# NDIS Participant experience in rural, regional and remote Australia

Prepared by the RACGP Rural Faculty

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## 1. About the RACGP

The Royal Australian College of General Practitioners (RACGP) is the voice of general practitioners (GPs) in our growing cities and throughout rural and remote Australia. For more than 60 years, we have supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

As a national peak body representing over 40,000 members working in or towards a career in general practice, our core commitment is to support GPs from across the entirety of general practice to address the primary healthcare needs of the Australian population.

We cultivate a stronger profession by helping the GPs of today and tomorrow continue their professional development throughout their careers, from medical students and GPs in training to experienced GPs. We develop resources and guidelines to support GPs in providing their patients with world-class healthcare and help with the unique issues that affect their practices. We are a point of connection for GPs serving communities in every corner of the country. Patient-centred care is at the heart of every Australian general practice, and at the heart of everything we do.

## 2. Executive Summary

Consumers living in rural and remote areas face complex and unique health challenges that are entrenched in historic disadvantage and isolation. The quality of life and health outcomes of rural and remote consumers are inextricably linked to the social determinants of health.

To truly address the structural disadvantage that is experienced by rural and remote consumers, policymakers must consider any changes to health policy through the lens of the social determinants of health. With a strong body of research suggesting that the social determinants of health account for 30-55% of healthcare outcomes, the profound impact that these factors have on health outcomes, particularly for people living in rural and remote communities cannot be ignored.[1]

Historically, healthcare policy has not considered the complexity of this demographic, in favour of policy that reflect metrocentric trends in healthcare service provision, resulting in a limited healthcare workforce in these areas that has a high turn-over rate due to a system that does not meet the needs of the consumers. These policies perpetuate geographic disadvantage. It is well established that health risks increase with rurality and these risks and mortality rates further increase for people living with disabilities. The cumulative effect of living in rural areas increases the vulnerability of this cohort, making support services even more important. Due to the high level of complexity of this demographic, those who are providing support must be trained to provide trauma-informed and culturally appropriate care.

RACGP Rural has approached this submission through the lens of the general practitioner. As the most accessed medical profession,[2] general practice provides a conduit between the social and physical health of rural and remote communities. This relationship that continues from the cradle to the grave grants a unique insight into the consumer journey and what healthcare policy looks like at the grassroots of its implementation. 91.1% of NDIS participants accessed general practitioner (GP) services, making general practice the most accessed health service for people on the

[1] World Health Organization (WHO) (n.d.) Social determinants of health. World Health Organization. Available online: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[2] The Royal Australian College of General Practitioners (2023) General Practice Health of the Nations 2023. RACGP. Available online: https://www.racgp.org.au/getmedia/122d4119-a779-41c0-bc67-a8914be52561/Health-of-the-Nation-2023.pdf.aspx

NDIS and demonstrating the importance of general practice-led care models for people living with a disability. [3]At the core of health issues affecting consumers in rural and remote areas are the issues of access and equity. During the consultation phase of this submission, RACGP Rural found that there was consistent feedback from members highlighting the difficulty in providing patients with the necessary specialists to gather evidence and reports to apply for NDIS funding. When funding was granted, members found that this did not necessarily translate into health outcomes. This is due to the limited availability of trained support workers and a lack of variety of care interventions in rural and remote communities. Ongoing workforce shortages have resulted in people missing out on the necessary funding and support to grant them control over their physical and social mobility and quality of life while maintaining their ability to stay in their rural communities.

RACGP Rural calls for the government to further commit to addressing the structural historic disadvantage experienced by Australians living in rural and remote areas. This includes bolstering the rural and remote healthcare workforce to allow for interdisciplinary teams to provide person-centred wrap-around support to consumers living with a disability. Only by addressing these issues will there be true changes to the issues experienced by these consumers. Flexible policies that are adaptable to the diverse needs of rural and remote communities are necessary to make important changes to the lives of people and families living in with disability in rural and remote communities.

A fractured approach to strategies and plans across service systems has led to uncoordinated efforts and gaps in responsibility. Currently, there is a lack of collaboration between general practice and the disability sector, including the NDIS.

GPs have a unique perspective on the operation of the NDIS. By providing evidence of disability and functional impact, essential care coordination, facilitation of appeals processes and support of patient health literacy, and playing an important role in assisting patient access and navigation of the scheme.

