CONSULTATION RESPONSE

Allied Health Professions Australia

Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the NDIS Workforce

May 2020

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to the Joint Standing Committee on the National Disability Insurance Scheme (NDIS) inquiry into the NDIS workforce. We represent 19 national allied health associations and collectively work on behalf of their 120,000 allied health profession members. Many of those allied health professionals are involved in providing services to people with disability, people who may or may not be participants in the National Disability Insurance Scheme (NDIS). AHPA and its member associations are committed to ensuring that all Australians, regardless of disability, can access safe, evidence-based services to assist them to realise their potential for physical, social, emotional and intellectual development.

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

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Introduction

AHPA thanks the Committee for the opportunity to respond to its Inquiry into the National Disability Insurance Scheme (NDIS) workforce. This inquiry is very timely in light of the major impact on the disability sector and participant community of the COVID-19 pandemic. It also fits well with other current initiatives such as the Department of Social Services (DSS)-led development of an NDIS Workforce Plan.

Australia's disability system is a largely fee-for-service system provided by private and non-government organisations with a primary national funder and a national regulator. From the perspective of the allied health sector, we have noticed an increased recognition by government that the interaction of this system with other systems such as health, is not working effectively to support the coordinated growth and development of the disability workforce. This is at least partly due to the range of different government stakeholders involved in initiatives that impact the workforce, and an overall uncertainty about roles and responsibilities in relation to the allied health disability workforce. We've outlined these different roles and responsibilities below, along with some commentary, to show some of the structural issues that impact NDIS allied health workforce planning and how that workforce interacts with other sectors. We've also referred to some of the issues that have arisen in relation to COVID-19 and where responses were hampered by structural issues.

At a national level, the Health Minister has acknowledged that responsibility for the allied health workforce sits in his portfolio and with his Department, and the Department of Health is the only Department that has undertaken any workforce planning work in relation to allied health. However, this has been largely limited to workforce reports based on Australian Health Practitioner Regulation Authority (AHPRA) data, which leaves out key self-regulating professions such as speech pathology, dietetics, music therapy and audiology. The Department of Health has no current allied health workforce development programs that we are aware of and also lacks senior allied health leadership. The allied health sector has long argued the need for a dedicated Chief Allied Health Officer at an equivalent level to the Department's Chief Medical and Nursing Officers, both of which are senior roles with dedicated resourcing.

The limitations of the Department in relation to allied health expertise and internal representation have been evident during the COVID-19 response – a response that has been significant for the allied health NDIS workforce, particularly in relation to safe delivery of essential ongoing services and access to personal protective equipment (PPE). While Departmental staff have worked extremely hard to address the needs of the community and to provide guidance to the allied health sector, they have been hampered by that lack of internal allied health expertise and resourcing. While there were quick and clear responses in relation to medical service access, and rapid work to secure access to PPE for general practices and other settings such as aged care homes, it has taken many weeks to begin developing a response to PPE access for potentially critical services provided by allied health providers. Protocols are only now being developed that identify what critical allied health services are.

The lack of internal allied health leadership in the Department of Health may also be why there appears to be limited interaction with key government disability sector stakeholders and limited understanding of the role of allied health in providing disability services. This was also clear in the responses to the needs of the disability sector in relation to COVID-19 where a range of government agencies each sought to support the sector and participants but the overall response would have been more effective if there had been more coordination and engagement with the sector. Given these structural limitations, it is difficult to see how the Department of Health can be effective in driving workforce planning and development programs for the disability sector. Yet it is also clear that Health has a crucial role in driving many of the policy responses and funding programs required in order to address allied health workforce issues and that there needs to be strong coordination between the Commonwealth health and disability portfolios.

