SARRAH
Services for Australian
Rural and Remote Allied Health

Submission to the

Joint Standing Committee of the NDIS

NDIS Planning Inquiry

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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 the Joint Standing Committee on the NDIS inquiry into NDIS Planning. We provide this submission 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 Joint Standing Committee in considering the implementation, performance and governance of the NDIS and specific focus of this inquiry into NDIS Planning. SARRAH are committed to promoting planning, assessment and service arrangements that enable equitable access for NDIS participants to the services they need and to the long-term effectiveness and viability of these services.

There are significant issues impacting the accessibility, quality and viability of services for people living with disability in rural and remote Australia.

Reviewing the quality and coherence of NDIS planning, assessment and delivery arrangements will help optimise performance of the Scheme in relation to participant outcomes, operational efficiency and effectiveness and the viability of service investments required to achieve NDIS objectives.

The Terms of Reference for the inquiry includes reference to:

a) the experience, expertise and qualifications of planners;
b) the ability of planners to understand and address complex needs;
c) the ongoing training and professional development of planners;
d) the overall number of planners relative to the demand for plans;
e) participant involvement in planning processes and the efficacy of introducing draft plans;
f) the incidence, severity and impact of plan gaps;
g) the reassessment process, including the incidence and impact of funding changes;
h) the review process and means to streamline it;
i) the incidence of appeals to the AAT and possible measures to reduce the number;
j) the circumstances in which plans could be automatically rolled-over;
k) the circumstances in which longer plans could be introduced;
l) the adequacy of the planning process for rural and regional participants; and
m) any other related matters.

We offer a response to each of these issues as appropriate and in turn.

a) The experience, expertise and qualifications of planners

Rural experience and knowledge is crucial for planners covering rural and remote areas. Crucially planners covering rural and remote areas need support and ongoing development to keep abreast of a constantly changing NDIS environment.

SARRAH members have received and provided feedback from participants that planners often do not understand their conditions or the challenges they face and this makes it hard for planners to visualise or appreciate the individual's unique challenges (particularly in dealings over the phone). Disturbingly, participants have also reported instances of planners, faced with situations they do not understand, arguing with the participant about their needs, even when supported by reports from Occupational Therapists and General Practitioners on the basis of information they "googled".

Lack of knowledge about allied health and how various disciplines can help participants is a major concern.

- For example, many planners may have little awareness that a Speech Pathologist has expertise in non-verbal communication or assists people with issues such as (re-) developing the capacity to swallow, for example after a person has a stroke.

- Similarly, assistive technology may be crucial for many NDIS participants, but is a highly complex and rapidly evolving area.
    - Identifying its potential application or optimising its effective use which be extremely difficult without specific participant and professional engagement. Sophisticated voice and other enabling technologies offer immense potential in support of the Scheme's objectives. However, SARRAH and other organisations, receive frequent reports of people in rural and remote communities waiting many months for even well-known items such as wheelchairs. When they arrive they are frequently not suited to the environment and conditions and require repair or replacement within a short period (again leaving the participant without vital supports).
    - Other feedback on assistive technology is that devices may be underfunded in a plan, requiring supplementary funding from another source/organisation and contributing to participant concerns about what to do in the event of breakage, with insurance, replacement and etc.
    - These issues may act as a deterrent for NDIS participants to optimise their potential social, economic or other activities.

Other examples could be cited from across the allied health professional practice and could not reasonably be expected to be within the knowledge of NDIS planners - especially inexperienced planners as occurs with high levels of churn.

Further, many (potential) NDIS participants have little or no experience of allied health services and consequently are unlikely to identify these or consider them on an informed basis in planning discussions. This is a major risk especially where few publicly funded or private allied health services are available, as in much of rural and remote Australia.

Poor access to allied health services in rural and remote Australia is a chronic issue.

- The shortage of allied health professions in rural and remote Australia pre-dates the NDIS and is associated with the relative lack of employment opportunities and funding supports to enable viable practice in many communities.
- As the Australian Government's National Health Workforce Dataset shows[1] the geographic distribution of many allied health professions is heavily skewed toward major population centres (where financially viable and professionally supported

[1] https://hwd.health.gov.au/publications.html#alliedh17
Note – there is no reliable data on the number or location of around half of all allied health professions in Australia. Reliable data is only available for professions registered under the National Registration and Accreditation Scheme (NRAS) for health professions, and so excludes professions such as speech pathologists, audiologists, dieticians, social workers and exercise physiologists to name a few.

practice is more viable) and often resembles more closely the distribution and shortage patterns of (non-GP) medical specialists than it does other doctors and nurses.

