

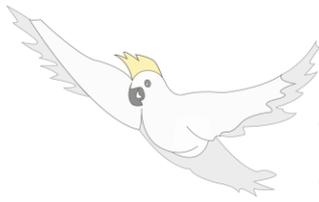


**SARRAH**

Services for Australian  
Rural and Remote Allied Health



# Department of Social Services NDIS Thin Markets Project



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Services for Australian Rural and Remote Allied Health

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Thank you for the opportunity to provide input to this project on behalf of the members of Services for Australian Rural and Remote Allied Health (SARRAH).

SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector. SARRAH was established in 1995 and advocates on behalf of rural and remote Australian communities in order for them to have access to allied health services that support equitable and sustainable health and well-being. AHPs are tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury and support people with disability.

SARRAH maintains that every Australian should have access to equitable health and disability services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAH welcomes the work of the Department of Social Services (DSS) and the National Disability Insurance Agency (NDIA) to address the issues arising from thin markets so that NDIS participants have equitable access to the services they need. SARRAH also acknowledges the work of programs such as *Boosting the Local Care Workforce* that quantify and forecast demand for services across Australia, and work with local service providers to resolve service delivery issues. These measures go some way toward addressing the significant issues impacting on the accessibility of services for people living with disability in rural and remote Australia.

The Thin Markets Project Discussion Paper identifies potential responses to the issue across four domains:

1. Market Facilitation
2. Market Deepening
3. Regulation
4. Alternative Commissioning Models

SARRAH will respond to each in turn.

## **Market Facilitation**

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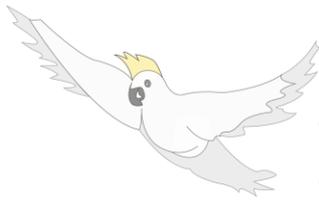
SARRAH challenges the assumption that in thin markets service providers have the capacity and the need to meet an increasing demand for their service. The concept of a market for disability services is appropriate in major cities and major regional centres, but the concept of a market is no longer tenable with increasing remoteness. Disability services, whether provided through the NDIS or through mainstream services have extremely limited reach into small rural and remote communities.

The lack of a market in rural and remote communities renders ineffective efforts to improve market competition, such as demand-supply matching via electronic platforms including My Aged Care (MAC). Our members' experience of the implementation of MAC identified the following issues:

- Insufficient access to information in the MAC Service Portal about the full range of relevant allied health professionals who provide services to older clients, therefore limiting the potential of plans approved through the MAC program.
- The Service Portal does not provide geographically accurate information to enable the easy connection of clients with available allied health services, as post code based searches can cover huge rural areas.
- The National Health Services Directory contains inaccurate and out-of-date information concerning allied health practitioners, thereby limiting access to services.

## **Services for Australian Rural and Remote Allied Health**

ABN 92 088 913 517 | T: (02) 6285 4960 | [sarrah@sarrah.org.au](mailto:sarrah@sarrah.org.au) | [www.sarrah.org.au](http://www.sarrah.org.au)  
Unit 4, 17 Napier Close, Deakin, ACT, 2600 | PO Box 74, Deakin West, ACT, 2600



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- Delayed release of discharge information from hospital-based allied health professionals can negatively impact the work of Aged Care Assessment Teams (ACATs) and Regional Assessment Services (RASs) on the ground.
- Personnel within RASs and ACATs may have limited knowledge of the scope of allied health professionals and their services of relevance to the frail elderly. This leads to sub-optimal care plans and reduced attainment of independent living in the community – due to a failure of appropriate referral to allied health services on behalf of clients.
- The expense of delivering services in many remote settings precludes private allied health service provision. Significant travel time and expenses associated with regional, rural and remote services are not sufficiently offset by provisions under present funding instruments to support small rural business models.

It is likely that were the NDIA to implement a platform like MAC, similar issues will be encountered. Feedback from our members suggests that the NDIS register of service providers is very inaccurate. Furthermore, the resources required by providers to keep a system such as this up-to-date would increase the already overwhelming administrative burden that the NDIS imposes.

