Services for Australian
Rural and Remote Allied Health

27 February 2024

Joint Standing Committee on the National Disability Insurance Scheme
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Services for Australian Rural and Remote Allied Health (SARRAH) submission to the Joint Standing Committee on the National Disability Insurance Scheme:

NDIS participant experience in rural, regional, and remote Australia

Thank you for the opportunity to contribute to the consultation on the NDIS participant experience in rural, regional, and remote Australia.

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, disability, aged care, and other service systems. SARRAH was established in 1995 as 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.

We note that SARRAH receives no government financial assistance to support its representational, advisory, general membership engagement or support, advocacy, or related operational activities.

Our representational and advocacy activities seek to address systemic issues that contribute to (and sometimes entrench) the disadvantage experienced by NDIS participants, other people with disabilities and everyone who should have access to and would benefit from allied health care in rural and remote Australia.

At the outset SARRAH recognises the NDIS and the NDIA are undergoing fundamental (re-)alignment. SARRAH has always strongly supported the NDIS and, in the main, welcomes the current emphasis and direction of reform as exemplified by the NDIS Review process and recommendations and the effort to establish a NDIA culture and operational capacity that is

more participant and outcome focused. We strongly support an effective. sustainable and accessible NDIS.

SARRAH also welcomes developments through National Cabinet and Australian disability Ministers to create a more complete disability service environment. The NDIS must function as a core component within a broader, coherent, and sustainable disability services system nationally.

Against this backdrop, SARRAH also welcomes the continuing role of the Joint Standing Committee (JSC) on the NDIS, and focus of this inquiry. The JSC has provided a very important oversight role and independent avenue to raise issues while seeking to ensure the effective implementation and development of the NDIS. We hope the JSC continues to perform this role.

SARRAH is optimistic the NDIS Review will lead to a more participant-centred, outcome-focussed, hopefully equitable and cost-effective NDIS, we are also acutely aware that reform agendas are not carried through and implemented sufficiently well to deliver the intended benefits to the community, and that frequently people living in rural and remote continue to experience the same inequitable access and outcomes, compounded by other forms of disadvantage that are well understood in terms of the social and economic determinants of health and wellbeing.

The main point SARRAH would like to impress upon the JSC is that improving the NDIS participant experience in rural, regional, and remote Australia depends on services and workforce being available and accessible to help achieve participants' therapeutic and capacity-building needs, their ambitions and potential.

We have addressed this point against the Terms of Reference in the Attachment to this covering letter. In it we reiterate the same issues regarding service and workforce shortages and maldistribution that SARRAH has raised with the JSC, Government agencies, other Parliamentary Committees, and a great many government consultation processes previously.

Unfortunately, the situation rural and remote Australians faced in accessing NDIS, other disability, aged care, and health services over the past decade remain essentially the same today. People who hope to see someone to have their allied health service needs assessed frequently must wait months or longer and then to access treatment (even with an approved NDIS package) may wait just as long to receive important therapies.

The development and distribution of a sufficient, skilled NDIS and related workforce (including Allied Health Professionals and Allied Health Assistants) must be an immediate and first order priority. Without it, the experience of NDIS participants in rural, regional, and remote Australia will be lacking.

Other NDIS reform imperatives should not distract from enhancing workforce and service capacity. For instance, there is considerable current focus on stopping opportunistic provider behaviour in the system. That should continue and proceed in an informed way to ensure genuine service providers working within the constraints of various systems h are not confused with opportunistic price gouging of NDIS participants' packages. As important is the need to ensure the availability and accessibility of allied health services for people who would choose to benefit from them. The outcomes for participants (especially in rural and remote Australia)

and capacity to deliver therapeutic, enabling services depends on a mature and balanced approach to these issues.

We hope these and the attached comments are of assistance to the Joint Standing Committee..