We must *'build a safe and inclusive society so 'people with disability cannot just survive but thrive in their lives and do whatever they want to do'* as per The Royal Commission Report.[4] The Government must appropriately support GPs to provide the essential care and coordination that enables this.

## 3.Summary of recommendations

- Bolstering the rural and remote healthcare workforce including the GP workforce
- End changes to payroll tax to ensure that rural and remote practices can continue servicing rural and remote communities
- Support innovations in rural general practice including flexible pathways for additional training including rural generalist pathways
- Commit funding to support additional college-led training programs to create rural-specific training and CPD courses for GPs managing disability and NDIS pathways.
- Review recruitment process of NDIS workforce and implement mandatory minimum checks and training requirements for working with vulnerable cohorts.

[3] Australian Bureau of Statistics. (2021). *Characteristics of National Disability Insurance Scheme (NDIS) participants, 2019: Analysis of linked data*. ABS. Available online: https://www.abs.gov.au/articles/characteristics-national-disability-insurance-scheme-ndis-participants-2019-analysis-linked-data.
[4] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023. Final Report Executive Summary, Our vision for an inclusive Australia and Recommendations, Commonwealth of Australia, Canberra, Sept 2023. Available online: https://disability.royalcommission.gov.au/system/files/2023-09/Final%20Report%20-%20Executive%20Summary%2C%20Our%20vision%20for%20an%20inclusive%20Australia%20and%20Recommendations.pdf

- Provide opportunities and incentives for recruitment and training within rural and remote communities as NDIS support workers
- Expand resource hub and include dedicated advocates and information officers to provide direction and vital information for self-managed clients.
- Engage in consultation directly with rural and remote communities to understand the complex and diverse requirements NDIS policy should meet
- Codesign rural inclusive NDIS policies that reflect missing demographics identified through consultation.
- Commit to larger policy reform to provide infrastructure and housing for rural and remote communities to provide the foundations for healthy communities
- Recruit advocacy-specific workers who understand the needs of rural communities and can advocate for people in rural and remote communities who are seeking screening/on NDIS funding. These workers should be non-clinical supports that work with GPs as a part of multidisciplinary healthcare teams.
- Providing adequate remuneration for GPs providing care to patients living with disability, including Medicare Benefits Scheme (MBS) funding for helping patients apply for the NDIS and the non face-to-face time required to write detailed reports
- Removing the financial barriers people with cognitive disability face when they attempt to access care, including:
    - providing adequate renumeration for GPs can be reimbursed for time spent preparing reports and other relevant documentation to support NDIS applications
    - expanding the list of disability-related health supports funded by the NDIS to include some general practice supports not covered by Medicare
    - effectively promoting the uptake of GP Management Plans (GPMP) and Team Care Arrangements (TCAs) by eligible NDIS participants to enable GPs to plan and coordinate care for those with complex conditions who require ongoing care from a multidisciplinary team.
- Increasing patients' Medicare rebates to reflect the real cost of practitioners providing comprehensive care to patients with disability
- Expanding funding to include telehealth consultations to better support patients with disability who have difficulties travelling and people in rural and remote areas.
- Ensuring the key role played by GPs in disability and support is included in any future reforms.
- Support pathways for recruiting and educating Aboriginal and Torres Strait Islander people to become NDIS support workers
- Review current safety measures for workers in rural and remote areas. Commit funding to support safe accommodation and upgraded equipment to allow people wanting to work in these communities to be able to safely undertake their work.
- Adapt NDIS policies to be more culturally inclusive and flexible to support Aboriginal and Torres Strait Islander models of care.
- Consider implementing annual reporting cycles on individual NDIS participants to ensure that they are receiving quality care.

- Explore and implement a communication strategy that focuses on patient-centred, multidisciplinary healthcare teams

- Consider funding non-clinical positions to assist consumers and medical professionals in directing support and navigating the NDIS in rural and remote communities.

## 4. Introduction

RACGP Rural advocates for the improvement of health outcomes for consumers living in rural and remote areas as well as the support and improved conditions of the healthcare workforce that services these communities. General practitioners hold a unique insight into not only the medical issues that face rural and remote consumers, but also the unique infrastructure and social implications of rurality.

