National Rural Health Alliance

... healthy and sustainable rural, regional and remote communities

12 October 2022

NATIONAL RURAL HEALTH ALLIANCE

**SUBMISSION TO THE
JOINT STANDING COMMITTEE ON THE NATIONAL DISABILITY INSURANCE SCHEME (NDIS)
INQUIRY INTO THE CAPABILITY AND CULTURE OF THE NATIONAL DISABILITY INSURANCE AGENCY (NDIA)**

BACKGROUND

The National Rural Health Alliance (the Alliance) is the peak body for rural and remote health in Australia. We represent 46 member bodies (see Appendix 1), and our vision is for healthy and sustainable rural, regional and remote (rural) communities. The Alliance is focused on improving the health and wellbeing of the 7 million people residing outside our major cities. Our members include health consumers, health care professionals, service providers, health educators, students, and the Indigenous health sector.

The Australians who live in rural, regional and remote Australia enjoy the benefits of living in smaller communities with a strong sense of community spirit, less congestion and, depending on location, more affordable housing. However, people living in rural Australia have poorer access to health and disability services than other Australians, with the number of health professionals (including nurses and midwives, allied health practitioners, general practitioners, medical specialists and other health providers) decreasing as geographic isolation increases. Per capita, rural areas have up to 50 per cent fewer health providers than major cities. As a result, Australians living in rural, regional and remote areas have, on average, shorter lives, higher levels of disease and injury, and poorer access to and use of health services, compared with people living in metropolitan areas.[i]

The Alliance believes that all Australians, wherever they live, should have access to comprehensive, high-quality, accessible and appropriate health services and disability services. The Alliance does not consider that poor access to disability care and support services, poor health or premature death should be an accepted outcome of living in rural, regional and remote Australia.

DISABILITY AND THE NDIS IN RURAL AUSTRALIA

The proportion of the population who live with a disability is higher outside Major Cities and highest in Inner Regional areas. Approximately 4.4 million Australians, or 17.7 per cent of the population were living with a disability in Australia in 2018[ii]. Geographic disparities (higher rates outside of Major Cities) persisted when data was analysed by age and degree of disability. Of people living with disability aged 0 to 64 years of age, 16.8 per cent live in Inner Regional areas and 12.9 per cent live in Outer Regional and Remote areas compared to 10.4 percent in Major Cities.[iii] Rates of disability are

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higher in Aboriginal and Torres Strait Islander peoples in all geographic areas but highest in Inner Regional areas.[iv]

People under 65 years of age who live with a disability in households in Outer regional and remote areas are less likely to see a GP, medical specialist or dentist than those living in Major Cities. At the same time they are more likely to visit a hospital emergency department.[v]

Relative to the rest of Australia, using the Monash Modified Model (MMM) remoteness classification, Regional Centres (MM2), Large Rural Towns (MM3) and Medium Rural Towns (MM4) have the highest prevalence of NDIS participants, compared to the national average. For example, the proportion of NDIS participants in Large Rural Towns (MM3) is 1.4 times the average across Australia, indicating a higher need for disability services in these areas, related at least in part to the higher prevalence of disability. In contrast, the prevalence of participants in Very Remote Communities (MM7) is 0.7 the national average.[vi] The contributing factors may include lack of awareness of, or ability to access, the scheme by those who may be eligible for the NDIS.

There were 16,417 Aboriginal and Torres Strait Islander participants in the NDIS (as at 30 June 2019), making up 5.7 per cent of all active NDIS participants. The proportion of Aboriginal and Torres Strait Islander participants of the NDIS living in remote or very remote areas is much higher (11 per cent) than for non-Indigenous Australians (1 per cent).[vii]

