Allied Health Professions Australia

# Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the NDIS Workforce – National Workforce Plan

August 2021

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

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**Advocating on behalf of Australia's allied health professions to create fairer and more equitable health, aged care and disability systems**

## About AHPA and the allied health sector

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 130,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

AHPA supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, including. providing services to people with disability 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. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

## Introduction and general comments

AHPA welcomes the opportunity to comment on the NDIS National Workforce Plan: 2021-2025 ('the Plan'), and thanks the Joint Standing Committee for the extension of time granted to enable consultation with our members.

For background to our comments on the Plan, we refer to our previous submission to the Joint Standing Committee's Inquiry into the National Disability Insurance Scheme (NDIS) workforce ('2020 Submission').[1] AHPA has also otherwise engaged extensively with allied health disability workforce issues.[2]

Overall, AHPA is profoundly disappointed that the Plan is almost identical to the Overview for Consultation produced by the Department of Social Services in June 2020 ('the Overview'). The main differences are that in some initiatives, the Plan is less focused than the Overview (see our comments below on Priority Actions 2 and 3). The Plan certainly does not contain the minimum elements required by the Joint Standing Committee.[3]

[1] AHPA, Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the NDIS Workforce (May 2020).
[2] See eg Submission to the Joint Standing Committee Inquiry into the operation of the NDIS Quality and Safeguards Commission (August 2020); Submission to Queensland Productivity Commission Inquiry into the National Disability Insurance Scheme (August 2020); Submission to Senate Community Affairs Legislation Committee Inquiry into the National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Bill 2021.
[3] Joint Standing Committee on the National Disability Insurance Scheme, NDIS Workforce Interim Report (December 2020) ['JSC Interim Report'], xviii, 155-157.

Indeed, the Plan cannot be genuinely regarded as a plan – it is at best a vision of a plan, or a 'plan for a plan'. It is also rife with unhelpful motherhood statements; for example, in relation to supporting sector efficiency and innovation (Plan, 13).

We first address key overall themes relevant to the Plan, before proceeding to comment on specific priority actions and initiatives.

### *Allied health remains on the margins*

AHPA is very concerned that despite our and others' best efforts over a substantial period, the Plan focuses almost exclusively on disability support workers. We acknowledge that support workers comprise the bulk of the NDIS workforce; however, allied health professionals not only contribute over 7% of workers; they are also key to the self-determination and reablement of most people living with a disability.

Further, the Plan itself notes that a 40% increase in allied health professionals will be required to fulfil projected NDIS participant need (Plan, 11). This percentage could well be considerably higher, given that such projections rely on incomplete data sources for allied health;[4] as well as the fact that they are also based, at least in part, on National Disability Insurance Agency (NDIA) data on existing service use rather than estimation of actual participant needs.

In addition, it is not always clear at different points in the Plan whether allied health is considered to be included as part of the workforce, and therefore is intended to be addressed by particular priority actions and initiatives. For example, two of the three challenges outlined in Chapter 2 on the current state of the care and support workforce seem to apply only to disability support workers, but confusingly, 'Grow the workforce' (Plan, 5) includes allied health professionals, even though the reference to micro-credentials in 'Maintain quality of support delivered by workers' suggests that this too is aimed at disability support workers (and see similarly, Plan, 17).

The statement in the Plan that the care and support sector will create thousands of new jobs across Australia at a critical time (Plan, 13) also would appear not to encompass allied health, given that the minimum time to acquire basic allied health professional qualifications is three to four years, and the Plan only projects to 2024.

AHPA supports the recommendations in the submission to the Committee of our member Exercise & Sports Science Australia, that planners and LACs must be appropriately trained and educated in the role and value of allied health professions.

### *Data*

The Plan is notable for the complete absence of any workforce data strategy under its priority actions and initiatives. With specific reference to allied health, the Report for the Minister for Regional Health, Regional Communications and Local Government by the National Rural Health Commissioner, *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* (June 2020) ['NRHC'], emphasised that data and evidence limitations in the allied health sector have been reported for many years.

