Jennifer Hewitt	Clinical Physiotherapist
Angeline Violi	Exercise Physiologist and Director of Concentric Healthcare Services
Nicholas Young	Physiotherapist and Director of Concentric Healthcare Services
Lidia Conci	Speech Pathologist and Managing Director of AvantiCare

Claire Hewat	CEO, Allied Health Professions Australia
Professor Esther May	Occupational Therapist and Executive Dean, Clinical and Health Sciences Academic Unit, University of South Australia
Josephine Boylan-Marsland	Executive Services, Southern Cross Care (SA, NT and VIC)
Dr Tim Henwood	Group Manager of Connected Living – Community Wellness & Lifestyle, Southern Cross Care (SA, NT and VIC)
Allen Candy	Chief Executive Officer, Churches of Christ Life Care
Dr Nigel Lyons	Deputy Secretary, Health System Strategy and Planning, NSW Ministry of Health
Dr Christopher McGowan	Chief Executive, SA Health
Penny Shakespeare	Deputy Secretary for Health Financing, Australian Government Department of Health
Tania Rishniw	Acting Deputy Secretary for Health System Policy and Primary Care, Australian Government Department of Health

Policy alignment

The Victorian Healthcare Association, in its submission to the Royal Commission, made a number of recommendations which were reflected in witness testimony and the Royal Commission's propositions. In particular, the submission had a focus on oral health; the VHA's recommendations to build the oral health capacity of the aged care workforce and ensure access to dental professionals in residential aged care are reflected in the Royal Commission's propositions. Other areas where VHA recommendations were echoed in the hearings include:

- the need for holistic, multidisciplinary care that is flexible and meets the changing needs of residents
- incentivising the delivery of services including allied health professionals
- the opportunity to utilise telehealth provide alternative models of care efficiently and effectively, when appropriate
- greater investment to support state-based health services to increase and expand service provision through residential-in-reach programs to improve the quality of care for residents and avoid unnecessary emergency department presentations.

Next steps

The Commission is holding its next hearings between 10-13 August 2020 in Sydney, which will focus on the response to COVID-19. There will also be another hearing in Sydney immediately afterwards (13-14 August) which will focus on accommodation and its impact on aged care delivery. The VHA will monitor these proceedings.

The VHA will continue to update members as the Commission progresses in its work.

For further information contact

Ben Rogers
Advisor, Policy and Advocacy
ben.rogers@vha.org.au
03 9094 7777