The following table illustrates the geographic distribution and practitioner to population ratios of a selection of allied health professions[2].

Profession	Distribution by remoteness area: FTE rate per 100,000 population - 2017				
	Major cities	Inner regional	Outer regional	Remote	Very remote
Occupational Therapists	65.1	50.8	48.5	37.0	23.7
Physiotherapists	107.8	68.2	57.2	50.9	44.9
Podiatrists	18.0	17.8	11.3	10.7	8.4
Psychologists	105.0	62.3	46.7	37.2	24.6

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. The significance of these issues could be better appreciated in reflecting on the practicalities of servicing a similar population over an area of several city blocks versus an area the size of Victoria.

In addition, rural and remote allied health practitioners face other service and viability challenges including:

- lower population income levels (and demand for PHI-supported services etc); and
- higher burdens of chronic disease, disability among this population[3] (especially among Aboriginal and Torres strait Islander people).

Compounding the shortage of allied health professionals (and hence NDIS service options) in rural and remote, is the apparent inaccuracy of the NDIS register. Feedback from SARRAH members suggests the register of service providers is very inaccurate. Further, the resources required by providers to keep a system such as this up-to-date would add to already burdensome administrative requirements of the NDIS.

Local Area Coordinators face significant challenges in knowing the range of local services available and in knowing where and how to sources 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.

b) The ability of planners to understand and address complex needs

The breadth of individuals' capabilities, motivations, conditions, environments, therapies, supports and overlay and intersection of these factors are essentially limitless. The role of the NDIS Planner, the supports they have available and the procedures that guide their work must recognise this situation. Disability is highly variable and complex.

Drawing on the health sector for illustrative purposes, an individual with complex needs would have their situation assessed by a range of health (and other professionals) and often

[2] Ibid – drawn from the 2017 Factsheets - using the latest available data.
[3] These statistics are well known and can be readily found in information reported by the Australian Institute of Health and Welfare (AIHW) and the Australian Commission on Quality and Safety in Health Care (ACQSHC).

in cases conferences, where the 'team' would bring their expertise to determining an effective treatment plan / approach for and with a patient/participant. The NDIS deals with similarly complex issues.

Rurality denotes added complexity. We frequently hear that planners are not aware of rural issues, particularly the feasibility of accessing services due to 'thin markets' and travel costs, both for providers and for families/ participants.

In some cases (potential) participants and/or their advocates are aware of allied health services and what participants require but these may be either:

- Not (understood and) supported by the planner; or
- Not available through the NDIS.

In either circumstance, subsequent review /re-assessment/planning activity may be required which further clogs up the system and adds to administrative rather than to support provision and costs.

Where allied health services are included in a participants' plan the allocation may be completely arbitrary with no apparent association with the therapeutic need or requirements to deliver a benefit to the participant. Feedback provided to SARRAH through members noted preliminary research findings that suggest that four times the service allocation would be needed to achieve the identified outcome.
Inadequate allocations also have the following implications:

- An annual allocation of 10 hours of an allied health service may equal, for example, 4 hours of actual therapy in settings requiring significant travel;
- A detailed assessment and report preparation may take a participants' entire annual allocation of that service, leaving little capacity for actual intervention, and repeated subsequent experiences as previous assessments may no longer be reliable.

Such restrictions may contribute to current year outlay constraints but are likely to be achieve little benefit to the participant, false economy and does not align with the investment, prevention and enabling objectives and ethos of the Scheme.

There are anecdotal reports of Planners, who may have a reasonable understanding of important service circumstances - such as the absence of an allied health or other service type in a community - distorting planning to include what's available rather than what's needed – thereby undermining broader planning and demand management/supply considerations.

Planners are the frontline staff of the agency in many cases, and there may be continuous improvement value in strengthening mechanisms for planners to provide feedback to the Agency on issues for participants that come up as part of plan development and review.

The skills and duty statements of NDIA planners do not appear to include any clinical, therapeutic or related requirements that might better equip them to identify issues, coordinate triage and refer them on in developing plans.

The emphasis of the Planner role is primarily procedural. This may be effective where participants have substantial supporting information and effective communication /advocacy to engage well in the planning process. Unfortunately, this is often not the case and in such situations NDIS planners may have little incentive or awareness of a possible need to investigate the circumstances and needs of the individual beyond that required to complete a planning process.