Within the disability sector itself, there are three major Commonwealth departments and agencies that each share responsibility for different aspects of the workforce. Each significantly impact the NDIS workforce, however it is not at all clear from the perspective of the allied health sector that there is effective coordination of these roles or consideration of how they intersect and impact the current and future workforce. This apparent lack of coordination is further complicated by the work of the state- and territory-based health departments, many of which are themselves running workforce-focused programs and initiatives and continue to have local regulatory requirements that impact on the consistency of requirements at a national level. We understand a key driver for some state-based programs for the NDIS workforce is concern about the adequacy of the Commonwealth response. AHPA has argued previously for the need for strong allied health leadership in key government departments and we argue that the most effective way to improve coordination across Commonwealth agencies and across jurisdictions would be to have a Chief Allied Health Officer working across the Departments of Health and Disability, or to have similar roles in both Departments with a remit to work closely together.

As the funder of most disability services for Australians, the National Disability Insurance Agency (NDIA) is a critical enabler for the disability workforce. Pricing and policy decisions by the Agency impact the growth and sustainability of allied health services for people with disability. For example, the limited funding of mental health services in participant plans is likely to be a key driver for the low numbers of psychologists and other mental health practitioners currently providing services for participants. This policy approach impacts not only current participants but also future potential access to services as it limits growth. The overall funding structure of the NDIS, focused as it is on the remunerating allied health services provided directly to participants in a fee-for-service structure, is the most significant contributor to the challenges of providing student placements and sustainable, early career opportunities with appropriate mentoring and supervision to new allied health graduates. Funding is a crucial foundation for workforce initiatives and the issue of a funder that can't address limitations in the capacity of current funding structures to support key workforce needs cannot be understated. We also note that the NDIA has the capacity to provide block funding in areas of market shortage, a potential mechanism to address workforce issues but one that depends heavily on its capacity to identify thin markets. It does not appear that the NDIA currently has the capability to effectively identify thin markets and areas of workforce shortage effectively.

The NDIS Commission, in carrying out regulatory responsibilities for the NDIS, can significantly impact the available workforce for NDIS participants that are NDIA-managed (also referred to as Agency-managed). The cost and complexity of registering as an NDIS provider plays a significant role in determining whether Agency-managed participants have access to an equivalent workforce as participants that are plan- or self-managed. The Commission has made changes to reduce the regulatory burden for providers but the role of registration in impacting the available workforce for participants, based on their ability to self-manage or use plan-management services, is one that does not yet appear to be clearly addressed in workforce responses. In addition, the Commission is increasingly developing capability frameworks that will both support the skills of disability practitioners and add further requirements on disability providers. These additional requirements are likely to further impact the size of the workforce available to some participants.

Given the focused roles of the NDIA and NDIS Commission, AHPA and its members understand that DSS is the organisation most likely to have within its scope and remit a focus on the NDIS workforce. DSS has led a number of initiatives focused around workforce including the Boosting the Local Care Workforce program, a 33-million-dollar program delivered by an EY-led consortium. It's not yet clear that this program has been very effective in addressing the workforce issues that impact the allied health sector, and which are outlined in more detail below. AHPA is aware that a large amount of allied health research was undertaken as part of that program and we are hopeful that this will support future policy responses by DSS. Recent work by DSS to begin developing an NDIS Workforce Plan suggests an increased recognition of the role of the Commonwealth in relation to the NDIS workforce and we are optimistic that this might result in policy changes to support funding and support in areas of workforce development.

Responses to the terms of reference

a. the current size and composition of the NDIS workforce and projections at full scheme

AHPA argues that the most important foundation for understanding the current and future NDIS workforces is a strong and nuanced set of workforce data that can be used by both policymakers and funders to identify gaps and potential issue areas. From our perspective, a national workforce dataset is required for the allied health sector, which aggregates and integrates all current data sources to form a meaningful overall picture of the Australian allied health workforce at national, regional and local levels. This data set will need to incorporate not only current disability providers but also the broader private and community-based allied health workforce as these are an important potential NDIS workforce, particularly in areas where there is only likely to be a low volume of NDIS services required. It will also require the ability to identify where additional granularity is required in order to provide meaningful data about available services. For example, an occupational therapist may work as a mental health occupational therapist providing targeted mental health interventions. Another occupational therapist may provide assessment and fitting support for complex assistive technology such as powered wheelchairs or home hoists. A dataset that only identifies the availability of occupational therapists in a region cannot be considered sufficient to genuinely understand the local workforce.

