CONSULTATION RESPONSE

Allied Health Professions Australia

Queensland Productivity Commission

Inquiry into the National Disability Insurance Scheme

August 2020

Allied Health Professions Australia (AHPA) thanks the Queensland Productivity Commission (QPC) for the opportunity to contribute to its inquiry into the National Disability Insurance Scheme (NDIS). AHPA is the recognised national peak association for allied health professions and works with its membership to work collectively represent some 130,000 individual allied health professionals. A significant proportion of those allied health professionals are involved in providing services to people with disability, people who may or may not be participants in the National Disability Insurance Scheme (NDIS). AHPA and its member associations are committed to ensuring that all Australians, regardless of disability, can access safe, evidence-based services to assist them to realise their potential for physical, social, emotional and intellectual development.

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

Allied Health Professions Australia
Level 8, 350 Collins Street
Melbourne VIC 3000
Email: office@ahpa.com.au
Website: www.ahpa.com.au

Introduction

The introduction of the National Disability Insurance Scheme (NDIS) resulted in a major shift in how services for people with disability in Queensland are funded, delivered, and structured. For participants in the NDIS, there are no longer the same rationing issues limiting access to services, choice and control has become a genuine reality for many participants, and decisions about the supports and services in a person's life are far more likely to be participant-driven. For the allied health providers that deliver services to participants in the NDIS, there are now far greater opportunities to support participants to realise their goals and ambitions and to support genuine participation in the community. The allied health sector has welcomed many of the changes resulting from the rollout of the NDIS across Australia and continues to work closely with Australian governments, and their Departments and Agencies, to support a strong, effective NDIS.

While the introduction of the NDIS has been largely positive for people with disability and the broader disability sector, its introduction has been accompanied by a range of issues that continue to affect the Scheme and the experiences of providers and participants. Some of the most significant issues are the result of a shift from state-based services to a largely fee-for-service, market-based system and by ongoing shared responsibility across multiple governments, Departments and Agencies in relation to policy, workforce development, regulation, last-resort arrangements and pricing. From the perspective of the allied health sector, addressing issues that hamper the effectiveness of the NDIS remains more difficult due to the overlapping and at times uncertain responsibility for different aspects of the scheme shared by the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission, and Commonwealth and State Departments of Health and Social Services.

This is perhaps most evident in the ongoing lack of a coordinated disability workforce strategy focused on supporting the growth and development of the disability workforce. While there is strong recognition by governments and the NDIA that the NDIS has brought about a significant increase in demand for services in key areas such as allied health, and recognition that access to NDIS-funded services is hampered by thin markets and workforce maldistribution, there is little evidence that systematic approaches to quantifying and addressing these shortfalls are being developed. Similarly, despite widespread recognition of the need to ensure that practitioners are enabled to gain the skills and experience needed to provide high-quality services for participants, and well-documented evidence that current funding structures are hindering that workforce development, it is not clear that this is being addressed by nationally-consistent, locally-relevant policy responses.

With a large rural and remote population, a geographically widely distributed population, and a significant number of remote Aboriginal and Torres Strait Islander communities, participants and providers in Queensland appear to be particularly impacted by many of these issues. A genuine focus on the allied health workforce pipeline will be essential to ensure participants in Queensland are able to fully benefit from the NDIS and AHPA hopes that the QPC will recognise the importance of driving reform in this area.

Responses to the Issues Paper

In responding to the QPC Issues Paper, AHPA has chosen to focus its response on provider issues and the specific questions outlined in the Short Form Issues Paper – Providers document. Rather than providing direct feedback from the lens of a provider, the AHPA response has sought to amalgamate feedback from a wide range of providers and the individual expertise and experience of our allied health profession members. The AHPA response attempts to focus primarily on system-level issues.

Transitioning to the NDIS

As a provider, how well prepared were you for the introduction of the NDIS? What were the greatest barriers to transitioning to the NDIS? What are the key changes that your organisation has made to operate in the NDIS market? What barriers remain for the scheme to achieve its potential in Queensland? How can these be addressed?