Local Area Coordinators face significant challenges in knowing the range of local services available and in knowing where and how to source external support, and may require them to work across sectors to source viable options. As a result of our member feedback SARRAH is of the view that electronic demand-supply matching is of little benefit to rural and remote communities.

Supply partnerships that are focused on the disability sector in isolation to the broader service needs of rural communities risk ongoing fragmentation of supports and development programs. SARRAH recommends that service development programs targeting thin markets adopt a cross-sector focus to build capacity and gain optimal benefit from the resources invested.

## Market Deepening

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Pooled funding streams and “bundled” services hold some promise in identifying place-based solutions to unmet service demands. A recent review of access to rural allied health services undertaken by the National Rural Health Commissioner found that regional partnerships and networks between public sector, non-government and private providers, including shared care, optimised the use of the available workforce and contributed to the delivery of more comprehensive services<sup>1</sup>. Further, “...Opportunities for integration with the NDIS, My Aged Care and other sector revenue streams could ... enable greater growth in the private sector.”<sup>1</sup> The review concludes:

*“At the regional level, patient-centred service planning and coordination of public and private providers underpins access to more comprehensive and high quality services. For smaller communities, outreach and virtual consultations are critical for early intervention and continuity of care, but viable business models and an adequate staff base are essential to improve service distribution. A number of these areas have direct application to Commonwealth Department of Health policy and equally require strong engagement with jurisdictions and rural representation across the sector”.*

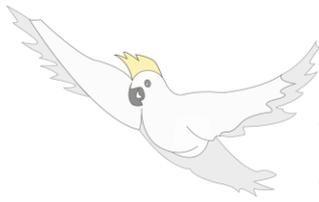
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[https://www.health.gov.au/internet/main/publishing.nsf/Content/815AFEED0337CF95CA2581D30076D095/\\$File/NRHC-Rural-Allied-Health-Options-Discussion-Paper-2019.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/815AFEED0337CF95CA2581D30076D095/$File/NRHC-Rural-Allied-Health-Options-Discussion-Paper-2019.pdf) Accessed 10/07/2019

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Commonwealth agencies with an interest in improving access to allied health services in rural and remote Australia must collaborate to ensure that policies and programs are aligned in such a way as to maximise the impact for rural and remote communities. Further, disability service providers should be encouraged to collaborate with state-based health services and the private sector to pool resources in order to create viable service delivery models that meet local needs. Primary Health Networks are well-positioned to facilitate such collaborations through their health needs assessments, mapping of local services and engagement with local providers in public, private and non-government sectors.

Critical to the success of localised collaborative partnerships that pool resources to work across sectors is the development of an allied health workforce with broad skills enabling them to work across a range of client populations. The term “rural generalist” refers to a service, or to a position or practitioner delivering the service, that responds to the broad range of healthcare needs of a rural or remote community. It is important to note that rural generalists practice under the regulatory instruments of their specific allied health profession and the policies of their employer. A rural generalist is NOT a “generic allied health worker” without a primary health professional qualification.

The Allied Health Rural Generalist Pathway (AHRGP)<sup>2</sup> is a multijurisdictional workforce development initiative that aims to support the growth, sustainability and value of the rural and remote allied health workforce and the proliferation of rural generalist service models that deliver accessible, safe, effective and efficient health services for rural and remote health consumers.

The AHRGP may be readily applied to disability service settings. The formal training program associated with the pathway includes subjects relating to disability. SARRAH recommends that promoting the awareness of the AHRGP among disability service providers and offering support to identify training positions will improve the recruitment and retention of allied health professionals in rural and remote Australia. Incentives to service providers to consider training positions that includes backfill for trainees undertaking formal professional development towards a recognised qualification should be considered. This is especially important since the introduction of fees for services delivered by allied health assistants. It will be important that the safe delegation of clinical tasks to allied health assistants, included in the training program of the AHRGP, is well-understood by clinicians and administrators alike.

## Regulation

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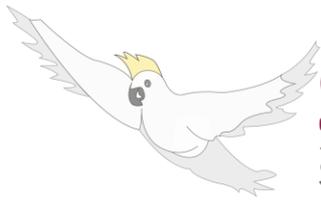
The government's role in ensuring the operational environment supports service delivery in rural and remote settings should not be underestimated. Allied Health services have not received the same level of support from the Commonwealth when compared to medical and nursing development programs, with significant consequences. The National Rural Health Commissioner's review seeks to address this oversight.