While AHPA is aware that significant work has already been undertaken by both DSS and the NDIA to map the current workforce and any areas of workforce shortage, and to provide projections on the size of the NDIS workforce at full scheme, we are not at all confident that this work will result in the sort of workforce data that we argue is required. Furthermore, while AHPA is generally confident that future projections are reasonable and that they will continue to be refined in order to accommodate changes to the Scheme such as adjustments to eligibility criteria, policy changes in relation to funding and services covered by the NDIS, and other factors impacting the workforce needed to provide care, we are concerned that current gaps in understanding of the needs of the workforce due to lack of data will be exacerbated if they are not addressed. That is, if we do not have the capacity to accurately identify service gaps now, how effective can any future projects and planning be.

In addition to our concern about the lack of a national allied health workforce dataset, AHPA argues that the Australian government is limited in its ability to respond to current and future NDIS workforce needs due to a lack of current mechanisms to address areas of known workforce shortage, particularly those in rural and remote areas (though we note that thin markets and workforce shortages exist in metropolitan and peri-urban areas as well). It has been well established by a wide range of programs and research initiatives, including the recent work undertaken by the National Rural Health Commissioner and his team, that the most effective mechanism for increasing rural workforces is increasing opportunities to study, and to participate in student placements, in rural environments. Similarly, it has been established that scholarship and incentivisation programs can attract health professionals into rural regions.

Despite this recognition, our education system continues to function independently of workforce need with the result that there can be significant oversupply of allied health graduates in metropolitan areas while at the same time regions with major workforce shortage, such as Tasmania, lack allied health courses for key professions. This results in the need to incentivise allied health practitioners to move from metropolitan to rural regions. Yet AHPA is not aware of any current programs focused on attracting an allied health NDIS workforce into areas of workforce shortage such as are provided for general practice through the General Practice Rural Incentives Program (GPRIP).

AHPA argues that urgent policy change is needed to ensure that our education system is able to respond to current and future workforce needs, and that universities are funded to deliver education where it is most needed rather than where it is most cost-effective. We further argue that the work of the National Rural Health Commissioner in implementing a range of initiatives to support the rural allied health workforce should be expanded to include a specific focus on NDIS workforce needs. We understand that university departments of rural health will play an important role in programs to encourage greater rural opportunities and we strongly argue for the need to ensure that a complementary or expanded offering building on that work but funded through disability is introduced to support the rural NDIS workforce.

b. challenges in attracting and retaining the NDIS workforce, particularly in regional and remote communities

The introduction of the NDIS has represented a much-needed increase in funding for disability services, attracting many new entrants to provide allied health disability services. The rates paid by the NDIA are generally very competitive and likely to act as an incentive rather than disincentive for providers to enter the Scheme. Despite this, there are still a range of issues that impact the attraction and retention of allied health providers and many current providers continue to operate in an environment of significant uncertainty. This not only reduces the likelihood that they will remain in the market, but also that they will support incoming members of the workforce through employment of new graduates.

For example, entry to the Scheme can be expensive and time-consuming for allied health providers with the audit requirements associated with registration with the NDIS Commission leading some to make the decision not to register. This can particularly be the case for providers with an expectation of delivering only a low volume of services for NDIS participants as is more frequently the case in rural and remote regions. The issue is exacerbated by the additional audit costs experienced by providers based outside metropolitan areas, who may need to pay additional travel and accommodation costs for auditors. While this does not limit the NDIS workforce for plan- and self-managed participants, it does do so for Agency-managed participants. Working as an NDIS provider typically also carries high transactional costs when compared with other Schemes or funding sources, with significant administrative work required to manage interaction with the Scheme and the NDIA. This may include managing service agreements and the need to manage and adjust these whenever there are pricing changes, the need to manage what can still be inefficient payment processes, particularly in relation to bad debts and services delivered when plans have been expended.