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

Yours Sincerely

Catherine Maloney
Chief Executive Officer

SARRAH Submission to the JSC NDIS Inquiry into the NDIS participant experience in rural, regional, and remote Australia

Responses to the Terms of Reference

Terms of Reference

As part of the committee's role to inquire into the implementation, performance, and governance of the National Disability Insurance Scheme (NDIS), the committee will inquire into and report on the NDIS participant experience in rural, regional and remote Australia, with particular reference to:

a. *the experience of applicants and participants at all stages of the NDIS, including application, plan design and implementation, and plan reviews;*
b. *the availability, responsiveness, consistency, and effectiveness of the National Disability Insurance Agency in serving rural, regional and remote participants;*
c. *participants' choice and control over NDIS services and supports including the availability, accessibility, cost and durability of those services;*
d. *the particular experience of Aboriginal and Torres Strait Islander participants, participants from culturally and linguistically diverse backgrounds, and participants from low socio-economic backgrounds, with the NDIS; and*
e. *any other related matters.*

Each of the Terms of Reference is addressed in turn below.

a. the experience of applicants and participants at all stages of the NDIS, including application, plan design and implementation, and plan reviews;

As mentioned in the covering letter of this submission, SARRAHs comments focus allied health workforce and service capacity issues as they impact the NDIS participant experience in rural, regional and remote Australia. SARRAH has provided numerous Submissions to the Joint Standing Committee's Inquiries, including to the NDIS Workforce Inquiry in 2022 (Submissions 50 and 50.1) , the NDIS Planning Inquiry in 2019 (Submission 72) among others.

Critical social service and support systems cannot be delivered without a skilled workforce, even with technological enablers. Similarly, full utilisation of the skills and potential of that workforce need to be deployed at the best possible time and in the places they are needed most. **Maldistribution of allied health workforce leads to disparate service access and outcomes, which leads to avoidable costs (e.g. avoidable hospitalisations, severity of disease and disability) and loss of health, well-being, participation and productivity.**

In the NDIS this negatively impacts the capacity of potential participants to develop therapeutic relationships prior to assessment (which would generally not be subsidised through the MBS), assessments themselves, therapy following assessment, for reviews and so on.

Access shortages in rural and remote Australia face further pressure. Workforce and service demand across the health and social sector continues to lead all other sectors and is projected

to continue to do so[1]. Within the health and social assitance sector, **demand for allied health is as strong or stronger than for all other occupations, and greater capacity is needed to meet demand across the the NDIS, other disability services, health, aged care, veterans, early childhood development and more.**

The evidence in support of immediate action to build and distribute the allied health workforce is compelling. Gaps in workforce capacity and service access are already well known and have been identified as an express concern in many of the national priority health reviews, documented in this submission. **Development and distribution of a skilled allied health professional and assistant workforce must be prioritised.**

This podcast demonstrates the value of allied health professionals (also undertaking the Allied Health Rural Generalist Program pathway with SARRAH) in enabling NDIS service access services across northern NT.

Pre-existing workforce maldistribution have worsened in recent years[2], highlighted by the high demand for allied health professionals arising from the roll out of the NDIS and increasing need in aged care service settings; and further exacerbated by the COVID-19 pandemic, impacting the mobility of the workforce across state borders within Australia, and adversely affecting the numbers of overseas-trained allied health professionals entering the country in recent years.

- There are more than 200,000 allied health professionals in Australia[3], but not enough to meet community need.
- Recruitment and retention of allied health professionals into rural and remote communities is an ongoing challenge.

SARRAH has been raising these and related concerns with other Parliamentary Committees, in government consultation processes, with Ministers, officials and others over many years. Unfortunately, there is evidence suggesting that even with the increased overall allied health workforce over the past decade (substantial, but insufficient to meet community need or demand) the maldistribution of that workforce over the past decade has worsened, becoming even more concentrated in our major cities.

