SARRAH

Services for Australian Rural and Remote Allied Health

30 September 2022

Department of Health and Aged Care

Attention: mike.herbert@health.gov.au

Services for Australian Rural and Remote Allied Health (SARRAH) submission: Aged Care data strategy consultation

Thank you for the opportunity to contribute to the development of an aged care data strategy in response to recommendations 67 and 108 of the Aged Care Royal Commission.

Recommendation 67: *Improving data on the interaction between the health and aged care systems*[1]

Recommendation 108: *Data governance and a National Aged Care Data Asset*[2]

As background, 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, and other service systems. SARRAH was established in 1995 by a network of rurally based allied health professionals and continues 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. 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 strong interest in the provision of accessible, comprehensive and high-quality aged care services, which include enabling allied health care, wherever people live in Australia. Our particular focus is supporting the development and distribution and retention of the allied health workforce in areas of service need. The aged care data strategy is an important asset for policy review, development, service delivery and performance improvement purposes.

The *Consultation information guide* developed to assist with the consultation is a clear, helpful and succinct document: thank you.

[1] Page 252 - *Royal Commission into Aged Care Quality and Safety: Final Report: Care, Dignity and Respect: Volume 1 Summary and recommendations*

[2] Pages 279-282 - *Royal Commission into Aged Care Quality and Safety: Final Report: Care, Dignity and Respect: Volume 1 Summary and recommendations*

As an overarching comment, the *Consultation information guide* provides a welcome understanding of the importance and fundamental value of an effective and well-integrated data strategy geared toward and set within a framework that prioritises policy and service effectiveness and impact.

We note the statement under the heading **Relationship to other strategies**: *The data strategy will align with other department strategies, including several under development:*

- *2022-25 Data strategy*
- *Aged care digital strategy*
- *Aged care workforce strategy*
- *Aged care workforce action plan*
- *National ageing and aged care research strategy.*

SARRAH would encourage the Department to ensure the linkages between the data strategy and these, **especially the workforce strategy and action plan** are strong and assessed regularly to identify and draw our correlations between detailed service and workforce access and the health and well-being of aged care recipients. This information has great potential to steer and target future policy and service settings that optimise aged care recipient outcomes and cost-effective service interventions and investments.

1. **What do you think of the draft Vision, Purpose and Guiding principles?**

These are clear and concise. Drawing on Table 1 of the *Consultation information guide:* **Core elements of the data strategy, including draft content for discussion –** the content identifies key issues that can be diluted or lost in overly detailed and/or technocratic documentation relating to data strategies. The overarching purpose remains clear. For example, against "Purpose" (highlight added to emphasise priority)

The data strategy will explain why we are improving the aged care data system, including providing information about aged care that will better support:

- *people to make informed choices about aged care*
- *services and providers to improve their provision of safe, high-quality and dignified care*
- *government to design, administer, evaluate and improve the aged care system secondary users of data (such as peak bodies and academic researchers) to study and provide insights that can improve the aged care system.*

Against "Guiding principles":

- *Data that supports evaluating the performance of the aged care system and supporting future improvements*

These comments are not to suggest detailed technical development is less important, but that it must align with key objectives etc, as are evident in the draft document. Obviously, the data strategy needs to be able to enable testing and assessment of potential anomalies in reporting and compliance, especially in an environment which has relied heavily on self-reporting and divergent outcomes. It also needs to facilitate accurate identification of high-quality providers from others and enable targeted policy supports - distinguishing major contextual constraints (e.g., workforce shortages) from opportunistic /other negative behaviour. The framing of the data strategy to date suggests this is well understood and guiding developments.

2. **How well do the Vision, Purpose and Guiding principles align with your organisation's strategies or objectives?**

Following from our response to the previous question, these align well with what we believe should be the primary focus of this work and should enable our ongoing contribution to support the development and delivery of quality services to people eligible to receive aged care.

We note and support in particular the highlighted elements of the following excerpt:

> *Based on a review of other data strategies, and alignment with the department's data strategy focus areas, strategic priorities / focus areas could include Governance; Culture; Capability (Government and Workforce).*

3. What do you think of the draft Scope in relation to aged care data?

The description of the Scope appears clear and sensible. It describes broadly the necessary elements and controls.