It is well established that those living in rural areas have higher rates of preventable mortality, lower income, and significantly limited access to health and social infrastructure. People living with disability are also likely to report more than one chronic condition resulting in multimorbidity and a higher health burden.[5] General practitioners have close working relationships with their communities and have significant insight into not only the needs of the healthcare consumer but also the broader issues that face rural and remote communities.

To increase human capital in rural and remote areas that can adequately support people living with disability and their support networks, policies must be responsive to the unique needs of people living in rural and remote communities. At the core, a whole of systems approach must be considered when understanding the complexities of improving participant experience in the NDIS for rural and remote consumers.

During the consultation phase of this submission, RACGP members have expressed the difficulties that they have experienced in being able to engage appropriate specialists and care teams to support not only the referral process but also the lack of scope for engaging in the necessary multidisciplinary healthcare teams needed to provide holistic patient-centred care. Members have recognised that these issues are indicative of wider, persistent issues facing healthcare in rural and remote areas. This includes a lack of incentives to cultivate a stronger healthcare workforce in rural and remote areas, limited support for education, training, and employment opportunities in these communities, and a lack of flexibility in healthcare policies to support the unique issues facing rural consumers.

The requirements of adult patients with complex health needs in the community are often unmet. This means people live with chronic ill-health and untreated health conditions, which restrict their independence and ability to participate in and contribute to their communities, decrease quality of life and may result in avoidable and costly hospital admissions.

General practice is the most efficient part of the healthcare system. As outlined in the RACGP Vision for General Practice and a sustainable healthcare system, a well-resourced general practice sector is essential to addressing the existing and future challenges facing patients, funders and providers – including care for patients with disability.[6]

People with disability have the right to the full and equal enjoyment of all human rights and fundamental freedoms[7] and the government must embed human rights in the design and delivery of disability services (*as per Recommendation 10.1*).

Transformational change is needed in laws, policies and practices relating to people with disability (*as per Recommendation 10.1*), and the government has a fundamental role to play in focusing on 'practical strategies that lead

[5] Australian Institute of Health and Welfare (2023) *Chronic conditions and multimorbidity*, AIHW, Australian Government, accessed 15 January 2024.
[6] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023. Final Report Executive Summary, Our vision for an inclusive Australia and Recommendations, Commonwealth of Australia, Canberra, Sept 2023. Available online: https://disability.royalcommission.gov.au/system/files/2023-09/Final%20Report%20-%20Executive%20Summary%2C%20Our%20vision%20for%20an%20inclusive%20Australia%20and%20Recommendations.pdf

to better outcomes for people with disability.[7] **This includes ensuring safe, high-quality, person-centred care is accessible from their regular GP.**

We must *'build a safe and inclusive society so 'people with disability cannot just survive but thrive in their lives and do whatever they want to do'* as per The Royal Commission Report. The Government must appropriately support GPs to provide the essential care and coordination that enables this.

The RACGP Submission to the Independent review of the NDIS in August 2023 outlined overarching principles to improve function of the NDIS. Funding for support coordination should reflect the NDIS participant's support and communication needs. Funding for hours of support coordination should also be sufficient to facilitate face-to-face contact at least monthly (*as per recommendation 10.3 of the Royal Commission's report regarding adequate support coordination*[8]).

RACGP Rural thanks the Joint Standing Committee on the National Disability Insurance Scheme for the opportunity to contribute to the NDIS participant experience in rural, regional, and remote Australia.

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

A significant concern raised by RACGP Rural members is the user experience of people applying for NDIS funding in rural and remote areas. Members have expressed that issues in the consumer journey begin with the evidence-gathering stage before even being approved for participation in the NDIS. For a consumer to provide the necessary evidence of their disability, the current process requires assessments from allied health and hospital specialists. The current process assumes that these services are readily available for all consumers including those living in rural and remote areas.

Rural GPs work within a varied scope due to the limited health services and the diverse needs of their respective communities.[9] Due to limited services, including patient advocacy support, there is a higher burden for providing administrative services in the evidence-gathering stage for NDIS reporting. Currently, inadequate funding limits the ability of GPs to provide comprehensive care. GPs typically aren't remunerated for the additional time they spend writing reports after consultations with patients living with disability. High-quality reports required to support a patient's application for NDIS funding. Coordinating multidisciplinary care teams are not recognised by MBS if completed in the patient's absence. GPs are not supported to liaise with NDIS service providers to advise of issues being experienced by their patients (with patient consent) which hinders the needs of people with disability being adequately met.