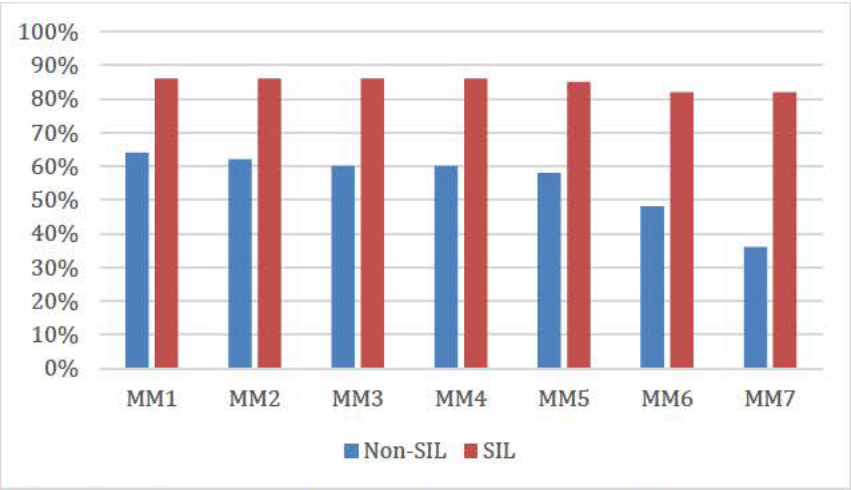
Despite a higher need for disability care and support services in rural areas, barriers to access are evidenced by the reduced use of funds allocated to people living in rural Australia under the NDIS. The Interim Report of the Disability Royal Commission released in 2020, reported that people with disability in rural areas experience a number of barriers to accessing supports. This is particularly the case for Aboriginal and Torres Strait Islander peoples.[viii]

There are shortages of disability support workers across Australia that affect access and use of the NDIS more broadly. Rural people, including those living with a disability, experience a level of access to services that are limited by the available supply of the health workforce in rural areas. The availability of a workforce to provide care and support for people living with a disability decreases with remoteness, including services provided by the allied health workforce and pharmacists. Long travel distances and limited choice of providers also impacts on the availability of support for people with a disability in rural Australia.

NDIS data highlights potential gaps in the availability of disability care and support in rural areas across Australia. For both supported independent living (SIL) participants and non-SIL participants, the utilisation of plan funding declines with remoteness, as shown in Non-SIL supports are those other than SIL, including support with social and community participation, transport and capacity building. Allied health professionals are part of the workforce delivering non-SIL plan supports to NDIS participants.

Figure 1. This is more pronounced for non-SIL participants, compared to SIL participants. Non-SIL participants in remote areas (MM7) utilise only 35 per cent of their allocated plan value, on average, compared with 62 per cent of non-SIL participants in metropolitan (MM1) areas.[ix] Non-SIL supports are those other than SIL, including support with social and community participation, transport and capacity building. Allied health professionals are part of the workforce delivering non-SIL plan supports to NDIS participants.

Figure 1: Average utilisation of supports in participant plans, June 2020.[x]



Source: Participants across remoteness classifications | NDIS, 2020, June 30.

The NDIS Markets Insight Dashboard indicates that there are fewer providers in rural areas, with 80 per cent of the NDIS's thinnest markets located in rural Australia. This suggests that thin markets are a significantly greater issue in rural areas, compared to metropolitan areas. It is important to note that these data include a range of provider types, from very large providers (with a number of employees) through to sole traders, making it difficult to get a clear picture of the services available to rural people.[xi]

WORKFORCE CHALLENGES

The disability care and support workforce is made up of a variety of professionals, with approximately 138,000 full-time equivalent workers across Australia. This workforce includes disability support workers (66 per cent), allied health professionals (10 per cent) and other workforce, such as coaches, fitness instructors and counsellors (24 per cent). Of these workers, 79 per cent of permanent staff work part time and 21 per cent work full time. Twenty-two per cent of workers are casually employed.[xii]

The available workforce declines with remoteness, impacting the ability of providers to deliver care and support in some areas. The greatest shortages are for allied health professionals.[xiii] In addition to workforce shortages, there is also higher demand for NDIS services in Regional Centres/Large and Medium Rural Towns (MM2 to MM4), which have higher relative numbers of NDIS participants than Metropolitan (MM1) areas. This creates further service gaps in addition to those due to workforce shortages.[xiv]

There is also a significant shortage of disability support workers across Australia. Whilst shortages of disability support workers have been reported, there is limited data available on the numbers of disability support workers by MMM area.[xv]

People living with disability and wishing to access the NDIS are asked for evidence of disability and functional impairment as part of completing the 'Access Request Form'. Health professionals play an important role in documenting the evidence for this request. Reduced access to, for example to medical practitioners (GPs, other medical specialists), mean additional barriers to initial access to the NDIS, especially in outer regional and remote areas.

