

Marathon Health Submission

Standing Committee on Health, Aged Care and Disability Inquiry into the Thriving Kids initiative

October 2025

Contents

Introduction to Marathon Health	3
Terms of reference.....	4
1. Effectiveness of programs and initiatives that identify and support children and their families	5
Current barriers.....	5
Effective programs and initiatives.....	5
Flying Start Paediatric Service.....	6
WARATAH for Kids	8
2. Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse	9
3. Identify gaps in workforce support and training required to deliver Thriving Kids	11
Lack of diagnostic services	11
Lack of Medicare-billed services and the NDIS	11
Recruitment and retention of workforce.....	12
4. Identify mechanisms that would allow a seamless transition through mainstream systems for all children	13
Enhancing Paediatrics in Primary Care (EPIPc) program	13
Conclusion	14

Introduction to Marathon Health

Marathon Health was established in Western NSW in 2015 to address gaps in high quality, community-based health and wellbeing services for people living in regional, rural and remote areas. We deliver face-to-face services across 56% of NSW and virtual services Australia-wide. All our staff live and work in regional communities. We are a non-profit organisation with a vision of empowering these communities to thrive through equitable health and wellbeing.

During the past 10 years, we have become the largest not-for-profit employer of allied health in regional NSW. In 2024-25, our multidisciplinary teams supported 22,096 people – 27% identifying as First Nations. We deliver support to 90 local government areas Australia-wide from our regional service hubs at Bathurst, Dubbo, Albury and Wagga Wagga. We are a large provider of headspace services in Australia, providing wrap-around mental health and wellbeing services to young people through centres at Dubbo, Orange, Bathurst, Lithgow, Cowra, and Queanbeyan. We also deliver one of Australia's first headspace outreach First Nations-focused services to 10 rural communities in Western NSW.

Our purpose is to collaborate with communities to create the services they need to improve their quality of life. Our services cover four key domains:

- **Early intervention and disability supports** – person-centred community-based allied health services for children and people with a disability. We also deliver Australia-wide after-hours crisis support for NDIS participants on behalf of the National Disability Insurance Agency (NDIA). This domain represented 18% of our work in 2024-25.
- **Mental health** – a range of services spanning the stepped-care spectrum, including psychology, headspace services and psychosocial support for people with severe mental illness. This represented 52% of our work in 2024-25.
- **Preventive health and chronic disease** – supporting people to navigate the healthcare system to keep them well, including care coordination, chronic disease management, prevention allied health supports and after-hours GP services. This made up 16% of our work in 2024-25.
- **Wellbeing** - place-based health, person-centred programs focused on bespoke models of care based on community need. This represented 12% of our work in 2024-25.

As a key provider of community-based allied health services in regional NSW, Marathon Health is part of the paediatric working groups led by the Western NSW and Murrumbidgee Local Health Districts to identify opportunities for greater collaboration focused on improving the long-term health, wellbeing and developmental outcomes for children across the western NSW region.

Marathon Health also participates in the Foundational Supports for Children Advisory Group, alongside peak bodies, advocates and service providers, to share advice to the NSW Department of Communities and Justice on the design and delivery of targeted foundational supports for children aged 0-8 with developmental concern or autism, with low to moderate support needs. Marathon Health provides a rural and regional voice, ensuring that design principles incorporate the needs of rural and remote communities in terms of equity of access, vulnerable cohorts and thin markets. This group first met in July this year, with the purpose of supporting the design of activities and services that could be delivered as foundational supports for children and provide insights into how these could be delivered efficiently and effectively in NSW, ensuring no young person gets missed out.

We applaud the Committee's focus on understanding the services needed to ensure quality care is provided in child development, early childhood intervention services and other foundational and disability supports for children and young people with developmental concerns, delays, differences or disabilities. We welcome the opportunity to provide insights and recommendations that we hope will support equitable access to services for families, no matter where they choose to live.

Australian Early Development Census data shows that children in remote and very remote areas are significantly more likely to be developmentally vulnerable – with nearly 60% not on track to start school and more than 20% vulnerable in multiple domains (AEDC, 2024). This review presents an opportunity to recognise and build on existing infrastructure and local community supports – the good models of practice that are already in place and are delivering outcomes that improve the lives of vulnerable children and their families. Now is the time to harness what is working well and to support the essential need for place-based approaches in hard to reach communities.