These transactional and barrier to entry issues are compounded by the relative lack of certainty about future income that arises in a fee-for-service environment where participants are encouraged to move services. For more experienced and established providers, particularly those with strong business skills, this may not be of particular concern. But for providers who may have transitioned from employment with a state- or territory-based service, or for newer graduates who are establishing businesses, the challenge of managing not only the clinical requirements of providing high quality disability services but also needing to learn to work effectively within the NDIS can be challenging and lead to burnout.

One of the most significant challenges to the retention of practitioners is that there is little support in the Scheme's pricing structure for supervision and mentoring of practitioners. Instead, practitioners often operate in relative isolation, yet due to the needs of people with disability, are likely to have case loads that are complex and highly varied. This is exacerbated by the lack of dedicated case discussion items in the current pricing structure of the NDIS and difficulties in using the current pricing structure to support multi- and inter-disciplinary interventions. While AHPA strongly supports a participant-driven Scheme and a sense of ownership by participants of their plans, it is clear that this approach is one that limits the funding of work that may not directly and immediately benefit participants. AHPA very much understands that participants may not see it as appropriate that their plan funds anything that doesn't directly benefit them. But from the perspective of the broader Scheme and the ongoing development and retention of the workforce, this structure has real risks.

c. the role of Commonwealth Government policy in influencing the remuneration, conditions, working environment (including Workplace Health and Safety), career mobility and training needs of the NDIS workforce

AHPA supports the work of the NDIS Commission to identify and support appropriate training of the NDIS workforce, such as through the development of the Positive Behaviour Management Support Framework. As a national Scheme and one that is providing new opportunities for people with disability, AHPA argues that the Commonwealth has an important role in identifying gaps and opportunities in relation to the skills and expertise of the NDIS workforce.

AHPA also argues that the Commonwealth has an important responsibility in relation to funding training. We have noted above that the structure of the NDIS is such that funding is paid from a participant plan for the delivery of services that meet the needs and wishes of the participant. That structure has major limitations in being able to support training and development of the NDIS workforce as it only funds direct service provision or limited additional services such as reporting that are agreed by participants in service agreements. This means that the system currently relies entirely on the provider being able to self-fund training. Feedback from the sector suggests that this is not realistic and not sustainable—while there are many providers that employ less experienced practitioners and invest in training and support to help develop their staff, many report that this is not proving sustainable as the demand for the workforce is such that wages may not necessarily be significantly lower even for newer graduates. As such, providers do not necessarily earn the margins

required to support training. Given the structure of the NDIS, there is no incentive for providers to invest in training and support of their workforce beyond minimum standards. Those that choose to do so, base that decision on a commitment to providing high quality care. However, they find themselves competing with other providers that may not have the same commitment to workforce development.

AHPA argues strongly for the development of Commonwealth policy and programs that identify ways to ensure that the disability funding system can support both student placements and early career development of the workforce with a focus on appropriate supervision and mentoring. We argue that this should be developed separately from the funding of service delivery through the NDIS and instead be seen as an investment by government in the long-term development of the disability workforce. We propose that this arrangement would see funding for providers that opt in and meet program requirements by making a commitment to providing targeted on-the-job training and development for new graduates. Such a program could be designed so as to also allow targeting of training where skill gaps are identified. For example, AHPA understands that there are significant workforce shortages in relation to allied health professions with the skills to support behaviour management or prescription of complex assistive technology. Both of these skills shortages will only be resolved by ensuring that allied health professionals with the necessary base skills and qualifications are able to gain on-the-job experience through strong supervision and mentoring arrangements. The proposed approach would be an effective way of supporting a flexible and sustainable approach to workforce development, focused around that practical, workplace training. Should government consider implementation of such a program, we encourage consideration of whether it is appropriate to do so in conjunction with other initiatives being considered to increase access to student placements, such as the current work of the National Rural Health Commissioner highlighted previously.