ISSUES AFFECTING DISABILITY CARE AND SUPPORT IN RURAL AUSTRALIA

The experiences of NDIS providers, participants and their families and carers, and the disability care and support workforce in rural Australia differ from those in metropolitan areas. These experiences are shaped by several barriers to the provision of, and access to disability care and support in rural areas. These include:

- Thin markets, limited local provider options and capacity: this means that whilst NDIS participants may have funding to spend on disability care and support, a lack of provider capacity in rural areas means that this funding cannot be utilised.[xvi]
- Considerable travel distances to access or deliver services: this increases the cost of service delivery (noting that the NDIS does accommodate increased costs in their pricing, and also funds some travel time and costs), which may limit support workers willingness to travel to a person's home or community to deliver services. Similarly, long distances, lack of appropriate or accessible transport and support may also reduce participants' ability to travel to and from service locations.[xvii]
- Limited competition among providers and limited choice for participants: large providers may be the only providers in an area, which means that there is little choice for participants, and less "competitive tension" among providers (which may impact on their responsiveness, customer focus, and quality).[xviii]
- Issues with workforce recruitment and retention, leading to shortages of disability support workers and allied health professionals.[xix],[xx]
- Limited access to the benefits of a multi-disciplinary approach to medication management including pharmacists, to help prevent medication complications, improve access to medication reviews and improve medication management overall.
- The process of accessing the NDIS is more complex in rural areas due to a lack of information and advice.[xxi]
- A lack of professional support and supervision for workforce.[xxii]

IMPLICATIONS FOR THE CAPABILITY AND CULTURE OF THE NATIONAL DISABILITY INSURANCE AGENCY

There are two key issues that the Alliance believes require greater focus from the NDIS to ensure equitable access to disability services for people with disability living in rural Australia:

- Addressing thin rural markets
- Improving data on NDIS participants and providers in rural Australia.

Thin markets

In response to a request from the NRHA, the Department of Social Services (DSS) has provided the Alliance with an outline of recent activities with regard to thin markets.

The Alliance was encouraged to learn that the DSS is working with the NDIA and the Australian Government Department of Health and Aged Care to develop an integrated care model that proposes to use more innovative and coordinated approaches to better support the needs of regional and remote communities. The Alliance has been strongly advocating for a rural-specific model of primary health care to overcome the professional, financial and social barriers to attracting and retaining a rural health workforce and would, therefore, support efforts to encourage models of care which better integrate the services that are available in rural communities.

The Alliance's proposed model, currently called Rural Area Community Controlled Health Organisations, is intended to build the rural primary healthcare workforce to improve access to

affordable, high quality, culturally safe care when and where it is needed. This model provides a flexible employment structure enabling the payment of a salary and accrual of attractive employment conditions, it facilitates the delivery of multi-disciplinary care, and is grounded in principles of co-design and strong local governance and leadership. This model is beneficial as it provides a single organisation which can co-ordinate the scarce rural health professional workforce, including primary health professionals such as general practitioners and allied health professionals such as physiotherapists, speech pathologists, occupational therapists etc, so essential not only to primary health but also to the provision of disability services. This co-ordination optimises the utility of these health professionals to better meet the needs of all members of the community, including NDIS participants.

The Alliance would be keen to see greater recognition by the NDIA of the widely held understanding of the longstanding workforce and market failure challenges of providing disability, health and aged care services in rural areas, and less focus on reviews and trials. Regardless of the model of care, the NDIA needs to engage more with rural health stakeholders given the disability, health and aged care sectors are in the business of seeking to attract and retain what is effectively the same workforce, particularly in terms of allied health.

It is important that the capability and culture of the NDIA recognise that rural and remote communities are not just “smaller urban communities” but require different models of care and funding.

Improvements to NDIA data on rural NDIS participants and providers

In seeking to improve its advocacy on behalf of people with disability living outside capital cities in Australia, the National Rural Health Alliance has identified significant data gaps relating to the circumstances and experiences of this group of rural Australians.