Given the size, complexity and statutory eligibility conditions of the NDIS it must be operationalised efficiently and administered to ensure fairness. This requires procedures and

guidelines that reduce arbitrary and/or inconsistent decision-making and introduces a degree of categorisation and procedural inflexibility. This is inherently in tension with NDIS objectives such as personalisation and efforts to ensure equitable access and treatment when needs and circumstances vary infinitely. Scheme objectives and operations must be reviewed regularly to ensure balance in optimal efficiency and delivering on the objectives/intent of the Scheme.

- There appears to be considerable scope to review and amend existing procedures to better achieve a balance between administrative efficiency, access, targeted and effective supports and system sustainability.
- Possible options, such as incorporating (on a triggered or as required basis) a general clinical-based triaging assessment and localised service/environmental knowledge of the participants' circumstances, could improve the quality of plans and performance, support utilisation, increase process flows and efficiency and reduce review activity and related resource impacts.
- It should be possible, at least, to trial and evaluate such approaches.

c) The ongoing training and professional development of planners

There is a significant need for professional development for planners in rural areas due to churn and lack of experience. This is more of a concern in rural and remote areas due to the smaller applicant pool. Such professional developmental may contribute to improved planner retention rates.

We have noticed inconsistency between planners' understandings both within and across geographical regions. It appears key messages are delivered or interpreted and applied differently across sites. This has been evident in public forums in which planners have been involved in disagreements (broadly and among themselves) on how situations are handled.

Further consideration should also be given to training required by 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 and planner roles given their specific understanding of the benefits of allied health services.

d) The overall number of planners relative to the demand for plans

Many rural and remote planners are based in larger regional centres and may have a very large area to cover. Telephone planning or online planning meetings are part of the required mix for rural and remote areas, but planners need additional training and consideration to be able to do this type of planning well.

Increasing the number of planners is an important consideration in rural areas, but it may be more important to develop and enable planner knowledge of locations, environments and conditions as well as mechanisms to facilitate more informed and effective plans.

Other or supplementary approaches that could help address these issues include enabling more extensive and skilled assessment and planning processes – possibly involving allied health professionals, allied health assistants and/or a range of planning support mechanisms, tiered and triggered on the basis of complexity or other factors. This should

i. Improve identification and targeting of need;

ii. Involve additional frontloaded capacity and resourcing but reducing (potentially) the need for reviews, re-assessments and other process driven costs; frequency of reviews in some cases – offsetting costs (e.g. people with conditions and/or circumstances where there needs may not change markedly – for example, some people cerebral palsy, quadriplegia or a significant intellectual disability – possibly drawing on evolving approaches to targeted re-assessment, such as in aged care.

a) Improve understanding of context, environment, knowledge of service needs / availability and access issues, including cultural requirements, transport and so on.

The lower than expected number/ slower rate of plan establishment also suggests there may be too few planners, at least to deal with the early implementation stages of the Scheme.

The *NDIS Annual Report 2017-18* notes that expenditure on 'Participant plan expense' during the year was substantially lower than projected in the Budget: being $5.42B compared with a Budget of $8.05B[4] – a shortfall of $2.6B (or 33%) over the year. The explanatory statement cites several factors as contributing to the lower than expected expenditure result, including, lower than expected participant numbers, difficulties contacting participants, people choosing to not enter the Scheme and lower utilisation rates for committed supports, among others.

The adequacy of the planning process, access and capacity of planners are not mentioned explicitly. However several reasons provided as an explanation suggest:

- There may not be sufficient planners to provide timely access for the number of potential NDIS participants;
- The skills and resources available to planners may not be sufficient to support timely processing, especially of complex cases;
- Communication / engagement between planners and (potential) participants is sub-optimal, and ineffective for a large portion of the population;
- The underutilisation of committed supports may reflect (to a substantial degree) the inclusion of supports that are of little interest to, unable to be accessed by or not available to the participant.
    - This would be consistent with concerns raised about under existing arrangements some planners lack adequate understanding of the participant and/or their circumstances to negotiate a plan to suit the needs or to be of use to the participant.
    - This has direct impacts on service access and the well-being of NDIS eligible people and the relative effectiveness of the Scheme in delivering on its objectives and the public's investment.

SARRAH believes the Inquiry could helpfully examine, or instigate other work to assess, these issues.

e) Participant involvement in planning processes and the efficacy of introducing draft plans

SARRAH Members cite experience of participants being uninformed about the planning process, their role in it, the critical nature of evidence for planning meetings and the need for them to advocate and detail all of their needs during the planning process.