Feedback from the AHPA membership suggests that allied health providers in Queensland have varied widely in their readiness for the NDIS. Many allied health providers registered with the NDIA in the early stages of the NDIS rollout in Queensland with the intention of offering services to participants in the scheme. Provider data from the NDIA and NDIS Commission shows that the allied health sector represents the largest volume of registered NDIS providers, suggesting a high degree of interest in the NDIS. We note that the comparatively larger volume of allied health registrations in comparison with other provider types is in part due to the prevalence of small and solo allied health providers.

Despite the strong interest in working in disability reflected in this high registration rate, data on active provider rates in the NDIS show that approximately half of those allied health providers never provided any services to participants in the scheme. Data also shows that the introduction of new registration requirements with the NDIS Quality and Safeguards Commission further reduced the number of allied health providers registered to provide NDIS services. This disparity suggests that there were significant barriers for many providers wishing to provide services, a view that is supported by feedback from the sector. That feedback suggests that some of the major reasons are were: mainstream practitioners hoping to branch out into NDIS service delivery struggling to understand how to work within the NDIS, challenges in connecting available services to participant demand, issues with the NDIS planning process undermining access to allied health services, a requirement to make significant time investments in supporting participants before being able to charge for NDIS services, and issues with NDIA payment and administration systems.

Many of these issues have been documented in previous inquiries and AHPA notes the importance of recognising how quickly the scheme is changing and the size of the challenge in establishing a new national scheme and supporting providers to adapt to the shift that this represented. However, we also argue that the QPC should seek to further investigate this disparity.

Feedback from the sector also suggests that while there has been significant investment in supports to help providers transition, there may not always have been a strong awareness in the allied health sector about which supports were available and how to access these. An overall lack of apparent coordination between programs funded by DSS through the Sector Development Fund, the Jobs and Market Fund, the Boosting the Local Care Workforce (BLCW) program, state-based programs, NDIA ILC grants and other grants has led to frustration about the ineffectiveness of the investment made. Many practitioners still do not feel they have access to the services and supports needed to help them operate within the NDIS particularly first-time entrants into the scheme.

Supply of services and supports

What are the most important factors that affect your decision to supply into the NDIS market? Is market information sufficient to inform your decision-making about services/supports to offer and your service locations?

Allied health providers report that some of the most important factors influencing their decision to provide supports into the NDIS market is their understanding of how to set themselves up to provide services as an NDIS provider, and their ability to invest in meeting provider requirements imposed by the NDIA and the NDIS Commission. For providers that have participated in delivering services within the NDIS, the major factors are their ability to derive a sustainable income while addressing the significant non-face-to-face and unbillable aspects of working within the scheme that many providers report. This includes working with participants to advocate for services where planning processes fail, chasing payments, adjusting service bookings when the NDIA introduces scheme-wide changes such as pricing indexation, limitations in charging for travel, and achieving registration with the NDIS Commission. The other key factor for many practitioners is the volume of services they are likely to provide NDIS clients—where practitioners are not expecting to provide a high volume of services, many report that the requirements to participate in the NDIS market are too costly and onerous to justify participation.

The improvements made in developing market forecasts and market information to support providers in making decisions about providing services have been welcomed by the sector. Resources such as the BLCW Demand Map[i] and the NDIA-developed Market Position Statements[ii] have the potential to support providers in making decisions about where to provide services and where there may be opportunities to expand. However, despite the potential value of these resources, providers report uncertainty about how best to use these documents as they are high-level projections and limited by lacking live NDIA data about the range and type of participants, including whether participants are self-, plan- or Agency-managed, and the current availability of services. Allied health professionals seeking to understand current available services would generally look at either the Therapeutic Supports or Early Childhood categories. This only shows them the raw volume of providers, without providing Equivalent Full Time (EFT) data or the specific profession. It is also important to note that many providers report a lack of awareness of the information available to them.

Perhaps even more importantly, the allied health sector argues strongly that there are significant limits to the extent to which the market can be relied on to deliver services. Many rural and remote regions have long-standing issues recruiting stable workforces, even where providers are able to offer full-time, ongoing employment. AHPA argues that it is highly unlikely that the open market can address the need for lower-volume, niche services without additional targeted efforts to support providers to bring services to a region.