The **NDIS Review Report,** *Working together to deliver the NDIS*, released on 6 December, **is clear that building allied health workforce and service capacity is crucial and needed immediately to meet NDIS demand**:

> *Allied health workers : 36,000 workers in 2021-22 51,000 workers required to fully meet demand by June 2025. This group includes both allied health professionals and allied health assistants. In the year to 20 September 2022, allied health services accounted for around 13% of NDIS payments.* (Page 192)

[1] Jobs and Skills Australia: https://www.jobsandskills.gov.au/data/employment-projections

[3] A summary of allied health workforce professions, its size and distribution is available on the Commonwealth Department of Health webpage: About Allied Health Care. The estimate of 200,000 allied health professionals nationally appears to be conservative, and may be due to there being no national data held on the numerous self-regulated allied health professions, not covered by the National Registration and Accreditation Scheme (NRAS) for health professionals: which include speech pathologists, dieticians, exercise physiologists, audiologists, orthoptists/prosthetists, social workers among others.

The following excerpts from the NDIS Review Report illustrate the importance of the allied health workforce to the future NDIS, access, value and outcomes:

- Recommendation 15 and related actions specifically address the need to *Attract, retain and train a workforce that is responsive to participant needs and delivers quality supports*.
- From Recommendation 4.2: *Specialist navigation should be provided locally by staff with lower caseloads than other Navigators and have relevant experience managing complex situations and risks* ***and ideally are qualified in allied health, social work or related fields****.* (Page 105)
    - Consideration should also be given to including Allied Health Assistants as navigators and specialist navigators.
- From Action 6.4: *The National Disability Insurance Agency should change the basis for setting a budget to a whole-of-person level, and introduce a new needs assessment process to more consistently determine the level of need for each child and set budgets on this basis* ….(includes)…. *Delivering this would require an investment by government in ensuring the assessment is delivered by a highly experienced and qualified Needs Assessor (ideally an allied health professional experienced with children) who is able to spend sufficient time to understand a child and family. (Pages 125-6)*
- From Action 13.2 *The National Disability Insurance Agency should progressively roll-out provider panel arrangements for allied health supports in small and medium rural towns or where participants face persistent supply gaps.* (Page 184)

> ***In addition to the challenges around access in remote and First Nations communities …), we've heard from participants about the continuing issues in accessing allied health supports in regional and rural parts of Australia. Over 33 per cent of participants — who have been in the scheme for at least one year — are not accessing any therapy supports in small and medium rural towns, despite having funding for these supports.*** *(Page 180, NDIS Review Report)*

The NDIS has substantially improved access for many participants; a situation not matched in the broader disability of private/community health systems. However, workforce shortages and maldistribution inhibit rural and remote access even where NDIS participants have packages to support their therapy needs.

The NDIS National Workforce Plan 2021-25 (the Plan), released in June 2021, essentially acknowledged Australia had not adequately planned for or built the workforce capacity to deliver the NDIS and that workforce constraints were a factor inhibiting the access to and success of the Scheme. The lack of allied health service and workforce capacity, especially in rural and remote Australi, has inhibited of NDIS assessment, service access and use of capacity building package resources. Over several years, reported package utilisation rates have been the lowest among 'remote' participants.

The status of the Plan may be uncertain and was possibly superseded by the NDIS Review Report and actions in response to that, as well as broader work under the National Strategy for the Care and Support Economy.

An update on the status and efforts to coordinate these agendas is needed as is an urgent and sustained commitment to develop the workforce.

b. the availability, responsiveness, consistency, and effectiveness of the National Disability Insurance Agency in serving rural, regional and remote participants;

SARRAH has previously raised concerns with the JSC about the capacity of the NDIA to facilitate quality access to services and participant outcomes, noting issues such as:

- The knowledge base, skills and independence of NDIA planners;
- The capacity for planners and other NDIA staff who are located remotely from a community to realistically identify the needs, opportunities and/or supports available to a person / participant;
- Arbitrary decisions that limit a person's capacity to utilise a therapy, sometimes contrary to professional therapeutic advice, without any objective rationale for that decision.

These and others have been documented by the JSC and feature in the NDIS Review. We accept that the Commonwealth and relevant agencies intend to continue to improve the participant experience and opportunities afforded through the NDIS, but welcome the JSCs continuing oversight of progress.