Also, many individuals tend to downplay their needs. As mentioned above, many may not be aware of what their needs may be or what services are available to assist them to

[4] Refer pages 77-78 of the NDIS Annual Report 2017-18.

achieve their goals. Similarly, many participants lack the health literacy (or literacy in general), cognitive capacity or social skills to participate effectively in planning meetings or to be able to clearly define their support needs.

Planning for use of individualised funds remains a very new experience for many rural people with a disability and their families. Ways of supporting the development of their planning skills and understanding of the implications of plan allocations and breadth is likely to be a key factor in enabling the success of the NDIS for individuals. Introducing draft plans as a potential tool to assist participants and their families to consider a range of options that may be appropriate and assist them and having opportunity to contribute and adjust plans will support confidence and engagement. Draft plans are worth considering in conjunction with other possible adjustments noted in this submission.

f) The incidence, severity and impact of plan gaps

Plan gaps are a significant concern in rural and remote Australia.

The relationship between the quality and appropriateness of NDIS plans for participants in rural and remote Australia and the limitations of service knowledge and availability is complex and highly iterative.

- Plans may include allied health services that are not accessible or available in the participants' community or region – so go unused.
- Planners and participants may have no awareness of interventions that could be of great benefit to the participant – so are missed.
- Planners may be aware of beneficial services but not suggest or include them in a plan because they are not aware of suitable service provider for the participant to access.

Several gaps and the implications of these are cited in this submission. To reiterate one example:
If repair and maintenance of equipment is not included in a plan, people can be without their required equipment for some time. For example, in rural areas wear and tear on wheelchairs can be much higher, requiring repair and maintenance at a much higher rate than in other areas. If this is not included in the plan, it further exacerbates the problem.

A major factor contributing to plan (and as importantly) service gaps is the shortage of allied health professionals and service capacity in rural and remote Australia (detailed in response to item a)). Current work being undertaken by the National Rural Health Commissioner[5] addresses these issues and warrants consideration by the Joint Standing Committee.

In the context of the NDIS, planning and service gaps might be improved for private sector service providers if the administrative burden (e.g. NDIS registration and accreditation fees, reporting and the process for applying for assistive technology) were reduced.

To bolster the viability of rural allied health practices, the Commonwealth might also 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. Changes of this type may be difficult to achieve quickly, however a more immediate option to improve access to allied health services for

[5] *Rural Allied Health Quality, Access and Distribution: Options for Commonwealth Government Policy Reform and Investment* (current policy development process)

rural NDIS clients may be to enable participants to utilise local service providers who may not be registered with NDIS.

g) The reassessment process, including the incidence and impact of funding changes

SARRAH Members have noted challenges with reassessment related to administrative issues, such as:

- The need to establish new service agreements and service bookings;
- Lack of opportunity to engage with a participant before the end date of the current agreement and ensure continuity of services for participants - noting difficulty in anticipating what new plans will contain, especially given experience of major variations between plans for the same client.
- In some cases there is a risk that existing service agreements are in place and plan reviews are conducted prior to the expected date. Providers may not be informed of changes and then carry the risk that services will have been provided for which payment cannot be claimed.
- Instances, where clients have had goals associated with community participation and have, on review, identified additional goals: however, rather than goals being added to the plan, they have mistakenly replaced existing goals. Participants have advised they were not aware of this and only discover the change after receiving a copy of their plan. The participant may then feel abandoned and isolated as there are no funds to continue supports they valued.

h) The review process and means to streamline it

Nil comment.

i) The incidence of appeals to the AAT and possible measures to reduce the number

Feedback from SARRAH Members indicates that:

- participants regularly indicate they wanted someone with experience to discuss their needs with planners on their behalf and the current process does not enable this opportunity.
- plans were developed by inexperienced people.

Both are cited as having resulted in appeals to the AAT that could have been avoided.

Uptake of earlier recommendations about training, qualifications and ongoing professional development of planners may help to reduce the rate of incidence of appeals.

j) The circumstances in which plans could be automatically rolled-over

Notwithstanding the importance of regularly reviewing a person's capacity noting the real prospects of changes in their condition and circumstances as well as developments in intervention techniques, therapies and assistive supports, there are cases where less frequent reassessment driven by process and/or compliance considerations might be reduced.