With no other avenue for GPs to be remunerated for their time and expertise, GPs either must charge the patient a private fee or ask the patient to attend a face-to-face consultation. Additional consultations are often not in the best interests of the patient as it requires unnecessary travel and expenses which can be a significant barrier faced by people with a disability. Alternatively, GPs are able to conduct a telehealth consult, however, for rural patients, telehealth is often not a viable option due to a lack of appropriate infrastructure including unstable phone and internet services. Patients may also have to pay out-of-pocket fees for telehealth consults as well. There is a lack of awareness regarding GP Management Plans (GPMP) and Team Care Arrangements (TCAs) by eligible NDIS participants to enable GPs to plan and coordinate care for those with complex conditions who require ongoing care from a multidisciplinary team. National strategies on issues such as health and Closing the Gap should be aligned with Australia's Disability Strategy 2021-31 (ADS) and the recommended new National Disability Agreement. ADS recommends the Federal Government provide support for service providers delivering services to people with disability.[10]

Providing care for patients living with a disability should not be an administrative burden for GPs, currently this is the case as NDIS forms do not integrate with common Clinical Information Systems (CIS) used by GPs and their practice

[7] Ibid.
[8] Ibid
[9] Royal Australian College of General Practitioners (n.d.) What is rural general practice? RACGP, Australia. Available online: https://www.racgp.org.au/the-racgp/faculties/rural/about-us/what-is-rural-general-practice
[10] Australian Government (2023). National Disability Strategy 2021-32, Australian Government Department of Social Services, Canberra, Sept 2023. Available online: https://www.dss.gov.au/disability-and-carers-disability-strategy/national-disability-strategy-2010-2020

teams. Current forms are cumbersome and inefficiently designed, with an emphasis on the requirement for the use of correct phrasing to obtain approvals as opposed to a narrative that conveys what support the patient requires.

In consultation, during the evidence-gathering stage, RACGP members have described a typical consumer journey as having to travel long distances at their own expense, waiting for specialists to become available in travelling rotations, which often results in the consumers and their families having to continuously self-advocate and repeat details regarding their disability and how it impacts them on multiple occasions to a variety of people, causing overwhelm and traumatisation. One RACGP Rural member reported patients being on waitlists for two years just to seek appropriate evidence to submit their NDIS paperwork. On average, people living in rural and remote areas earn less than their urban counterparts.[11] The cost of travelling great distances, missing work, sourcing transportation, and paying for out-of-pocket expenses associated with engaging these specialists create a significant burden for people sourcing this support. For people in rural and remote communities, this first step in the NDIS support journey becomes a luxury few can afford to engage in, rather than the necessary support system it was designed to be. Consequently, RACGP Rural members have stated that this process causes many individuals to reconsider seeking help and not pursuing vital funding to help them manage their conditions. Beyond providing a significant amount of paperwork to be approved for funding that is complex and in-depth, many consumers in rural and remote areas who are granted support through the NDIS are concerned with how to access support in the scheme. RACGP Rural members called for streamlined and coordinated assessment services to maximise the most cost-effective and patient-centred journey for rural and remote communities.

Many rural and remote consumers are unable to access appropriate support and struggle to engage the skilled practitioners necessary to provide appropriate therapeutic interventions due to their rurality. Members have also expressed concern regarding the quality of support in rural and remote communities due to limited resources. This often under-skilled workforce can potentially cause a significant amount of harm to an already vulnerable consumer demographic due to inadequate skills and training. Currently, only NDIS workers in risk-assessed roles are required to have police checks. Other NDIS workers can work with an NDIS worker screening assessment. [12] RACGP Rural members have called for police checks to be implemented for all workers engaging with NDIS participants due to the vulnerability of the demographic. RACGP Rural members have also reported a lack of transparency in understanding what services have been provided to patients by their support teams. To ensure there is coordinated care and less fragmentation for this cohort, RACGP Rural members have suggested transparent annual reporting be implemented for each NDIS participant, to be completed by their care team. This will ensure that their GP can understand their care journey and adapt care plans as necessary.