Regarding workforce, SARRAH notes that we have on numerous occasions offered to work with the NDIA and/or the Department of Social Services to help develop or otherwise contribute to improving the allied health workforce and service capacity for NDIS participants in rural and remote Australia. SARRAH has a wide range of members located across Australia delivering NDIS services into rural and remote communities. It is an issue of considerable interest to our members. Nonetheless, while SARRAH has had some positive engagement with various staff in these agencies we would welcome a more direct involvement in representative or advisory roles where our members offer extremely valuable experience and expertise.

c. participants' choice and control over NDIS services and supports including the availability, accessibility, cost and durability of those services;

Reflecting the material provided in response to other items, SARRAH recommends that the JSC address the question of choice and control in a very practical sense as it impacts the experience of participants living in rural and remote Australia especially. What choice and control exists where services a person might benefit from most do not exist/are inaccessible due to distance and/or the lack of professional or assistant service workforce?

SARRAH is aware, and understand the JSC may have been alerted to, situations where:
For example, a planner or other decision-maker (e.g. a GP) may identify a participants therapeutic and other support needs based on what is known to be available rather than the therapy/service that would best align with the participants' goals and therapeutic benefit.

It is critical for rural and remote participants that concepts such as choice and control, market-oriented responses etc have been incorporated into the NDIS as a means of empowering participants and delivering options. They have not delivered either in much of rural or remote Australia. In the NDIS, as in health, aged care and other service systems that are supposed to be available in large sparsely populated areas of Australia as well as metropolitan centres, greater flexibility in approach is needed to deliver more equitable access and outcomes and to do so on a value for money, sustainable basis. New, more flexible and integrated models of service delivery are required that prioritise access and outcomes over sameness of process or mistaken concepts of what constitutes equity or efficient use of public funds.

Further, the NDIS Review also identified structural and approach issues, such as currently focusing too much on diagnosis of disability, and not enough on what a child (or other person) needs to achieve their potential, with positive interventions often delayed. Again, rectifying these limitations requires multi-faceted actions including streamlining administration and processes, redirecting NDIA operating priorities and capacity and ensuring there is an accessible and skilled workforce to provide services. In this vein, the following Recommendations and Actions would be supported by the proposals in this submission:

- From Action 14.1:…. *progressively roll-out alternative commissioning arrangements for both First Nations communities and remote communities, starting as soon as possible.*
- From Action 3.4: …. *introduce new needs assessment processes to more consistently determine the level of need for each participant and set budgets on this basis.*
- From Action 3.7: …. *reform the NDIS early intervention pathway to provide supports to individuals where there is good evidence the intervention is safe, cost effective and significantly improves outcomes.*
- From Action 4.1 …. *the lead commissioner of a local navigation function to help people with disability find supports in their community and make the best use of their funding.*
- From Action 11.1 …. *a new NDIS pricing and payments framework … including better ways to pay providers to promote the delivery of efficient and quality supports and continuity of supply.*

> ***I also recognise that in remote areas or thin markets, we're going to look at alternative commissioning as well. In other words, if you work if you're living in Maningrida or if you're living in Longreach, the idea that everyone's going to fly in from a bigger town for each individual package is preposterous, which is leading on one hand to overcharging and on the other hand to an underutilization of packages. So, we want to build up capability in local communities. So, whilst there will still be an individual package, we're interested if there's a common need for a physio, if there's a common need in northwest Tasmania for speech pathologists, let's look at what is there on the ground and direct people to that.***
>
> ***Minister Shorten*** *– In answer to a question following a speech to CEDA, 13 December 2023*

d. the particular experience of Aboriginal and Torres Strait Islander participants, participants from culturally and linguistically diverse backgrounds, and participants

SARRAHs comments above also refer to the experience of Aboriginal and Torres Strait Islander participants and to other people from culturally and linguistically diverse backgrounds. In addition, cultural responsiveness in service design and delivery, including a culturally safe and responsive workforce will improve participant experience, access and outcomes.