Options to improve the viability of rural markets under consideration by the Rural Health Commissioner include<sup>1</sup>:

- Provision of incentives for rural practice allied health services, for example, in MMM4-7, such as:
  - rural loading on fees for allied health services (e.g. on Medicare payments)
  - a bulk billing incentive
  - the application of initiatives such as the General Practice Rural Incentive Payment to allied health services
- Remove caps on the number of allied health services any one patient within MMM4-7 can receive for items under Better Access, Chronic Disease Management, and

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<sup>2</sup> <https://sarrah.org.au/ahrgp>



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Medicare Follow-up Allied Health Services for People of Aboriginal and Torres Strait Islander Descent.

In the context of the NDIS, improving the viability of private sector service providers includes reducing the administrative burden for existing service providers by waiving the NDIS registration and accreditation fees, streamlining reporting for NDIS plans and streamlining the process for applying for assistive technology.

Further, consideration of the challenges faced by clients living with disability in rural and remote locations should be considered to improve access to local allied health services. Our members advise that in rural and remote areas virtually all clients are complex regardless of their condition due to the additional challenges faced because of reduced access to specialist service and fewer resources available to assist them to cope with their condition. To bolster the viability of rural allied health practices, the Commonwealth should consider changes to the way services are remunerated, such as supplementary funding, infrastructure grants, loading of fee schedules based on rurality, and practice incentive payments to ensure that rural and remote clients can access allied health interventions to an equivalent level with their metropolitan counterparts. As these changes are complex to implement, a short term solution to improve access to allied health services for rural NDIS clients lies in allowing flexibility to enable clients to utilise local service providers who may not be registered with NDIS.

The interface between primary health care and the NDIS is an area that requires attention through Commonwealth interagency engagement. Our feedback informs us that certain requirements for clients to utilise "mainstream supports" before turning to the NDIS impose barriers so significant that clients may not access services at all. An example is the requirement that clients with mental health conditions utilise services available through GP mental health care plans prior to applying for support through the NDIS. Since the MBS items available under GP mental health care plans are rebated at significantly lower rates than the market rate, health professionals find it necessary to charge a service gap in order to remain viable. This creates a cost impost to the client, which for some is too great, and so they do not access primary health care services at all, and are subsequently prevented from accessing the NDIS. Given the significant differences in funding arrangements for services under the NDIS, SARRAH suggests that such prerequisites to accessing NDIS services should be removed.

## **Alternative commissioning models (including community led responses)**

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Regulated monopolies or oligopolies providing services into rural and remote communities should only be considered when all other avenues have been exhausted. Such government interventions risk a siloed approach to service delivery that maintains fragmented funding, divides the local health workforce, and may stifle local efforts to identify innovative solutions resulting from rigid program guidelines.

SARRAH advocates for funding of programs that support the development of cross-sector collaborative efforts and medium- to long-term workforce development programs that are more likely to produce sustainable services to rural and remote Australia. Primary Health Networks would appear to be natural allies in the commissioning of broad, cross-sector services that meet community needs.

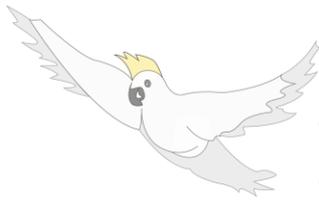
## **Addressing workforce development in the disability sector**

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SARRAH applauds the NDIA's recent amendments enabling services delivered by allied health assistants to be rebated through the scheme. This move has significant potential to increase the frequency of allied health service provision in rural and remote communities. Our engagement with service providers suggests that organisations will require support to implement effective governance arrangements for services delivered by allied health

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ABN 92 088 913 517 | T: (02) 6285 4960 | [sarah@sarah.org.au](mailto:sarah@sarah.org.au) | [www.sarah.org.au](http://www.sarah.org.au)  
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assistants. The safe delegation of work to allied health assistants requires a supervising allied health professional to have first undertaken a comprehensive assessment of a patient, develop a care plan, and determine that the allied health assistant has the necessary competencies to carry out elements of that care plan. The Commonwealth must continue to support service providers to ensure they have robust governance arrangements in place to manage the clinical issues arising from service modalities that utilise allied health assistants to ensure the safety and wellbeing of disability clients.