Individuals and their families seeking support and therapeutic interventions have reported the quality of support is below the standard that they had expected. Insufficient variety of support available in rural and remote areas was also reported, resulting in feelings of isolation, and a feeling that the current system in rural and remote communities was unable to support the needs of their families in obtaining services. [13]This consumer journey highlights the disconnect between policy and implementation for people in rural and remote areas. The on-the-ground experiences of consumers in these areas reflect the significant damage that geographic inequities and thin markets pose for rural and remote Australia. [14]

One study that explored the experiences of NDIS Support Coordinators in Tasmania reported that participants unanimously reported difficulties connecting NDIS participants to allied health services due to limited services, and overburdened resources. The same study reported that this compromised service quality led to a loss of participant

[11] Australian Institute of Health and Welfare. (2023). *Rural and remote health.* Available online: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[12] NDIS Quality and Safety Commission (n.d) Worker Screening Requirements (registered NDIS providers). Australian Government. Available online: https://www.ndiscommission.gov.au/providers/registered-ndis-providers/registered-provider-obligations-and-requirements/worker#ide

[13] Johnson, E., Lincoln, M., Cumming, S. (2020) Principles of disability support in rural and remote Australia: Lessons from parents and carers. *Health and Social Care in the Community* 28: 6. Available online: https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.13033

[14] Dew, A. (2022) What, if anything, has changed over the past 10 years for people with intellectual disabilities and their families in regional, rural, and remote geographic areas?, *Research and Practice in Intellectual and Developmental Disabilities,* 9:2, 103-107, DOI: 10.1080/23297018.2022.2109195. Available online: https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.13033

function and reduced future funding for participants.[15] Thin markets not only have significant implications for workforce and access but also impact the safety of participants requiring NDIS services in rural and remote communities. Due to critical skilled workforce shortages in rural and remote areas, members reported that many support workers do not have the appropriate trauma and cultural training to provide adequate care to people with disabilities. People living with a disability are also at an increased risk of experiencing violence and abuse.[16] Therefore, safe and trauma-informed practices are imperative to providing adequate care and protection for people living with disability, their support workers, and their friends and family.

The consumer journey for those living in rural and remote areas relies heavily on a range of uncertain variables that are beyond the control of the consumer. This includes the assumption that people are well-resourced and physically able to travel to access the professionals needed to assess their capacity. Additionally, the system places the responsibility on the participant to access the care they are entitled to. The current system requires the person to be able to either self-advocate or have support systems (e.g. family) available to advocate on their behalf. When these conditions are not met, this results in significant fragmentation of care for people with disabilities, resulting in cumulative harm to a vulnerable demographic that already experiences significant geographic and social disadvantage that is intrinsically linked to rurality.

**RACGP Rural recommends:**

- Expand resource hub and include dedicated advocates and information officers to provide direction and vital information for self-managed clients.
- Commit funding to support additional college-led training programs to create rural-specific training and CPD courses for GPs managing disability and NDIS pathways.
- Review recruitment processes for NDIS workforce and implement mandatory minimum checks and training requirements for working with vulnerable cohorts.
- Consider implementing annual reporting cycles on individual NDIS participants to ensure that they are receiving quality care.
- Explore and implement a communication strategy that focuses on patient-centred, multidisciplinary healthcare teams
- Recruit advocacy-specific workers who understand the needs of rural communities and can advocate for people in rural and remote communities who are seeking screening/on NDIS funding. These workers should be non-clinical supports that work with GPs as a part of multidisciplinary healthcare teams.
- Removing the financial barriers people with cognitive disability face when they attempt to access care, including:
    - providing adequate renumeration for GPs can be reimbursed for time spent preparing reports and other relevant documentation to support NDIS applications
    - expanding the list of disability-related health supports funded by the NDIS to include some general practice supports not covered by Medicare

[15] Jessup, B., Bridgman, H (2022) Connecting Tasmanian National Disability Insurance Scheme participants with allied health services: challenges and strategies of support coordinators*, Research and Practice in Intellectual and Developmental Disabilities*, 9:2, 108-123, DOI: 10.1080/23297018.2021.1969264. Available online: https://www.tandfonline.com/action/showCitFormats?doi=10.1080%2F23297018.2021.1969264

[16] Australian Bureau of Statistics (2021) Disability and Violence - In Focus: Crime and Justice Statistics. ABS. https://www.abs.gov.au/statistics/people/crime-and-justice/focus-crime-and-justice-statistics/latest-release

- effectively promoting the uptake of GP Management Plans (GPMP) and Team Care Arrangements (TCAs) by eligible NDIS participants to enable GPs to plan and coordinate care for those with complex conditions who require ongoing care from a multidisciplinary team.