Importantly, in application the data systems will need to support basic sensibility checks, in terms of claimed services and circumstances - supply and capacity – and other interrogative functionality. For example, ideally the detailed development of aspects of the data strategy might be informed / reviewed against testing – e.g., where service providers claim /report services as having been provided but where workforce/skilled practitioners are in very short supply (notwithstanding innovative service models). This sort of facility not only supports system integrity and compliance but enables anomalies and behaviour that distorts performance information to be identified and taken into account when developing more desirable and effective policy and capacity development initiatives.

Hopefully the data strategy would support capacity for dynamic system development to maintain /effectively adapt to evolving practice and circumstances and not introduce or reinforce constraints in this regard.

4. What areas and activities would you like to see prioritised in the Roadmap?

The following comment could apply in response to Questions 3, 4 and possibly other consultation questions.

The following is an example of the shortcomings and constraints of inherent and broader data issues that impact on aged care service provision, funding and data. Such issues present limitations and risks to the quality, usefulness and interactions of aged care data with other data sources / systems.

The following example is described principally as it relates to exercise physiologists as well as broader issues. We acknowledge the collaboration of Exercise and Sports Science Australia (ESSA) in providing advice on these matters.

- There are no nationally agreed definitions of the allied health sector and allied health patient outcome measures.
- The QFR Guide – Allied Health reporting for Residential Aged Care providers Guide to assist residential aged care providers to accurately report Allied Health costs in the Quarterly Financial Report has a category 'Other Allied Health expenditure and care minutes' which precludes the tracking of care and minutes by individual allied health professions, especially all those listed in Rec 38b of the Royal Commission into Aged Care Quality and Safety.
- Reporting frameworks including the Australian Bureau of Statistics industry and occupational classification systems do not to mirror the current groupings of health practitioners in various funding schemes including the Medicare Benefits Schedule. For example, exercise physiologists share an ANZSCO code with ceramic scientists.
- Most data collections from the ABS and AIHW do not integrate workforce data from self-regulating and independently regulated peak professional health bodies.

- Individual allied health professions are the only health professions to share **Medicare item codes** for the same service delivery item - i.e., in the telehealth Allied Health Chronic Disease Management (CDM) services.
- There are separate item codes for each face-to-face allied health CDM service (e.g., Item 10953 for exercise physiology), whereas a single shared code is only available for the following allied health telehealth CDM items:
    - Item 93000 for telehealth items via videoconference (used for 13 different service items)
    - Item 93013 for telephone items – for when videoconferencing is not available (used for 13 different service items).
- The sharing of multiple services in a shared single item codes has impacted on the monitoring and reviewing of telehealth/telephone usage data per service type resulting in a loss of historical data sets of total usage by individual service type.

5. What outcomes do you think are most important to this data strategy?

- Ensuring development continues with a clear emphasis on the Vision, Purpose and Guiding principles and these are not distorted or unduly compromised for reasons of marginal importance, cost or short-term convenience.

6. What are the most significant barriers and success factors for the data strategy?

- Data strategies and development processes can be compromised by factors such as the limitations of pre-existing and legacy data holdings and collection mechanisms (often ill-suited to the purpose). This has been a substantial issue over decades, for example, in the collection of high-quality performance/ impact data from major systems, such as those built for the assessment and payment of income support. Notwithstanding innovative and skilled developments to retrofit systems these can be extremely expensive and sub-optimal.

A further risk is the tendency for data to be collected and reported to accentuate favourable performance for those managing /accountable for the policy/program/system. It is important that the data strategy protects the capability to identify shortcomings and gaps which prevent improvement in the 'system'. Independent assessment and oversight on an ongoing basis help reduce this risk.

If you would like to discuss issues raised in SARRAHs response or require further information, please contact Allan Groth at allan@sarrah.org.au.

Yours Sincerely

Cath Maloney
Chief Executive Officer

Services for Australian Rural and Remote Allied Health (SARRAH) exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being. 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 is a national, multidisciplinary member association, has been operating for 26 years and the only peak body fully focused on rural and remote allied health working across all disciplines. (More information: http://www.sarrah.org.au/).