The AIHW, in their 2022 report summarising information from a range of sources, commented on addressing data gaps, including:

- enhancing existing data sources to better capture the intersectionality in the disability population, including for those with disability living in rural Australia
- filling gaps where no data currently exists, for example information about mainstream services of critical importance to some people with disabilities (allied health services, e.g. speech therapy).[xxiii]

From the perspective of the Alliance, there is a need for more nuanced information on providers, including by profession/occupation and geography, especially because in thin markets allied health professionals may be working simultaneously across health, disability and aged care.

CONCLUSION

Noting that a disproportionate number of NDIS participants live out Major Cities, and data indicates that the current NDIS service delivery mechanisms are not meeting the full needs of these participants, the NDIA should consider:

- Increasing its awareness of the challenges experienced by NDIS participants, funded providers and individual health and disability care providers in accessing and providing services in thin rural markets
- Acknowledging these challenges in the design and delivery of services in rural areas

- Ensuring that service delivery mechanisms support joint service planning between the health, aged care and disability sectors – noting that in rural areas this workforce is common across all sectors – to better co-ordinate and draw on cross-sectoral resources
- Incentivising providers to enter the disability services market outside capital cities by ensuring funding actually covers the higher costs associated with delivering supports in rural areas
- Developing flexible or alternative funding models, acknowledging that market-driven solutions often do not work in thin rural markets, noting precedents in other sectors, including health, which acknowledge market-failure in rural areas.
- The Alliance would be pleased to discuss with Committee members and the NDIA the model we have proposed for meeting the needs of primary care health services in rural locations which if supported and funded would provide the infrastructure and workforce for greater access to care and rehabilitation services for people with a disability in rural locations.
- Improving the scope and utility of data regarding participants, funded providers, and individual health and disability care providers, outside capital cities to better inform policy development and service delivery to NDIS participants
- Working actively to ensure that living outside a major city is not a justification for being unable to access NDIS services to which a person with disability is entitled.

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Appendix A: National Rural Health Alliance Members (July 2022)

Organisations with an interest in rural health and representing service providers and consumers

Allied Health Professions Australia (Rural and Remote Group)	CRANAplus
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)	Exercise & Sports Science Australia
Australasian College of Health Service Management (Regional, Rural and Remote Special Interest Group)	Federation of Rural Australian Medical Educators
Australasian College of Paramedicine	Isolated Children's Parents' Association
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (Rural Special Interest Group)	National Aboriginal Community Controlled Health Organisation
Australian Chiropractors Association (Aboriginal and Torres Strait Islander Rural and Remote Practitioner Network)	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Australian College of Midwives (Rural and Remote Advisory Committee)	National Rural Health Student Network
Australian College of Nurse Practitioners	Optometry Australia (Rural Optometry Group)
Australian College of Nursing (Rural Nursing and Midwifery Faculty)	Pharmaceutical Society of Australia (Rural Special Interest Group)
Australian College of Rural and Remote Medicine	Royal Australasian College of Medical Administrators
Australian Dental Association (Rural Dentists' Network)	Royal Australasian College of Surgeons (Rural Surgery Section)
Australian General Practice Accreditation Limited	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Australian Healthcare and Hospitals Association	Royal Australian and New Zealand College of Psychiatrists (Section of Rural Psychiatry)
Australian Indigenous Doctors' Association	Royal Australian College of General Practitioners (Rural Faculty)
Australian Nursing and Midwifery Federation (Rural members)	Royal Far West
Australian Paediatric Society	Royal Flying Doctor Service
Australian Physiotherapy Association (Rural group)	Rural Doctors Association of Australia
Australian Primary Health Care Nurses Association	Rural Health Workforce Australia
Australian Psychological Society (Rural and Remote Psychology Interest Group)	Rural Pharmacists Australia
Australian Rural Health Education Network	Services for Australian Rural and Remote Allied Health
Carers Australia	Society of Hospital Pharmacists of Australia
Council of Ambulance Authorities	Speech Pathology Australia (Rural and Remote Member Community)