- Increasing patients' Medicare rebates to reflect the real cost of practitioners providing comprehensive care to patients with disability

- Expanding funding to include telehealth consultations to better support patients with disability who have difficulties travelling and people in rural and remote areas.

- Ensuring the key role played by GPs in disability and support is included in any future reforms.

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

During the consultation, RACGP Rural members expressed the difficulty of applying an inherently metrocentric policy to communities that are in rural and remote areas. The absence of a flexible policy that reflects the rural and remote experience has deeply impacted the ability of available healthcare workers in rural and remote settings to form multidisciplinary healthcare teams, and the ability to provide holistic patient-centred care. Due to rurality and a lack of availability of specialists, resources, and adequately trained support workers, RACGP members felt that rural NDIS participants' choice and control over the NDIS services they access was hindered due to this lack of supportive infrastructure that understood their lives and supported their needs.

A lack of services and infrastructure in rural communities is not a new issue. These historically pervasive issues continue to impact people's decision-making when moving to rural areas. In the RACGPs Health of the Nation Report 2023, it was found that only one in three (32%) of GPs would consider working outside MM1 areas. Furthermore, the leading reasons for not wanting to work outside MM1 areas included family compatibility, social and professional isolation, and insufficient resources and healthcare services to support their work as GPs.[17]

High turnover of healthcare professionals in rural and remote areas has been found to have considerable direct and indirect consequences for community health outcomes.[18] One study found that although there was improved funding support for people in rural and remote areas with disability, there was an increase in pressure for the limited available clinicians to support this demand. This resulted in clinicians working beyond their workload capacity. Due to the complex nature of these roles, any work beyond capacity has the potential to negatively impact consumers and may result in harm to clients and clinicians.[19] Workforce sustainability in rural and remote areas must be a priority for the Australian Government. Healthcare policy, and in particular, disability policy must be robust, flexible, and responsive to the needs of communities that are outside metropolitan centres. Policy interventions that support access and equity must be accountable to the most at-risk demographics that they serve.

When considering the need to bolster the rural workforce, and particularly the healthcare workforce, it is important to understand the factors that are linked to rurality and adapting to rural life that contribute to, and ultimately determine rural retention. The links between employment, career opportunities, housing and education are restricted precisely due to their relationship with the economy and the availability of commercial opportunities and resources.[20] Statistics surrounding disadvantage and rurality are generally linked to education and economic outcomes declining with rurality.

[17] The Royal Australian College of General Practitioners (2023) General Practice Health of the Nations 2023. RACGP. Available online: https://www.racgp.org.au/getmedia/122d4119-a779-41c0-bc67-a8914be52561/Health-of-the-Nation-2023.pdf.aspx

[18] Cosgrave C, Malatzky C, Gillespie J. Social Determinants of Rural Health Workforce Retention: A Scoping Review. Int J Environ Res Public Health. 2019 Jan 24;16(3):314. doi: 10.3390/ijerph16030314. PMID: 30678350; PMCID: PMC6388117.

[19] Dintino, R., Wakely, L., Wolfgang, R., Wakely, K. M., & Little, A. (2019). Powerless facing the wave of change: The lived experience of providing services in rural areas under the National Disability Insurance Scheme. *Rural and Remote Health*, 19:3.Available online: https://search.informit.org/doi/10.3316/informit.153386638023954

[20] National Rural Health Alliance (2017) Social Determinants of Health. NHRA. Available online: https://www.ruralhealth.org.au/social-determinants-health