Thriving Kids presents a significant opportunity to build on the efforts of organisations like Marathon Health to develop the workforce and create a system that is accessible and responsive to the unique needs of families – particularly those living in rural and remote Australia.

Terms of reference

This submission addresses four items from the Standing Committee's Terms of Reference:

1. Examine the effectiveness of current (and previous) programs and initiatives that identify children with development delay, autism or both, with mild to moderate support needs and support them and their families (focusing on community and mainstream engagement, and including child and maternal health, primary care, allied health playgroups, early childhood education and care and schools).
2. Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse.
3. Identify gaps in workforce support and training required to deliver Thriving Kids.
4. Identify mechanisms that would allow a seamless transition through mainstream systems for all children with mild to moderate support needs.

1. Effectiveness of programs and initiatives that identify and support children and their families

Early intervention allied health services are crucial for children's development, improving long-term outcomes and independence. However, access to these services is neither universal nor affordable for many families in regional, rural and remote areas. It is well documented that children in rural and remote communities are twice as likely to be developmentally vulnerable in multiple domains compared to those in major cities. Despite this greater need, the current Government systems do not work in rural Australia, meaning local support services often aren't in place when children start school.

Current barriers

Several **barriers prevent effective early identification and support** for these children and families:

- **Low health literacy** – Many families are not aware when their child needs extra developmental support.
- **Limited access to GPs, paediatricians and specialists** – Long wait lists and shortages in many rural and regional communities mean families often cannot get timely assessments or referrals.
- **Limited community-based screening and assessment** – Key initiatives (e.g. the NSW Health Brighter Beginnings universal screening program) are not equitably available in rural areas due to workforce shortages in many Local Health Districts (LHDs).
- **Lack of local navigation support** – There are few community-based supports to help families navigate systems like the NDIS. For example, the NDIA has withdrawn community-based planners from some remote communities, leaving no local assistance for families before children start school.
- **Activity-based funding models** such as the NDIS or Medicare Benefits Schedule do not work in rural communities, where there is not adequate population to make it sustainable for providers to do business or develop a workforce.

Consequences: Because of these barriers, many country children who do not have an NDIS plan **miss out entirely on early intervention** that would ease their transition into school and improve their learning outcomes. For instance, one of every five children in regional NSW enters Kindergarten with unaddressed developmental concerns. These gaps can lead to more complex challenges later, and greater costs to the health and education systems.

Effective programs and initiatives

Previous community programs have shown promise in addressing these needs. Before the NDIS rollout, Marathon Health operated a network of Allied Health Assistants in preschools and schools across Western NSW. Under this universal access model, trained assistants—working under the guidance of visiting Occupational Therapists and Speech Pathologists—helped families carry out therapy plans between clinical visits. This approach effectively engaged families in ongoing early intervention at the community level. Unfortunately, the NDIS funding model made it unsustainable to maintain this enabling workforce, as it did not cover these support roles. The withdrawal of the allied health assistant workforce has increased pressure on a limited number of clinicians and on overstretched public health services.

The NDIS model has also put an untenable administrative and coordination burden for schools. The way the system is delivered has resulted in an influx of therapists into schools to support individual students.

This has become so unmanageable that schools are now shutting their doors to therapists. They are receiving conflicting recommendations for one student that are at odds with recommendations for another in the same class and teachers are simply not equipped to manage the challenge involved on top of their day-to-day classroom responsibilities.

Our experience delivering innovative community-led programs, using a workforce living and working in regional communities, shows it is possible to successfully identify and support children with developmental challenges, despite the systemic barriers. Our approach centres on collaborative primary care with strong local partnerships, integrating services around the child and family. This is often challenging when federal and state programs are disconnected, but we have found that building enduring local relationships is key to person-centred care. Below we highlight two of our integrated paediatric service models, illustrating the effectiveness of current initiatives in bridging service gaps for children with mild to moderate support needs.