[4] JSC Interim Report, 22 (fn 15), 25 (fn 32), 142.

AHPA has consistently argued that it is impossible to plan for future allied health service provision, including identifying specific shortfalls and particular practice and sector gaps, without having a detailed map of allied health professionals around Australia. The conclusion of the 2010 Workload Measures for Allied Health Professionals Final Report remains apt:

> 'Comprehensive and accurate information on the numbers and workload of the allied health workforce is urgently required for national workforce planning. If such data are not improved, then it will continue to be impossible to conduct national workforce planning for these groups in Australia. [reference omitted] Without complete and accurate allied health workforce data and expanding research capacity, the evidence base required by funding bodies and workforce planners to invest, is absent.' [5]

To understand the current and future NDIS allied health workforce, we need a workforce dataset that aggregates all current data sources to form a meaningful picture of the Australian allied health workforce at national, regional and local levels. That dataset must incorporate not only current disability providers but also the broader private and community-based allied health workforce, as these latter two groups comprise an important potential NDIS workforce, particularly in areas where there is likely to be only a low volume of NDIS services required.

If such a data strategy and dataset were in place, we would expect, for example, sufficient granularity that at the least, allied health could appear separately in the Plan's diagram of providers operating across care and support programs (Plan, 9; see also 18, 20), if not also as disaggregated by specific types of allied health practice.

Similarly, such a dataset must be able to inform a full understanding of the local workforce. For example, as previously submitted, simply having data available on the total number of occupational therapists is not sufficient.

As recommended by the National Rural Health Commissioner, the Commonwealth should develop a National Allied Health Data Strategy which includes building a geospatial Allied Health Minimum Dataset that incorporates comprehensive rural and remote allied health workforce data (NRHC, Recommendation 3). The Commissioner's Report notes:

> 'When completed, decision makers will be able to access the NAHWMDS to see a more complete picture of the allied health workforce (including students, clinicians working in dual roles and/or across sectors, locums etc) along with the modes of delivery (e.g. face-to-face, telehealth, outreach). They will be able to drill down to a particular geographical area from a national view. They will be able to contrast this information against health metrics (e.g. Quality Adjusted Life Years), indicators of wellbeing (e.g. patient satisfaction), and patient demographics. The data would identify exemplars and, by contrast, areas with sub-optimal balance of supply (quality, access and distribution) and demand (from reliable indicators of health and wellbeing). Users of the MDS will be able to measure the effectiveness of strategies in terms of the extent and durability of outcomes and derive a value for the return

[5] Quoted in NRHC, 26.

on their investment. The data would then inform further strategies for continual improvement.' (NRHC, 25)

### *Thin markets*

The issue of thin markets is well known and is particularly acute for allied health. AHPA has consistently critiqued the NDIS and Government approach to this problem, on the basis that it tends to assume that thin markets are only a challenge for rural and remote areas. The reality is that allied health services are also unevenly distributed in metropolitan and regional areas, with the result that those most in need of allied health services are the least likely to have affordable access to them.

The flawed conflation of 'thin markets' with 'rural and remote' is further compounded by Government insistence that a free-market approach will resolve the issue of unmet participant demand. This strategy depends heavily on private providers having the capacity to respond to market need through private investment, with little or no stewardship of the market by Australian governments. There are no clear interventions to address the impact of competition for services in an environment where the NDIS market itself has created a demand for services that may outstrip supply.[6]

Compounding the inequity for people with disability, the dominant funding models such as those for the NDIS, private health insurance, the Medicare Benefits Schedule and My Aged Care are designed to be market-driven solutions. These funding models are not effective in smaller rural and remote towns, prone as such locations are to 'market failure' (NRHC, 3).

The Plan provides little in the way of solutions, instead reiterating the market approach. On the contrary, AHPA continues to contend that lack of services can only be addressed through a model that focuses on more active stewardship of the allied health disability workforce, including more innovative and flexible funding solutions. We address more specific issues related to thin markets in our responses to the various Priority Actions below.