This is exacerbated by the lack of genuine data in relation to areas of market shortage or workforce maldistribution, which is addressed in greater detail below. AHPA recognises the important work of the NDIA Thin Markets team and the work the NDIA has undertaken in relation to established workforce shortages, and we understand that direct engagement with providers to encourage them to move into new service delivery areas appears to be successful. However, AHPA and its members are concerned that the NDIA Thin Markets work is picking up only some of the gaps and shortfalls in available allied health services. We argue that a more comprehensive approach is required, based on accurate, sufficiently granular workforce data, which considers both current and projected need, and which then seeks to work with the provider sector to identify where a market-based approach is insufficient.

AHPA also argues that commissioning and other approaches to market gaps should be underpinned by longer-term workplace development initiatives led by Australian governments. It is not clear that gaps being identified by the NDIA are then translating to targeted initiatives to build sustainable, long-term access to relevant workforces by Australian governments. We note our recognition that some areas, such as remote indigenous communities, are likely to always require market interventions.

AHPA also notes regular contact from 'mainstream' allied health practitioners, who have been contacted by NDIS participants to provide services. These practitioners represent a potential workforce for NDIS participants, however they can face significant knowledge barriers, as well as regulatory and/or administrative barriers, to providing services for people with disability due to the time and knowledge required, the logistics and cost of registration processes, and the potentially limited volume of disability services they are likely to provide. We argue that this demonstrates the need for more than just market information and recommend investment in cross-profession resources to support practitioners to understand and manage the requirements of entering the NDIS marketplace.

What differences arise from self-managed plans compared to plan- or agency-managed plans? Which types of providers or services/supports are in short supply? What are the key barriers to increasing your capacity to deliver services into the NDIS market in Queensland? Does the NDIS market reward efficient/effective providers? Are those operators thriving at the expense of less efficient/effective operators?

AHPA argues that there are significant differences that arise from the relative lack of restrictions on self-managed plans compared to plan- and agency-managed plans. These arise primarily in relation to equity of access for participants. The need to register with the NDIS Quality and Safeguards Commission is a significant financial and administrative burden for providers and one that, anecdotally, many of the more established and experienced providers are now choosing to avoid. Under the current system, providers that choose not to register avoid not only the cost of registration but have far greater freedom to negotiate costs. Those providers also avoid some of the administrative costs associated with engaging with the NDIA. Where those providers have sufficient demand for services, that creates a significant disincentive to support Agency-managed participants and, to a lesser extent, plan-managed participants. This in turn may result in less choice in relation to services for those participants that cannot or do not wish to self-manage, or may leave participants and their families feeling under pressure to self-manage even where this might not be in their best interest.

The market-based approach of the NDIS rewards providers that are able to provide services at the lowest cost, though this is not necessarily the lowest cost to the scheme or individual participants. This is quite different from rewarding the most effective outcomes or the best participant experiences. Importantly, it also provides no direct incentives for training new graduates and helping practitioners gain experience in providing services to people with disability. Providers consistently report high costs even for new and inexperienced staff that make the investment involved in appropriate training and supervision difficult for providers to sustain. Some providers also report investing in inexperienced staff, only to have those leave to set themselves up independently after having benefited from the support and training offered by the provider.

The impact of these factors is that those providers that are most focused on providing equitable services to all participants, and on training and supporting new entrants to the workforce, can experience significant financial disincentives as from the perspective of a market-based approach,

these providers are being less efficient. This appears to be at significant odds with the intentions of the Scheme more broadly, and the intention of having a Quality and Safeguarding Framework.

Do you provide other services to persons with disability outside of the NDIS? Are there economies of scope—where providing other services gives you a cost advantage in providing NDIS services? What are the key barriers to entering the NDIS market for those who operate outside of the NDIS, such as in aged care or health services?