However, the larger picture of the availability of well-remunerated and professional positions in rural, regional and remote areas declines with remoteness.[21] Lack of economic, housing, social, and educational infrastructure in these areas, due to the nature of the rural economy creates significant barriers for those choosing to live and work in rural and remote settings. During the consultation process, RACGP members highlighted the additional need for infrastructure mechanisms to enable workers to stay in remote communities and feel safe while working. One RACGP Rural member reported a significant risk in their community due to a lack of internet access, phone coverage, and access to security supports (e.g. secure housing). This was identified as a significant contributing factor to why healthcare workers decided to either not undertake rural and remote work or influenced workers to only engage with rural and remote communities in a fly-in-fly-out capacity. Notably, these issues eclipse the significant benefits of living in rural and remote settings, including greater life and job satisfaction.[22]

Research demonstrates that the environments people live, work, and interact have been shown to be important measures in supporting someone's overall health, and providing people with vital connections to their communities and autonomy and ownership over all aspects of life including decisions impacting their health. These factors are often neglected despite the importance of providing patient-centred and equity focused health interventions for people living with disabilities. [23]

Historically, disability policy in Australia has not acknowledged the importance of social determinants of health despite their impact on people living with a disability.[24] To ensure that the scope of the NDIS is meeting the needs of people in rural, regional, and remote communities it is important to consider disability care from a social perspective as well as a healthcare perspective. These non-medical factors significantly impact the ability of an individual to survive and thrive in their communities.[25] Without investment into creating sustainable communities for all residents that are well-equipped to support every person living in the area, growth in rural and remote areas will continue to be stymied.

The Australian Government must commit to supporting growth in rural and remote communities to cultivate a strong health workforce to support the unique health and social needs of rural and remote Australians. In addition, the Australian Government must create opportunities for flexibility within NDIS policies to meet the needs of rural and remote consumers. Extensive co-design and consultation with rural and remote consumers and their support networks must be undertaken to ascertain the changes needed to improve access to appropriate providers and health equity for people living with disabilities.

**RACGP Rural recommends:**

- Bolstering the rural and remote healthcare workforce including the GP workforce
- End changes to payroll tax to ensure that rural and remote practices can continue servicing rural and remote communities
- Support innovations in rural general practice including flexible pathways for additional training including rural generalist pathways
- Commit to larger policy reform to provide infrastructure and housing for rural and remote communities to provide the foundations for healthy communities
- Review current safety measures for workers in rural and remote areas. Commit funding to support safe accommodation and upgraded equipment to allow people wanting to work in these communities to be able to safely undertake their work.

[21] Ibid.
[22] Ibid.
[23] Green, C., Dickinson, H., Carey, G., Joyce, A. (2022) Barriers to policy action on social determinants of health for people with disability. Australia, Disability & Society, 37:2, Available online: https://www.tandfonline.com/doi/abs/10.1080/09687599.2020.1815523
[24] Ibid.
[25] Australian Institute of Health and Welfare. (2022). *Social determinants of health*. Available online: https://www.aihw.gov.au/reports/australias-health/social-determinants-of-health

- Engage in consultation directly with rural and remote communities to understand the complex and diverse requirements NDIS policy should meet

**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**

Due to the lack of available services in rural and remote areas, RACGP members have expressed significant concerns with support workers and other NDIS providers not having the appropriate levels of trauma-informed and cultural awareness training to adequately support Aboriginal and Torres Strait Islander consumers. There is an extensive body of research to support the importance of providing culturally safe and responsive care for Aboriginal and Torres Strait Islander people living with disabilities.

Aboriginal and Torres Strait Islander people equate to 6.8 percent of all people who use the NDIS, totalling approximately 30,763 people at the end of March 2021.[26] This figure has almost tripled since 2019. [27] The proportion of Aboriginal and Torres Strait Islander people increases with rurality. Aboriginal and Torres Strait Islander people represent a demographic that has significant unique healthcare needs due to the persistent historical and pervasive effects of colonisation with Aboriginal and Torres Strait Islander people still having lower life expectancies, higher disease burden, and a higher likelihood of hospitalisation. [28]

During consultation, RACGP members expressed the need for further investment in culturally informed and appropriate care for Aboriginal and Torres Strait Islander consumers. In many cases, Western-led models of care that focus on remediating individual pathology have been found to conflict with Indigenous understandings of disability, resulting in Aboriginal and Torres Strait Islander consumers feeling stigmatised.[29] A culturally safe workforce is imperative to ensure health equity is attainable. To be successful these interventions must encompass Aboriginal and Torres Strait Islander values and social practices. Providing community-based care may also be essential in lowering the instances of preventable hospitalisations.[30] For example, there is a strong preference for Aboriginal and Torres Strait Islander people to work with disability workers who are embedded in the community.[31]