### *System integration*

The current relationship of the disability sector to other systems such as health and aged care does not support the coordinated growth and development of the disability workforce. Some of the structural issues that impact upon NDIS allied health workforce planning were addressed in our 2020 Submission.

Our comments in that submission about the limitations to the way in which the Department of Health has addressed its responsibility for the allied health workforce mainly stand, with the qualification that there is now a dedicated Chief Allied Health Officer position within that Department. However, it is important to note that despite intensive allied health sector advocacy and the recommendation of the National Rural Health Commissioner,[7] this position does not have equivalent status to that of the Department's Chief Nursing and Midwifery Officer and Deputy Medical Officers, both of which are more senior roles with dedicated resourcing.

[6] JSC Interim Report, xvii, 134-135.
[7] NRHC, Recommendation 4 and 28-30.

AHPA contends that the most effective way to improve coordination across Commonwealth agencies and relevant sectors would be to have the Chief Allied Health Officer resourced and supported to work across the Departments of Social Services, Health, Disability and Education.

We also note the potential of cross-sector funding to support the establishment of provider hubs that we outline in our response to Priority Action 3. This must be preceded by better coordinated and aligned worker screening and registration or regulation requirements, across sector schemes.

#### *Future Plan development and collaboration*

We appreciate the Government's stated commitment to engaging and collaborating with stakeholders. However, we observe that to date AHPA has had considerable difficulties in even getting allied health onto the policy 'radar', let alone being genuinely consulted in this process.

Unfortunately, this experience mirrors our engagement record with the NDIA. The most striking example concerns a report which we were contracted to provide in September 2020, and which considered the development of the credentialing, training and quality assurance aspects of an independent assessor role for allied health practitioners. AHPA provided this report to the NDIA on the assumption that the assessment information obtained would only inform decision making related to access to the NDIS.

To date we have not received a response from the NDIA to this work. Instead, we discovered via the public realm that allied health practitioners would be contracted to provide independent assessment under the model – one that has since been rejected by the Minister for Disability and the NDIS – and our report was cited in the Evaluation of the Second Independent Assessment Pilot as having informed the Pilots, despite no further communication with us.[8]

It is therefore perhaps understandable that AHPA, despite being the national peak body for allied health, is not confident that we will have the seat that we deserve at the table for ongoing workforce development processes.

### Priority Action 1: Improve community understanding of the benefits of working in the care and support sector and strengthen entry pathways for suitable workers to enter the sector

Initiatives 1-4 are aimed at other than allied health professionals. For example, leveraging employment programs to ensure that suitable unemployed job seekers can find work in the sector is clearly inapplicable to our practitioners.

#### *Initiative 5: Better connect NDIS and care and support providers to employment and training providers and workers*

This initiative is elaborated upon as 'The Australian Government will use the Boosting the Local Care Workforce program to support stronger connections between employment service providers, universities, VET and NDIS providers' (Plan, 23). 'Why this is important' explicitly includes allied health students within job seekers, who are described as 'not always aware of NDIS or broader care and support sector opportunities' (Plan, 25).

[8] This reference to AHPA's report has since been deleted at our request.

The Plan also states: 'NDIS providers report great difficulty in attracting allied health professionals from university, with reports that universities do not recognise the growth potential in the NDIS and care and support sector more broadly' (Plan, 25).

There is no evidence provided for these claims, and no recognition of the real barriers that have been addressed in numerous reports and submissions, including the lack of resourced student placements and, in some areas of Australia, lack of training provision (see our responses to Priority Actions 2 and 3). Simply providing market information on demand to potential workers and employment providers will not address such fundamental problems.

In the associated 'How will this work' column, there is nothing that relates specifically to allied health. Other 'strategies' are just motherhood statements, such as 'Connections will be leveraged with other government programs to help promote care and support sector employment opportunities'; and 'Boosting the Local Care Workforce coordinators can support providers to improve the sophistication of their workforce and attraction strategies by fostering connections between business leaders to showcase innovation and success stories'.