Allied health providers more commonly focus on providing services under a particular funding program rather than working across schemes though this will vary depending on the individual profession and whether there is sufficient demand for disability services. Some providers may also work in both education settings and private practice to support children with disability, while others may work across several unrelated funding programs. Generally speaking, allied health businesses are likely to experience significantly increased costs for each system within which they may offer services due to the variation in requirements and approach between each. This may include differing regulation requirements to participate in the scheme, differing structures in relation to reporting and service delivery structures, differing payment systems and processes, differing referral pathways, and even different determinations of which professions can offer services.

For those operating outside the NDIS, there are significant barriers not only to understanding how to operate within the scheme and within a disability framework, but also barriers associated with registration and ongoing compliance with the requirements of the NDIS Commission. There is a risk that new regulatory requirements will be introduced to address some of the issues currently being identified within the aged care system and this will only exacerbate the challenge of working across systems. AHPA and its members have long advocated for consistent requirements across schemes, whereby professional accreditation or registration requirements are based on the services being offered rather than who is funding those services.

This would reduce the current inconsistency in our health system whereby a provider may provide services to a person with disability as long as they are funding those services themselves, however if they are accepted as participants in the NDIS, they can no longer access those services. For example, a young person with autism spectrum disorder can access services privately or through Medicare from any appropriate allied health professional who meets the regulatory requirements of their health profession. Similarly, an NDIS participant that is self-managing their plan or who has a plan manager can also access an allied health professional who is meets standard regulation requirements. However, a participant that is Agency-managed can only access a provider that meets the additional regulatory requirements of the NDIS Commission. The apparent risk profile here is based on the funding source rather than the participant. It is not at all clear why one set of regulatory standards is sufficient to protect consumers who access care for services not funded through an Agency-managed plan. If changes resulting from the current aged care Royal Commission result in a new and separate regulatory scheme, this issue will be further exacerbated.

We argue that health practitioner regulation requirements for allied health professionals have been established to protect any potentially vulnerable health consumer and, if there are limitations identified in these broad safeguards, they should be addressed for all cohorts by making changes to the requirements for normalprofessional regulation rather than adding additional layers of diseparate regulation.

We note in this context that each additional layer of regulation adds more complexity and uncertainty about which regulator is ultimately responsible for addressing issues with the risk that

ultimately no one takes responsibility or that a practitioner is sanctioned in one scheme but can continue to work in others.

What are the key sources of uncertainty for your organisation?

A number of allied health providers report that while they may have strong demand for services, they continue to experience significant uncertainty about their own sustainability and ability to provide services under the NDIS. This is often reported as resulting from the high rate of change occurring within the scheme. For example, pricing adjustments may be made as part of regular adjustments and which can make a functioning business model suddenly become unsustainable.

A recent example of pricing rules impacting provider viability is the change to telehealth funding under the NDIS. The change meant that rebates for services shifted from being determined on the basis of the participants location, to being based on the location of the provider. This had the effect of removing rural loading for services provided to rural participants in MMM6-7 regions by providers based in a non- or less rural location, which undermined the model of investment in outreach and family support developed by some providers. While the telehealth rules have since been adjusted to allow some degree of flexibility in relation to funding, and are likely to be examined further as part of future price reviews, they provide an example of where businesses that had been established around a particular pricing structure found themselves potentially unviable when the price guide was released at the beginning of June with no forewarning.

While AHPA and its members recognise the need for the Scheme to evolve and shift, and commend the NDIA on its ongoing commitment to improvement, we argue that there are real risks associated with the rapid rate of change and the lack of support for providers to understand and adjust to changes. Similarly, there appears to be little recognition that changes made by the NDIA can trigger very significant administrative costs for providers. This is often the case when NDIA changes require providers to update all service bookings.

Allied health providers also report that many still experience a degree of uncertainty in relation to receiving payment for services rendered to participants with plan-management. It appears that plan managers are not always advising participants and providers when funding has changed, such as through a plan review or because funds have been spent on other services, resulting in services being delivered despite participant budgets already being exhausted. This then results in participant debts that providers do not feel they can chase from participants, but which the NDIA does not take responsibility for. A more effective system to manage payments and participant budgets would address this for participants.