- For example, SARRAH members note a considerable level of concern among parents and others about the need for a child with Downs' Syndrome or cerebral palsy to undergo a reassessment. Similarly, a participant who lives with quadriplegia might have the right to a reassessment but not a requirement in this regard.

There are many participants whose capacity and requirements might be relatively stable and their support needs are unlikely to change significantly year to year (particularly core supports). In these situations, having a roll over option would reduce the administrative burden on the NDIA, providers and the participants. Rollover might be an option available to participants toward the end of an existing plan if supported by a report from a key support worker, GP or Allied health clinician.

k) The circumstances in which longer plans could be introduced

The rollover option outlined above would provide a more flexible option to longer plans and less risk of continuation when a change in plan is warranted.

l) The adequacy of the planning process for rural and regional participants

There are significant issues in developing plans for rural and remote participants.

Some 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.

- As mentioned previously, many rural and remote participants report meeting with planners who are not familiar with their location, the services (or lack of services) available and who lack understanding about issues such as distance of travel required to access services.
- While travel can be deducted from the support category for some services, it is of concern that planners are not well informed about the limitations that may apply to such travel (cost, availability etc) and the impact of such travel on plans.
- Planners must have a better understanding of delivery and timing of therapy supports, the number of trips involved and the distances a clinician is required to travel, in order to develop a plan that adequately meets the participants' needs.
- Coverage and access to planners is a key factor: Rural and remote communities are becoming more aware of the importance of relationship development in an individualised funding system.
- Awareness of the range of supports that may benefit individuals is a major issue.
    - Many people with disability in rural and remote Australia have done without supports due to previous absence of such services.
    - This may pre-dispose against recognising potential supports to increase participant engagement. For instance, many adults have been unable to access physiotherapy or exercise physiology services and have settled on the ideas that their physical abilities will inevitably deteriorate over time. They are unaware a program of activities/exercises may decrease their pain and maintain or even increase their level of movement and strength.
    - This type of opportunity may not have been available for many rural and remote participants and has not been considered in the development of their plans unless this type of support is raised by the planner or someone else in the planning process.

A further difficulty for rural and remote participants is the need to engage via phone with planners. Members report that many participants are not willing to do this. In some cases it may be culturally inappropriate. Members expressed a view that planning meetings should

be held face to face and preferably with locals who have established relationships within the community. This approach would be particularly important, and more effective, in engaging with rural and remote Aboriginal and Torres Strait Islander communities.

The following excerpt from the NDIS Annual report 2017-18 (page 58) raises questions about the extent to which issues such as those identified above contribute to the ongoing underutilisation of supports.

> *There were $7.7 billion in supports committed during 2017-18. Not all of the committed support in plans is being used by participants. The utilisation of committed supports has varied between 65 percent and 75 percent for supports committed in 2013-14 to 2016-17, and is projected to be about 73 percent for 2017-18. Utilisation rates vary across States/Territories and are generally lower for a participant's first plan and for those who have not previously accessed disability supports. The lower levels of utilisation in 2016-17 and 2017-18 are driven by high numbers of participants on their first plan.*

m) Any other related matters

SARRAH recognises that the scope of the NDIS entails major challenges and it will take time for the Scheme to mature and perform optimally. This requires a process of robust assessment, constructive feedback and iterative improvement.

There have been positive developments. 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.

- On this issue, our engagement with service providers suggests organisations will require support to implement effective governance arrangements for services delivered by allied health 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. This is an important implementation issue, but one that will ensure greater coverage and access to quality services.

The Joint Standing Committee might give consideration to other opportunities to improve the delivery and outcomes achieved through the NDIS, for example:

Trialling better planning and engagement around allied health involvement in the planning process and the assessment and use of assistive technology – with monitoring and evaluation of downstream impacts including costs and benefits;

Recommending the NDIA work with other organisations (such as SARRAH) to develop relevant training and ongoing professional development for new and existing planners around the allied health issues for rural and remote people with a disability, building of the experience and knowledge of our members;

Exploring the potential for greater use of supported telehealth as a potential enabler of service access improvements but as part of a broader package of coherent measures;

Supporting investment in focused research, such as the recently funded Australian Research Council (ARC) project considering the adequacy of NDIS planning for rural and remote participants, focussing on sites western NSW and the NT around Alice Springs and Tennant Creek.

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

If you require further information please contact me at catherine@sarrah.org.au.

Yours Sincerely

Cath Maloney

A/Chief Executive Officer