## Priority Action 2: Train and support the NDIS workforce

Initiatives 6-8 are not appropriate for allied health professionals.

### *Initiative 9: Support the sector to grow the number of traineeships and student placements, working closely with education institutions and professional bodies*

This initiative is relevant to allied health, but the Plan simply states: 'Governments will explore how training organisations, tertiary institutions and professional bodies can be supported to increase the number of traineeships and student placements offered in the sector'; and 'Governments will work with tertiary institutions and professional bodies to explore how student placements can be delivered efficiently in a disaggregated market.'

The Overview at least included 'develop a roadmap for a national portable training entitlement scheme for the care sector'; whereas the Plan's 'strategies' are a combination of motherhood and 'plan for a plan' statements. They are also underpinned by a market reliance which is discredited (see 'Thin markets' above).

Training of allied health professionals, including exposure to disability settings and clients, is crucial. This theme was raised consistently during the consultation, and the Plan acknowledges that clinical placements and work experience in disability for allied health professionals directly influences recruitment into disability positions, but that NDIS placements are increasingly limited (Plan, 16).

However, the Plan's proposal, that education providers, disability providers and state and territory governments should work together to re-establish pathways between education and industry that may have been disrupted through the introduction of the NDIS, makes no sense and fails to appreciate the well-known barriers to allied health placements.[9] Public health provides training placements in collaboration with the universities, but no longer manages disability clients in any

[9] AHPA, 2020 Submission.

substantial way. It will therefore require NDIA funding for NDIS providers to be able to take students on placement.

Other strategies cannot be one-size-fits-all. Solutions that might work in some rural areas are likely to need to be adapted for elsewhere. Data mapping and analysis is necessary to ascertain whether particular types of allied health shortages require specific training and support strategies. Allied health assistants do not have identical training needs to those intending to become or who are already allied health professionals (see our response to Priority Action 3, Initiative 14).

For the above reasons, AHPA certainly does not view recent initiatives such as the Allied Health Rural Generalist Workforce and Education Scheme ('the Scheme') as the complete answer to allied health thin markets. However, it is noteworthy that the Plan makes no mention at all of the Scheme. We argue that there is utility in considering, adapting and expanding this type of model of training and support, with a caveat that funding must be secure, ongoing and tailored to the service. For example, budget items must be allocated for student placements, scholarships for Allied Health Rural Generalists working in private practice and non-government organisations, mentoring and supervision, as well as, where appropriate to local context, for backfilling, travel and accommodation (NRHC, 14).

The resulting more flexible model could work in tandem with the establishment of Service and Learning Consortia as recommended by the National Rural Health Commissioner (NRHC, Recommendation 1, 8-18). This would provide pathways both for school leavers wishing to train as an allied health assistant or practitioner, and for allied health professionals contemplating rural or other specialised practice, such as in an inner urban area with a high number of recently arrived migrants with low socioeconomic status.

### Priority Action 3: Reduce red tape, facilitate new service models and innovation, and provide more market information about business opportunities in the care and support sector

Other than our comments on specific initiatives below, it is striking that the element of Priority 3 aimed at facilitating new service models and innovation is not addressed here or at any other point in the Plan.

AHPA regards the design and development of new service models as both the logical next step after Priority Action 2 – where those newly trained professionals will work – and a golden opportunity to operationalise the need to join up service provision across sectors and departments. Accordingly, potential models should at least dovetail with those implemented as part of the Primary Health Care 10 Year Plan, and with others put forward as elements of aged care reforms.

One possible example might be along the lines of proposed Rural Area Community Controlled Organisations (RACCHOs),[10] themselves influenced by the success of ACCHOs and community health centres. As with training and student placements, these preferred models or 'provider hubs' should be multidisciplinary, shaped to local context (including outside rural areas) and adaptable.

[10] https://www.ruralhealth.org.au/sites/default/files/Infographic-proposal-for-better-health-care-a4v2.pdf .