Flying Start Paediatric Service

The Flying Start Paediatric Service provides free access to a **multidisciplinary team** of local and visiting clinicians to provide wrap-around support, effectively **unlocking ongoing health, education, carer and social supports for children close to home**. Flying Start is an evidence-based, Tier 4 paediatric outreach model for children aged 2–18, designed by our allied health team to fill local service gaps and overcome barriers for rural families to accessing foundational supports. Under the model, families **do not need multiple specialist appointments** to gain a full assessment and leave the paediatrician appointment with the evidence they need to unlock the individual supports the child needs to thrive.

We trialled the program in four rural and remote communities through a blend of funding (Rural Doctors Network, philanthropy via Variety – the Children’s Charity, Medicare billings, and in-kind support from the Western NSW LHD) and it is ready to scale with sustainable investment.

Figure 1: Overview of the Flying Start Paediatric Clinic Model



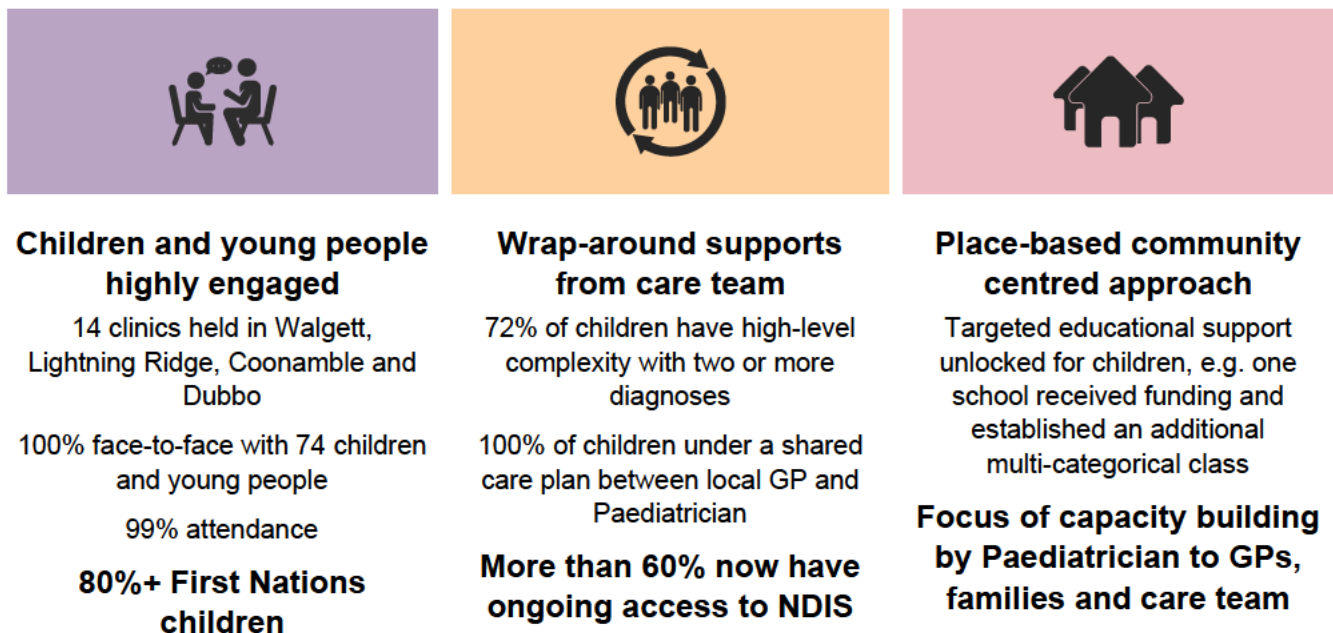
Impact

To date, Flying Start has delivered **holistic paediatric assessments and care plans** for over 70 children and young people across four Western NSW communities. It is effectively **addressing the critical shortage of paediatric services in remote areas**. Without this service, the nearest

paediatrician is three to four hours away for most families, with appointment wait times blowing out beyond 700 days in some cases.