To ensure that the service provision of the NDIS is truly meeting the needs of the Aboriginal and Torres Strait Islander community, the Australian government must consider further investment in providing culturally safe, community-led interventions for rural and remote people living with disabilities. This must include extensive community involvement in governance and development, and research into co-design and community-controlled approaches.[32]

Training and development opportunities must form a significant part of bolstering the rural and remote NDIS workforce. Research into recruitment and training methods to support residents in rural and remote communities to become skilled NDIS workers must be considered to ensure that community relationships can foster meaningful engagement in the

[26] Puszka S., Walsh C., Markham F., Barney J., Yap M., Dreise T. (2022) Community-based social care models for indigenous people with disability: A scoping review of scholarly and policy literature. *Health Soc Care Community.* Nov 30:6 doi: 10.1111/hsc.14040. Available online: https://pubmed.ncbi.nlm.nih.gov/36151739/
[27] Ibid
[28] Australian Institute of Health and Welfare. (2023). Rural and remote health. Available online: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health
[29] Puszka S., Walsh C., Markham F., Barney J., Yap M., Dreise T. (2022) Community-based social care models for indigenous people with disability: A scoping review of scholarly and policy literature. *Health Soc Care Community.* Nov 30:6 doi: 10.1111/hsc.14040. Available online: https://pubmed.ncbi.nlm.nih.gov/36151739/
[30] Ibid.

[31] Gilroy, J., Veli-Gold, S., Wright, W., Dew, A., Jensen, H., Bulkeley, K., Lincoln, M. (2023) Disaility workforce and the NDIS planning process in regional, rural and remote regions of Australia: Scoping review. *The Australian Journal of Rural Health.* 31:5. Available online: https://onlinelibrary.wiley.com/doi/full/10.1111/ajr.13020

[32] Puszka S., Walsh C., Markham F., Barney J., Yap M., Dreise T. (2022) Community-based social care models for indigenous people with disability: A scoping review of scholarly and policy literature. *Health Soc Care Community.* Nov 30:6 doi: 10.1111/hsc.14040. Available online: https://pubmed.ncbi.nlm.nih.gov/36151739/

NDIS. As embedded members of rural and remote communities and regularly accessed medical professionals, the Australian Government must consider opportunities for training and further investment in the GP workforce a priority to build collaborative, culturally safe, and medically appropriate relationships between NDIS workers and people living with disabilities.

One RACGP Rural member shared their experience as a remote GP working in an Aboriginal and Torres Strait Islander community in the Northern Territory. The GP expressed the need for a dedicated non-clinical community liaison position to coordinate services in rural and remote communities. It was also noted that this position would need to work between Aboriginal and Torres Strait Islander communities, medical teams, consumers, and the NDIS. This would allow for a strengthened understanding of community and individual needs and be able to support GPs and multidisciplinary teams in coordinating assessment and therapeutic services in the area.

**RACGP Rural recommends:**

- Codesign rural inclusive NDIS policies that reflect missing demographics identified through consultation.
- Support pathways for recruiting and educating Aboriginal and Torres Strait Islander people to become NDIS support workers
- Adapt NDIS policies to be more culturally inclusive and flexible to support Aboriginal and Torres Strait Islander models of care.
- Consider funding non-clinical positions to assist consumers and medical professionals in directing support and navigating the NDIS in rural and remote communities.

## 5. Conclusion

The RACGP would like to take this opportunity to commend the Joint Standing Committee on the National Disability Insurance Scheme for conducting this parliamentary inquiry. The healthcare system must undertake regular reflection and improvement to reflect the diversity of people engaging with the service. This parliamentary inquiry presents an important opportunity to investigate the historic issues surrounding access and health equity for rural consumers. Supporting the rural healthcare workforce and the best interests of the consumer are at the core of the RACGP and the RACGP Rural faculty. RACGP looks forward to engaging with the Joint Standing Committee in collaborative and outcomes-based opportunities focused on improving the health outcomes of all Australians.