AHPA notes that the increasingly complex regulatory requirements are likely to limit the mobility of allied health professionals to work across multiple schemes. Despite being regulated as health professionals, allied health professionals are increasingly needing to undertake additional registration or accreditation to work in specific areas such as disability. The issue of the cost and complexity of registering to be an NDIS provider is raised above, and that this can act as a barrier to entering the NDIS marketplace as a provider. Yet in many cases, the most effective means to ensure access for local communities and participant choice is supporting providers to work across multiple schemes. The needs of older people and people with disability and the clinical skills required to support these may be quite similar. If, as seems likely, the Royal Commission review of aged care quality and safety results in new regulatory requirements that impose additional costs and requirements on providers, it is highly likely to reduce the potential pool of providers available to provide services. These issues are exacerbated by the varying requirements being imposed by states and territories in addition to national requirements. AHPA argues that the Commonwealth should take a much more prescriptive role in coordinating regulatory requirements nationally and across schemes to reduce the bureaucratic burden on providers. By coordinating these requirements and aligning systems and processes nationally, AHPA is confident that costs could be lowered for government and providers while still maintaining appropriate safeguards for vulnerable consumers.

In relation to remuneration, AHPA broadly supports the current NDIS processes to determine price caps for allied health services. However, we note that there is a seemingly arbitrary gap in the price caps between exercise physiologists and other allied health professions that cannot be explained by differences in the qualification level of practitioners or in pricing of services outside the NDIS. Instead this appears to be a holdover from older and less transparent pricing process within the NDIA. We strongly argue for this to be addressed.

d. the role of state, territory and Commonwealth governments in providing and implementing a coordinated strategic workforce development plan for the NDIS workforce

AHPA strongly argues for the need to have a national coordinated, strategic workforce development plan that is led by the Commonwealth government and delivered as a cross-departmental series of programs and initiatives. AHPA further argues that this national workforce plan should have discrete sub-components reflecting the very different needs and program responses for the disability support worker and allied health professional workforces. To achieve this, each government stakeholder will need to make a genuine commitment to delivering a nationally consistent workforce plan.

AHPA also argues that the allied health aspects of the national plan must be the responsibility of a Commonwealth Chief Allied Health Officer who would be appointed and resourced to develop a national allied health workforce dataset, and to coordinate specific initiatives in relation to education and training and workforce development across government departments. This will require the Chief Allied Health Officer to have sufficient seniority, and appropriate connections with senior staff across associated key Commonwealth and state and territory portfolios including health, disability and education and appropriate agencies such as the NDIA and NDIS Commission. The current lack of strategic allied health leadership at Commonwealth level is likely to be a major contributor to the lack of coordination of workforce initiatives across governments and should be a priority recommendation to address NDIS workforce issues.

In addition to that national leadership, specific initiatives to address NDIS workforce shortages will be required and a robust workforce data collection program will be an essential foundation for policy development and program implementation. AHPA argues that a range of existing mechanisms to address workforce shortages, including disability-specific interventions such as NDIA block funding of services, could be leveraged through a more coordinated program that covers health, disability, aged care and education. By leveraging existing initiatives and funding, AHPA argues that there are significant opportunities to address specific NDIS shortages, current and future, and to also ensure that the overall workforce needs of the community are addressed. Where there are shortages for people with disability, it is highly likely that there are shortages for services needed by other consumer cohorts. We note in this context the potential of cross-sector funding to support sustainable employment and establishment of provider hubs, such as has been identified by the work of the National Rural Health Commissioner. The Commonwealth should provide the lead on this work but work closely with state- and territory governments to coordinate policy development and program-based solutions.

While AHPA recognises the role of the individual state and territory governments in the final stages of transition to a national Scheme, we strongly argue that a national funding program should be shaped and delivered by the Commonwealth. We have strong concerns about the continued work being undertaken by individual states and territories to impose additional requirements on the NDIS workforce. We argue that any genuine gaps in national frameworks and regulatory requirements should be addressed consistently across the country rather than through additional requirements.

AHPA argues that the Commonwealth has significant capacity to better identify future workforce need and provide funding to universities that better seeks to match funding with need, while also addressing the additional costs faced by rural and regional universities.

e. the interaction of NDIS workforce needs with employment in adjacent sectors including health and aged care

Demand for allied health services is increasing across health, disability, aged care and education. In many areas, demand significantly exceeds supply and leads to significant wait times for consumers seeking to access services. This can result in poorer outcomes due to lack of access to care. This can only be addressed by a coordinated, multi-sector approach to workforce development as outlined above.