Each child receives a comprehensive, individualised care plan and support to access all recommended services. Data shows that **72% of children seen have two or more co-existing diagnoses** (e.g. autism with anxiety, ADHD, global development delays, learning difficulties, sensory processing issues).

Figure 2 – Flying Start outcomes since 2024



Key success factors

Place-based, community centred delivery

- Flying Start provides **tailored services** focused on the individual needs of children and young people – it is community centred and ensures enduring local support pathways.
- By delivering face-to-face clinics in small towns like Walgett, Lightning Ridge, Coonamble and Dubbo, the service achieved very few cancellations.
- This community-centred approach **builds trust and ensures families engage with ongoing support** pathways locally. The model aligns with NSW and national strategies emphasising community health, early education, and addressing social determinants of health.
- The program **raises community health literacy** by improving awareness of referral pathways and services available for developmental issues.

Multi-disciplinary collaboration

- Flying Start brings together Marathon Health's allied health team, local GPs, Aboriginal Medical Services (AMS), local pre-schools and schools, and the Western NSW LHD. Joint case conferencing and care planning delivers **strong outcomes** for families.
- The local multidisciplinary team ensures there is **trust and engagement** in the service.
- The paediatrician's involvement has a **capacity-building** effect on local providers as well – there is a focus on upskilling GPs, families, and the care team through the process.

- Our model aligns with key NSW and national strategies and priorities for community health, education and social determinants.

Efficient, ongoing wrap-around supports

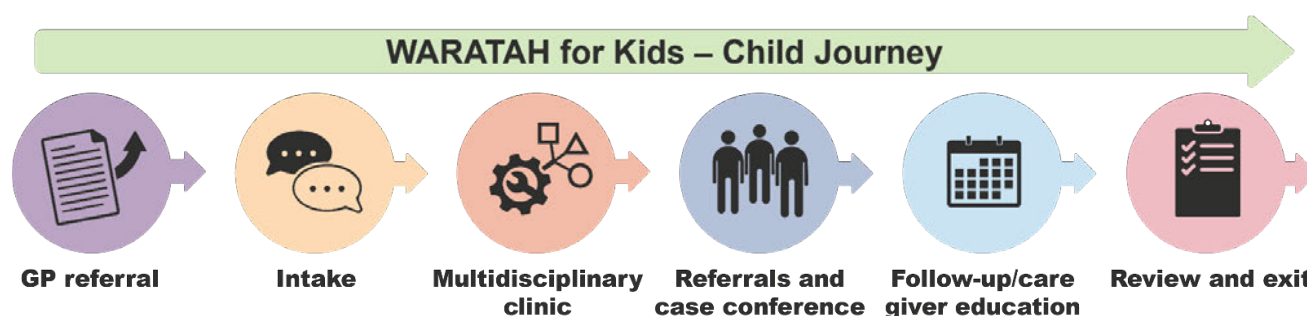
- The program provides **dedicated, culturally appropriate wrap-around support** to families before, during and after the paediatric clinics. A care coordinator ensures that follow-ups and referrals are completed, reducing the risk of families falling through gaps.
- By front-loading the information gathering and integrating care, Flying Start **saves roughly three specialist visits per child** compared to usual care – a significant efficiency for a scarce workforce. Children are connected immediately to supports (health, education, disability services) that continue well after the specialist's visit, ensuring continuity.

WARATAH for Kids

We co-designed and conducted a **pilot paediatric early intervention allied health service**, WARATAH for Kids, as a free service for children aged 0-7 years, living in the Murrumbidgee, who have a developmental delay or behavioural concerns. The program:

- Is funded by Murrumbidgee PHN
- Represents a **collaboration** with local GPs and AMS across the region to deliver monthly **community-based multidisciplinary clinics** and a Community of Practice
- Includes screening clinics; detailed allied health reports to support the GP in developing the child's individual care plan; participation in case conferences (as shown in Figure 3)
- Established **referral pathways** that include access to a paediatrician or ongoing funded early intervention allied health supports
- Gained additional funding to expand to new communities this year and added short-term early intervention therapy services to **build the capacity of families to support their child's journey**.