Further consideration should be given to the level of training required of local areas coordinators (LAC). Our members' feedback indicates major disparities between the care plans of clients with similar needs, seemingly arising as a result of the planners' different levels of knowledge. SARRAH believes that workers with allied health assistant qualifications are well-placed for LAC roles given their specific understanding of the benefits of allied health services.

Applying workforce development incentives may improve the supply of the rural allied health workforce, such as:

- Implementation of allied health rural generalist training positions within disability service providers to facilitate the development of relevant skills for early career allied health professionals
- Commonwealth funding of supervisors of allied health students in private practice in MMM4-7 areas for the time they spend teaching and demonstrating in practice settings (e.g. through a Commonwealth incentive program). Such funding would not prevent the supervisor from accessing other eligible service-related income (e.g. Medicare payments for services personally rendered)
- Fund HECS-HELP loan repayments for early career professionals working in a permanent or fixed duration contract in a rural location. These payments could be structured to include a loading to encourage professionals to work in areas of higher need.

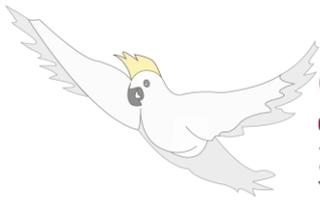
The NDIS provides the example of utilising allied health students in areas of workforce shortage as a means of addressing thin markets. All University Departments of Rural Health (UDRHs), through the Commonwealth-funded Rural Health Multidisciplinary Training (RHMT) program, are focused on contributing to the "rural health pipeline" through rural health placements, recruitment and retention support and other evidence-based strategies. Placements often follow a "service learning" model, whereby students are allocated to host sites to address community need, thereby creating a mutually beneficial placement experience.

There are, however, some key factors in effectively utilising students in the NDIS space.

- As NDIS providers are running private enterprises on a fee-for-service basis, student placements must be economically viable. Whilst service providers are able to charge for sessions conducted with a student, there are no arrangements in place to remunerate allied health professionals for additional clinical teaching activities such as provision of feedback and assessment of clinical competencies.
- There are some models in larger regional NDIS services, where there is a critical mass of co-located clinicians from a single discipline, the supervision of students is able to be shared, thereby minimising the impact on their individual billable hours. In smaller communities, low workforce numbers do not enable dispersion of supervision workload. In such circumstances disability service providers are not in a position to take students
- Additionally, demand for allied health services is most likely being under-reported and not accurately reflected in NDIS plans. For example, in a town in rural Victoria, adult disability services do not employ any allied health professionals, nor do many, if any

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of their more than 60 clients access allied health services, unless they have third-party funding through insurance schemes.

- Whilst disability clients should be accessing allied health (for example, for speech pathology regarding communication devices, occupational therapy for sensory processing assessment), services are so accustomed to not having access to allied health, that NDIS plans are being developed without any mention of allied health needs.

In conclusion, SARRAH is concerned at the impact of market failure in small rural and remote communities. Reliance on a competitive market approach is limiting the effective implementation of the NDIS and other disability services outside the major cities.

SARRAH believes that this issue is one that must be progressed through the overarching National Disability Agreements and policy developed both nationally and by State and Territory governments to support more flexible arrangements that will provide appropriate disability services for people with disability, their family and carers living in rural and remote communities.

SARRAH is committed to working in partnership with the NDIS and other disability organisations to develop culturally appropriate, financially viable services that meet the challenges presented in Australia's small rural and remote communities.

Yours Sincerely

Cath Maloney

A/Chief Executive Officer

**Services for Australian Rural and Remote Allied Health**

ABN 92 088 913 517 | T: (02) 6285 4960 | [sarah@sarah.org.au](mailto:sarah@sarah.org.au) | [www.sarah.org.au](http://www.sarah.org.au)  
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