AHPA has identified above that allied health providers, particularly in rural and remote areas, are ideally placed and should be enabled to provide clinical care across health, disability and aged care. While the needs of an older consumer may have specific aspects that may differ from those of a younger person with disability, many clinical interventions will differ only in terms of how they are funded. Yet current regulatory systems limit the capacity for providers to work across funding programs and it appears likely that regulatory requirements will only increase and further limit capacity to work across funding schemes. The impact of this is that providers are more likely to work within one funding scheme only, limiting options for consumers without significantly increasing quality or safety.

For example, a young person with autism spectrum disorder can access services privately or through Medicare from any appropriate allied health professional who meets the accreditation requirements of their health profession. Similarly, an NDIS participant that is self-managing their plan or who has a plan manager can also access an allied health professional who is accredited by their health profession. However, a participant that is Agency-managed can only access a provider that meets the additional regulatory requirements of the NDIS Commission. The apparent risk profile here is based on the funding source rather than the participant. It is not at all clear why one set of regulatory standards is sufficient to protect consumers who access care for services not funded through an Agency-managed plan. If changes resulting from the current aged care Royal Commission result in a new and separate regulatory scheme, this issue will be further exacerbated.

AHPA argues strongly for the need to better coordinate and align worker screening and registration or regulation requirements across schemes. While we recognise that the specific skills and capabilities required may vary across consumer cohorts, we hold the strong view that a coordinated

approach to regulation is the best possible way to ensure that the NDIS allied health workforce is large enough to meet the needs of all participants.

AHPA notes that where the available workforce is limited, differences in the remuneration of schemes can be an important determinant in relation to access. For some allied health professions, NDIS rates are higher than those paid by other schemes such as Medicare and the Department of Veterans' Affairs and this may limit access to health consumers. For other professions, such as psychology, rates to provide NDIS services are broadly similar to those that providers can charge for Medicare or private health insurance-rebated services but with significantly more administrative requirements and higher transactional costs. This in turn limits the available NDIS workforce for participants.

g. any other matters

AHPA and its members continue to have concerns about the push to use allied health assistants and support workers in place of qualified allied health professionals. Allied health professionals working in the NDIS report pressure on participants and providers from NDIS planners to use allied health assistants as a means of reducing costs without the clinical expertise to understand where this is appropriate. AHPA notes that there is still not national agreement on the use of allied health assistants. While we understand that the Victoria Supervision and Delegation Framework for Allied Health Assistants has informal endorsement, we remain concerned that there is not yet a formal NDIA policy that planners adhere to. Without this, there remains a risk that participants will experience less optimal outcomes and that both allied health assistants and the allied health professionals involved in providing supports are exposed to medicolegal risks.

Communication about policy and administrative changes remains an issue for the allied health NDIS workforce and the professional associations that support them. While we acknowledge significantly improved interaction between the NDIA and industry, communication channels continue to be less effective than they could be. Many potentially significant changes are only communicated by the NDIA through changes to the NDIS website. The locations of these updates are not consistent and providers and professional associations do not receive direct communications to advise that these changes are being made. As a result, AHPA and its members are often left to keep checking the website when changes are being made and frequently first become aware of important policy changes being communicated through alerts from members or other stakeholders. This is not efficient for providers or the professional associations that support them and results in significant missed opportunities for the allied health professional associations to play a role in supporting their members to be informed about, and understand, changes that the NDIA is introducing.

Payments continue to be an issue for some providers, most frequently as a result of participants accepting services without the budget to pay for them. In such cases, the NDIA advises providers to pursue the debt from participants but we strongly argue that this leaves providers to absorb the bad debt as no allied health provider we are aware of is willing to pursue this type of debt recovery. AHPA argues that NDIA systems need to be more robust and have mechanisms to ensure that providers are only providing services when participant budgets are sufficient to cover the cost of that service.