Figure 3: CARE pathway WARATAH 4 KIDS



Impact

Data for 2024-25 shows:

- 55 children screened at a multidisciplinary team clinic
- 22 clinics were held across seven locations - Hay, Deniliquin, Leeton, Gundagai, Lockhart, Wagga Wagga and Holbrook
- 395 referral recommendations were made
- Capacity building for 44 families
- 62% of children identified as First Nations.

Key success factors

An evaluation of the WARATAH for Kids model found the pilot was highly successful due to these factors.

Multi-disciplinary collaboration

- The program has been co-designed over time and continues to **respond to community needs**. It is evidence informed but is working in an area requiring innovation and adaptation.
- Benefits include greater support and information provided to families; children **receive the right support at the right time**; **collaborative upskilling** of local health practitioners; more **coordinated support**; and **better health workforce utilisation**.

Family-centred care

- WARATAH for Kids has a strong focus on **family empowerment and capacity building**. Parents and caregivers gain practical skills to manage challenges, reducing stress and foster stronger family dynamics.
- **Family-centred care** – interventions are tailored to the child's developmental stage and specific needs.
- Service **flexibility** – WARATAH for Kids is a flexible and responsive model, enabling us to pivot to meet the needs of families in new communities, GPs and other care partners.

Timely, ongoing wrap-around supports

- All children who access WARATAH for Kids have received an **individualised care plan** from their GP, based on collaboration with WARATAH for Kids screening and recommended supports and referrals, including speech pathologist and occupational therapist.
- Enhanced access – the provision of the **Paediatric Linker** reduces barriers to services by coordinating and streamlining access to care, while the blended service delivery model will provide more touchpoints for families, without significant cost increases.

2. Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse

Children from First Nations and culturally and linguistically diverse (CALD) backgrounds often experience additional barriers in accessing early childhood supports, requiring targeted strategies for equity. Notably:

- **Delayed identification of needs:** Many First Nations and CALD children have limited or delayed engagement with mainstream early childhood education and health services. As a result, developmental issues frequently **go unrecognised until the child starts school**, missing the critical early intervention window. In Marathon Health's experience, it is common that **First Nations children – and those from some CALD communities – are not identified until later years** because they have little contact with preschools or screening programmes before Kindergarten. This delay means these children enter school without the benefit of early supports that their peers might have received.
- **Cultural and linguistic barriers to access:** Standard services are often **not culturally safe or accessible** for many Indigenous and culturally diverse families. Factors such as historical

mistrust, lack of Indigenous staff, and language barriers can discourage families from seeking help through “mainstream” channels. The need for culturally tailored engagement is evident in Marathon Health’s approach – for example, the organisation has had to **partner with AMS** to successfully reach and support First Nations families. This highlights a service gap: many communities have **few local providers who understand and reflect their culture and language needs and preferences**.

- **Geographical and systemic inequities:** Equity issues are often compounded in rural and remote areas, where a high proportion of residents are First Nations. These communities face **severe shortages of local services**, long travel times and extensive waits for an appointment. Such extreme delays effectively exclude many Indigenous children from timely diagnosis and support. The withdrawal of certain federal services has also widened the gap. For example, the **NDIA removed community-based planners from remote communities**, meaning families in those areas lost their local help in navigating the NDIS and other supports. This disproportionately impacts First Nations families, who often relied on community-based touchpoints for guidance.

To address these inequities, we emphasise **culturally responsive practices and strong community partnerships** in our service delivery:

- **Partnerships with Aboriginal-controlled organisations:** We work closely with Aboriginal Community Controlled Health Organisations to design and deliver services in a culturally safe manner. For example, Flying Start is delivered in collaboration with local **AMS** at Walgett, Coonamble and Wellington, with Marathon Health staff even **co-locating at AMS clinics and jointly running paediatric sessions**. WARATAH for Kids clinics were co-designed and coordinated alongside local GPs and AMSs. These partnerships provide trusted entry points for First Nations families. By hosting clinics at familiar community venues and involving respected Indigenous organisations in care delivery, we have significantly improved engagement.
- **Culturally-safe workforce and practices:** A key strategy in improving equity is **building a workforce that reflects and respects the community**. We take pride in developing a diverse team, with 13% of our employees identifying as First Nations. We deliberately recruit roles such as **Aboriginal Health Workers and Aboriginal Wellness Workers** to support our clinical services. These team members play vital roles as cultural navigators and liaisons, helping to build trust with Indigenous families and ensure that services are delivered in a culturally sensitive way. All staff are trained in cultural safety, and programmes are delivered with respect for each family’s cultural context and preferences, which might include allowing extended family members to be involved in a child’s sessions, using culturally appropriate communication styles, and being mindful of language needs. Having Indigenous and culturally aware non-Indigenous staff means we create a welcoming environment for First Nations and CALD families, so they feel understood rather than judged when seeking help, with greater engagement and better continuity of care.
- **Community-based, family-centred delivery:** Our service models are deliberately designed to meet families where they are, rather than expecting families to navigate unfamiliar systems. Both Flying Start and WARATAH for Kids operate as **outreach clinics in local towns and villages** – often in primary care settings or community venues – so that families do not need to travel long distances or enter intimidating hospital environments. The care provided is holistic and wrap-around and provides **“before, during and after” support** to each family, which is tailored in a culturally appropriate way. This means engaging with the family prior to formal assessments (to build rapport and understand their context), supporting them during specialist visits (ensuring they comprehend the process and feel at ease), and following up afterwards to help them act on the care plan. Such intensive, culturally-sensitive support has proven successful. Families report

feeling genuinely listened to and involved in decisions about their child's care – a stark contrast to their experiences in many mainstream systems. Moreover, the community-centred approach allows for flexibility: the WARATAH for Kids team, for instance, can adjust the frequency or location of clinics based on community feedback, and even add home visits or phone check-ins if families are not attending appointments. This flexibility helps ensure that CALD families, who might face transport or language difficulties, can still receive consistent support through means that work for them.

3. Identify gaps in workforce support and training required to deliver Thriving Kids

Marathon Health's focus is on collaborative primary care models, with the GP at the centre of a patient's wellness journey. Our models of care are evidence-based and designed to take pressure off an already stretched hospital system. Our success in embedding services within communities is underpinned by our priority on building strong local relationships, acknowledging that person-centred care is only achieved when services are integrated and working together for a common purpose. This is often challenging where there is a disconnect between federal- and state-funded services.

Lack of diagnostic services

Currently there is no access to **Paediatric Developmental Assessment** programs through the Western NSW and Murrumbidgee LHDs for a child with developmental concerns. Also, referrals for places in metropolitan areas have very long waitlists. Many families, particularly those in rural and remote communities, do not have means to access private services.

Families in rural communities are often unaware of that their child requires early intervention support. There is a lack of skills and capacity in mainstream early childhood settings, such as preschools and daycare centres, to identify children who have developmental delays or to link them with appropriate referral pathways like early intervention NDIS plans.

The impact of this we have seen in communities across our footprint. Many children are first identified with very complex presentations when they start formal schooling in Kindergarten and have missed early intervention supports altogether. And, in our experience, many First Nations children and those from CALD backgrounds do not have contact with the education system until later years.

Service models such as WARATAH for Kids and Flying Start Paediatric Service highlight the benefits of embedding assessment services into primary health rather than State systems, and how the system can work effectively in rural NSW when local services are integrated, responsive and child-centred.

Lack of Medicare-billed services and the NDIS

Since the introduction of the NDIS, the availability of Medicare-billed services in regional, rural and remote NSW has practically disappeared from the market. The biggest disruptor to the supply side in rural communities is the **pricing of NDIS**. The NDIS is attractive to small sole providers, servicing less complex clients who are not required to travel, to make their business viable. The model is not viable to larger not-for-profit allied health providers operating at scale and doing outreach due to compliance, workforce development and travel costs.

There is now only **limited access to community allied health for children**, and limited opportunity to gain funding for supports for early intervention or preventive health. **Fee-for-service is too prohibitive** for many families to pay for services outside the NDIS. Across regional, rural and remote NSW, **a complete cohort of children who do not have an NDIS plan is missing out on early intervention**

that would support their smooth transition into school, help achieve their optimal learning outcomes and set them up for life.