SARRAH works closely with several First Nations' organisations to develop the Aboriginal and Torres Strait Islander allied health professional and assistant workforces: including, for example, Indigenous Allied Health Australia (IAHA) and Central Australia Aboriginal Congress (Congress). Through these partnerships, SARRAH is aiming to contribute to improving access the allied health services for First Nations' people but, critically, to support the growth of the First Nations allied health workforce in line with the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031. This

workforce is crucial to NDIS and disability service delivery as well as for health, aged care and other services. At present Aboriginal and Torres Strait Islander people are massively under-represented in the allied health workforce and needs to grow by around five times the present number in the next 7 years to reach population parity (just over 3 per cent of the allied health workforce).

SARRAH notes that First Nations organisations, such as the First Peoples' Disability Network (FPDN), IAHA and others should primarily inform the JSCs consideration of these issues as they relate to First Nations Australians.

e. any other related matters.

The following information on allied health workforce maldistribution ad projected demand reinforces the points made above.

Critical shortages in Allied Health across rural and remote Australia

A major challenge for rural and remote communities seeking to attract and retain allied health workforce and service capacity is that **the increasing demand (described above) comes on top of chronic and severe existing workforce shortages**. The shortage in rural and remote GP workforce receives close political, media and community attention. Workforce and service shortages of AHPs and other health professionals attract considerably less attention – despite increasing calls for multi-disciplinary and team-based approaches to care. Nonetheless, the accessibility or otherwise of allied health services impact demand on acute and sub-acute hospital-based care, aged care, primary healthcare, disability support, veterans' services, education, workers' compensation, occupational rehabilitation and more.

On a per head of population basis, the maldistribution of allied health professions is particularly severe. Figure 1 shows the distribution by remoteness (where MMM1 is inner metropolitan and MMM7 is very remote) for a selection of AHPS, compared with GPs.

Figure 1: **Health professionals by remoteness – MM 1 to7**

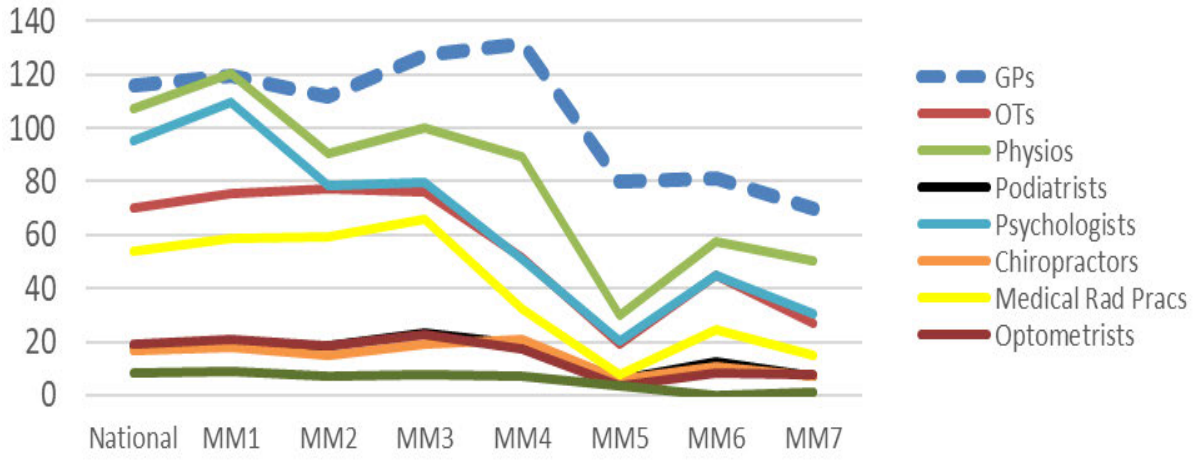

Figure 1. Health professionals by remoteness - MM1-7. FTE per 100,000 population – 2019[4]

[4] More recent national data is available. However, analysis indicates the pattern has not changed significantly since 2019 and SARRAH understands that for some professions (at least) distribution has become more concentrated in major cities over the past decade.