### *Initiative 10: Improve alignment of provider regulation and worker screening across the care and support sector*

The regulatory burden is an overwhelming issue for allied health, but it is not specifically addressed in the Plan, even under this initiative. This is regardless of the Plan's statement that NDIS administrative hurdles are the key challenge for allied health due to their creating additional barriers to entry for workers (Plan, 18-19); and despite the problem being raised consistently by AHPA and our members in the consultation, with the NDIA, and in other forums.

As AHPA has previously submitted, entry to the NDIS can be expensive and time-consuming for allied health providers, and the audit requirements associated with registration lead some to decide not to register, especially if they expect to deliver only a low volume of NDIS participant services. Working as an NDIS provider typically also carries high transactional costs when compared with other Schemes or funding sources, with significant audit expenses and administrative work required to manage interaction with the NDIS and the NDIA.

These 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.

AHPA contends 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.

### *Initiative 11: Continue to improve NDIS pricing approaches to ensure effective operation of the market, including in thin markets* and *Initiative 12: Provide market demand information across the care and support sector to help identify new business opportunities*

See 'Thin markets' above.

### *Initiative 13: Support participants to find more of the services and supports they need online*

We note that this initiative differs from its counterpart in the Overview in that it is not concerned with supporting businesses to improve their online presence and capabilities.

Digital and seamless communication interfacing are key challenges for the allied health sector, which lags behind other health and care sectors such as general practice. A genuinely useful initiative that facilitated the provision of allied health services would address this inequity.

### *Initiative 14: Explore options to support allied health professionals to work alongside allied health assistants and support workers to increase capacity to respond to participants' needs*

This initiative is welcome, not least because the allied health assistant workforce has generally been ignored in workforce considerations. Many allied health professionals work effectively with their assistants, but the structures to support this are not well developed. A good allied health assistant working under a delegation framework is invaluable – but they should not be seen as cheap substitutes for qualified allied health professionals, because that risks the safety of participants.

The establishment of a nationally consistent supervision and delegation framework was a feature of the Overview, but is absent from the Plan which makes no reference to the current and real dangers

of inappropriate use of this workforce without appropriate supervision and delegation. Instead, the Plan simply refers to exploring options through co-design and in future stages exploring additional training and regulatory requirements for allied health assistants and support workers.

AHPA recommends the development of uniform entry level qualifications and a national supervision and delegation framework for allied health assistant practice, and refers the Committee to the Victorian Supervision and Delegation Framework as a resource for this process.[11] Consistent with the National Rural Health Commissioner's Report, allied health assistants should then be integrated into all applicable allied health workforce training and employment pathways (NRHC, 2).

### *Initiative 15: Enable allied health professionals in rural and remote areas to access professional support via telehealth*

While this initiative is welcome, telehealth is not a universal panacea for either provision of treatment or workforce development and accountability – but it can still be useful in remote locations. However, it requires resourcing, including for some face-to-face professional support to augment remote technology. The Plan once again just resorts to a motherhood statement of 'exploring options'.

In addition, as AHPA has previously submitted, there is little support in the NDIS pricing structure for supervision and mentoring of practitioners. Instead, the current system relies entirely on the provider being able to self-fund this support. This is neither realistic nor sustainable, and means that there is no incentive for providers to invest in supporting their workforce beyond minimum standards. Those committed to providing high quality care despite the cost then 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. This should be developed separately from the funding of service delivery through the NDIS, and instead must be seen as an investment by Government in the long-term development of the disability workforce.

### *Initiative 16: Help build the Aboriginal and Torres Strait Islander community controlled sector to enhance culturally safe NDIS services*

This initiative is a new addition in comparison to the Overview and is welcomed by AHPA as essential. However, as with all of the other initiatives, it requires concrete actions, benchmarks, and short, medium and long-term timelines, together with identification of structures and entities in order to develop, implement, monitor and evaluate this aspect of the Plan.

[11] State of Victoria, Department of Health, Supervision and Delegation Framework for Allied Health Assistants (2012).