The Department of Social Services' (DSS) recent changes to NDIS plan variation and reassessments this year mean more children are falling through the cracks. The result is some children who were receiving NDIS support are being reassessed and are no longer eligible; while others, such as those on the autism spectrum, no longer meet requirements. Often children and young people do not quite meet the thresholds of the NDIS but still face significant challenges. According to the disability advocacy and education group, DSC, the NDIA is now conducting an average of 1,200 eligibility reassessments a week – 78% of these affecting children.

Recruitment and retention of workforce

One of the biggest challenges for the rural health sector is recruitment and retention of our allied health workforce. We have an **unwavering commitment to building and sustaining a strong health workforce** for rural NSW; however, this comes at a cost and we receive very limited Government support to do so.

We employ the **largest non-profit allied health workforce in regional NSW**, contributing \$25.7 million in wages into regional Australia in 2024-25. Our multidisciplinary workforce of more than 280 people include more than 100 clinicians in speech pathology, occupational therapy, clinical psychology, psychology, social work, mental health, counselling, Aboriginal health, dietetics and diabetes education, and nursing. Thirteen per cent of our workforce identify as First Nations. We also engage more than 110 clinical subcontractors, including GPs, specialists and allied health clinicians – further increasing our reach.

To support the growth of a skilled health and wellbeing workforce for regional NSW, we embed innovative workforce development models in our services. This includes a structured psychology **internship program** and a **targeted graduate and student pathway** through relationships and written agreements with universities across Australia. In 2024-25, we hosted and provided clinical supervision for 76 clinical students from 20 institutions across 14 disciplines and recruited 10 allied health graduates. Our biggest challenge in providing this support is the **resource commitment required to provide appropriate supervision** for students and early career clinicians.

In addition, we are building an **enabling workforce of VET-qualified professionals** to support the work of our clinical workforce, including Aboriginal Health Workers, Aboriginal Wellness Workers and Peer Workers, designed to build and engage trust in community and enhance clinical service delivery. Both Government and non-profit organisations continue to try and fail at recruiting and retaining staff to skilled roles in rural and remote Australia. We have recognised the benefits of **place-based, earn while you learn models of training** that allow local people to continue to live in their own communities, support their families and gain a qualification that they will use in their community. We collaborated with 12 host employers across 10 Western NSW communities to deliver three cohorts of learners in our Aboriginal Workforce Development Initiative. Engagement was high, with 29 completing the program – 83% graduating with a Certificate III or IV qualification and 100% gaining relevant employment on completion, with half remaining with their host employer.

To support the growth of the health workforce in rural areas, we also advocate and work with our partners to ensure **workforce development is embedded into service model design and commissioning**. This ensures that rather than service delivery being focused on activities and outputs, the model is more focused on delivering strong outcomes.

4. Identify mechanisms that would allow a seamless transition through mainstream systems for all children

The NDIS Review Report recommended creating a more unified and accessible system of support for people with disabilities, not just those within the NDIS. This includes establishing foundational supports for all Australians with disabilities, regardless of NDIS participation, alongside streamlining processes and improving access for all. The report also proposes changes to funding, regulation, and the workforce to ensure sustainability and improve outcomes for participants.

Marathon Health's experience supports many recommendations, but specifically:

- i. National Cabinet should agree to jointly design, fund and commission an expanded and coherent set of foundational disability supports outside individualised NDIS budgets.
- ii. Increase the scale and pace of change in mainstream and community inclusion and accessibility and improve the connection between mainstream services and the NDIS.
- iii. The NDIA, in partnership with the Department of Social Services, and the National Disability Supports Quality and Safeguards Commission, should require early intervention capacity building supports for children be based on best practice principles and evidence.
- iv. Create a continuum of support for children under the age of nine and their families.
- v. Attract, retain and train a workforce that is responsive to participant needs and delivers quality supports.

In our experience, there is a conscious effort happening in rural areas whereby mainstream supports and NDIS providers are working closely together to support children and families. This is particularly so in relation to child and family health nurses working with allied health practitioners.