Other research reinforces the evidence of maldistribution[5]. Analysis by SARRAH also indicates maldistribution of some allied health professions has worsened over the past decade and become more concentrated in the major capital cities.

Allied health professions are leading this forecast growth, with the demand for several professions projected to increase by over 25 per cent over the five-year period. Table 2 illustrates the high demand growth for allied health professions (bolded). Several other professional groups are included for comparative purposes.

Table 1 Projected Employment Growth for the five years to November 2026: National Skills Commission: selected.

Profession	Projected increase
Audiologists and Speech Pathologists	**34.7%**
Podiatrists	**31.8%**
Physiotherapists	**28.7%**
Dental Practitioners	**27.8%**
Social Workers	**23.2%**
Early Childhood Teachers	21.6%
Optometrists and Orthoptists	**15.1%**
Drillers, Miners, and Shot Firers	14.9%
Medical Imaging Professionals	**14.7%**
Registered Nurses	13.9%
Psychologists and Psychotherapists	**13.3%**
General Practitioners and RMOs	10.2%
Accountants	9.2%
TOTAL PROJECTED EMPLOYMENT GROWTH – AUSTRALIA	**9.1%**
Pharmacists	**9%**
Ambulance Officers and Paramedics	**8.4%**
Industrial, Mechanical and Production Engineers	5.5%

Source: National Skills Commission's Employment Projections

SARRAH estimates that around 100,000 or more of the 301,000 health and social services sector jobs are needed in regional, rural, and remote Australia. Demand for skilled workers, including in health and social/community services is extremely strong in rural Australia, and is not being met.

SARRAH is also advocating for support to build the Allied Health Assistant (AHA) workforce. AHAs exemplify the evolving structure and nature of Australia's employment and service demand profile. **The potential of the AHA workforce to expand service reach and continuity of care, working under the direction of AHPs, is enormous, especially in rural and remote Australia.** However, to enable this to occur, focussed and coordinated action is needed between the VET sector, employers, and others to improve training and work opportunities and capacity. For individuals, AHA qualifications provide the basis for skilled job in high demand, adaptable to a range of settings as well as mobility and a pathway for career progression (across and through health, disability, aged care, and other settings).

The relationship between the Allied Health Professional (AHP) and the Allied Health Assistant (AHA) involves the delegation of therapeutic tasks and is a defining feature and fundamental to the definition of an allied health assistant role and patient safety. While allied health assistants work within clearly defined parameters, the role is often flexible, involving a mix of direct patient care and indirect support activities. The mix of duties is determined by a range

[5] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0291962

of factors including the model of care, the needs of the professional/s delegating work to the allied health assistant, and the types of services delivered by the allied health team.

At present, neither AHAs nor Therapy Assistants (an outdated role description currently embedded in the Australian and New Zealand Standard Classification of Occupations (ANZSCO)) [6] are included on the Australian Government's Skills Priority List (SPL). The SPL is managed by Jobs and Skills Australia. This situation has implications which can result in AHA trainees and/or employers from accessing training subsidies and other supports. Unfortunately, the ANZSCO (and consequently the SPL) is based on the labour market classifications determined over 20 years ago. An extensive major review is underway. On 18 December 2023 the ABS released proposed changes indicating they expect to recognise Allied Health Assistant as an occupation. This is an important although belated development.

[6] For a detailed explanation of this issue, see SARRAHs submission to the *ANZSCO comprehensive review – consultation round 2 (August 2023)*. A relevant excerpt (from page 3) follows:
The coding for Therapy Aide places it in the occupation group "Nursing Support and Personal Care Workers", along with 423311 Hospital Orderly, 423312 Nursing Support Worker and 423313 Personal Care Assistant. SARRAH suggests this does not accurately reflect the nature of the role, which is to provide direct patient therapy and/or interventions under the delegation of an allied health professional to assist with therapeutic and program related tasks. "Delegation" is the process by which an allied health professional allocates clinical and health-related tasks to an allied health assistant with appropriate education, knowledge, and skills to undertake the task.