When funding is not individualised, supports can be provided with more flexibility and this can include building capacity and supporting people to navigate systems and referrals. This is particularly relevant in the cohort of children aged under nine, when working in programs supported with Government funding. Alternate commissioning markets that incentivise providers to work in areas of thin markets are another way to ensure no child misses out. Marathon Health has skilled, willing staff; however, funding and time availability can sometimes be barriers.

To achieve a **blended funding model of childhood early intervention**, we need health care professions to work more closely together, in a **child-centred model**, so that we can reduce the economic burden on the health care system and reduce the out-of-pocket expenses that are proving a significant obstacle for families accessing the therapies their children need.

Enhancing Paediatrics in Primary Care (EPiPC) program

In 2018, the MPHN funded the development of the Maternal and Child Health Strategy. Murrumbidgee PHN launched the strategy in 2019 in collaboration with the Murrumbidgee LHD. The strategy identified there was a need to strengthen the existing GP workforce by increasing the expertise and confidence in paediatrics to encourage the appropriate use of hospital-based resources and increase the uptake of child health screening. The EPiPC program was established in 2021 and comprises three key components:

- i. A community paediatrician
- ii. Five special interest GPs
- iii. Marathon Health's WARATAH for Kids program.

Working together, these components seek to overcome issues identified within the co-design of the program, including limited paediatric knowledge in primary care, inefficient use of specialists, and long

wait times. A 2024 evaluation found that the ongoing co-design of EPiPC meant that it remained responsive and adaptive to the needs of stakeholders and communities:

- **Health equity** – Special Interest GPs are seeing a considerable percentage of their community monthly, with practices seeing between six and 18 percent of their community's child population on an average month. Where appropriate, the EPiPC program supports these children to receive screening and identification of behavioural and developmental issues.
- **Family-centred** – All of the parents / carers engaged in the evaluation spoke positively about the support they had received from their GP and WARATAH for Kids. They felt listened to, involved in decisions about their child, and had confidence and trust in health professionals treating their children.
- **Flexible innovative program components** – WARATAH for Kids has pivoted their operation over time to suit the needs of the program. This has included creating more detailed reports back to GPs and parents; providing parents with referral recommendations and follow up instructions; being flexible around the location and cadence of clinics; and conducting follow up calls or assessments where there are low referrals.
- **Developing rural workforce** – WARATAH for Kids has also built relationships with relevant organisations and specialists to increase referrals and to find creative solutions to issues (i.e. simplifying referral pathways to the NDIS).
- **Effective early intervention** – stakeholders perceived that EPiPC was decreasing wait times for paediatric services, including reducing the number of appointments a child required with a Paediatrician due to information gathered through EPiPC.

Conclusion

In summary, the Thriving Kids initiative will only achieve its promise if these workforce gaps are addressed head-on. **Service quality and accessibility are directly tied to workforce availability:** a child cannot benefit from early intervention if no clinician is there to provide it.

Addressing equity and intersectional issues requires systemic changes to how support is delivered. Our experience demonstrates that investing in local partnerships, culturally competent staffing, and community-tailored service models is essential to reach First Nations and CALD children effectively. By embedding services within trusted community organisations and prioritising cultural safety, previously underserved families are now accessing early intervention supports. These approaches not only improve equity in service access but also build long-term trust and capacity within communities. Continuous collaboration with First Nations leaders and ongoing adaptation to cultural needs will remain critical as the Thriving Kids initiative is implemented, to ensure that **all** children – irrespective of their cultural or linguistic background – can thrive with timely, appropriate support.

Our submission therefore calls for a **dual focus on program funding and workforce funding** – with the latter encompassing training pipelines, support roles, and retention strategies. Strengthening the workforce is not a future aspiration but an immediate prerequisite for success.

As outlined above, there are many **successful, existing local models** in place that are **community-driven and child-focused**. These have trust with community and provide an evidence base of what is needed to deliver impact. We encourage the Standing Committee to consider these models for the benefit of supporting children with permanent and significant disability (and their families) and ensuring the NDIS remains sustainable. By address these issues, the inquiry can help build a resilient, well-supported workforce capable of delivering Thriving Kids across the nation - now and into the future.