Thin markets

Which services and supports have demand greater than supply? What are the key barriers to meeting those demands? Are there critical services where a lack of availability affects the demand for related services? If so, what are these? From your perspective, what barriers do participants face in finding providers and utilising their plans?

AHPA argues that there are significant structural impediments to responding to questions in relation to thin markets. These impediments must be addressed so that participants, providers, and governments can be confident in understanding and addressing areas of market shortage.

AHPA has long argued that the most important foundation for understanding the current and future NDIS workforces is a linked up workforce data set, which draws from all available sources held by

governments and regulatory bodies, that can be used by both policymakers and funders to identify gaps and shortages in access to providers. From our perspective, a national workforce dataset is urgently required for the allied health sector, which aggregates and integrates all current data sources to form a meaningful overall picture of the Australian allied health workforce at national, regional and local levels. This data set will need to incorporate not only current disability providers but also the broader private and community-based allied health workforce as these are an important potential NDIS workforce, particularly in areas where there is only likely to be a low volume of NDIS services required. It will also require the ability to identify where additional granularity is required in order to provide meaningful data about available services. For example, do participants in a particular area require providers with the experience and skills need to support CALD or Aboriginal and Torres Strait Islander participants? Are providers in a particular region registered with the NDIS Commission and how does this impact access to services? That data in turn must be matched against participant demand for services, not just underutilization of plans. Some mechanism for allowing planners, support coordinators, LACs and providers themselves to flag shortages should be developed to guide workforce planning as well as the work of the NDIA thin markets program.

AHPA argues that some of the key barriers to meeting allied health demand arise from the lack of a disability specific workforce pipeline, informed by available data about current service provider numbers, participant data, and graduate numbers, and supported by programs to address identified areas of shortage. It is clear that there are areas with significant workforce shortages that struggle to attract and retain practitioners, though without the data set referred to above, it can be difficult to precisely identify thin markets. AHPA argues that these are not yet being addressed strategically with a view to both short-term and long-term need. While scholarship programs and other incentives to attract practitioners can be an important short-term means of improving access in regional and remote areas, these programs typically struggle to address longer-term access issues. In addition, these programs are typically focused far more heavily on medical and health-based workforces meaning that there are few viable options to address allied health shortages.

AHPA strongly supports the recommendations of the Rural Health Commissioner in relation to rural and remote allied health workforces, which have identified the need to go beyond scholarship programs and to focus on improving opportunities to train in place and to attract rural students to health training programs. We argue that a wide range of programs and research initiatives have established that the most effective mechanism for increasing rural workforces is increasing opportunities to study, and to participate in student placements, in rural environments. As such it is disappointing to see a lack of investment in initiatives that focus on opportunities to access rural training and placements for the allied health disability workforce and AHPA argues that these should be developed as a matter of urgency. We note that such initiatives should not only be limited to rural and remote regions. The Modified Monash Model (MMM) is not always a reliable predictor of allied health service availability, and many regional areas also experience shortages. In addition, AHPA is aware that some types of allied health service are undersupplied in some lower socio-economic metropolitan areas, and initiatives to address these shortages are also important.

AHPA has strong concerns that Australian education funding is not tied to workforce need with the result that there can be significant oversupply of allied health graduates in some areas, while regions with major workforce shortages can lack allied health courses for key professions. Through engagement with universities seeking to offer courses in areas of shortage such as Tasmania, AHPA is aware that it can be very difficult for universities to fund the delivery of courses despite established workforce needs. With the significant additional pressure universities are currently experiencing as a result of the COVID-19 pandemic, AHPA is concerned that there will be even greater emphasis on the most profitable courses. AHPA argues that urgent policy change is needed

to ensure that our education system is able to respond to current and future workforce needs, and that universities are funded to deliver education where it is most needed rather than where it is most cost-effective or profitable. The current disparity between where practitioners are trained and where they are needed results in a need to incentivise health professionals to move from metropolitan to rural regions, an approach that has been shown to be relatively expensive and ineffective as a longer-term solution. AHPA also reiterates our concern that there are no current programs focused on attracting an allied health NDIS workforce into areas of workforce shortage such as are provided for other professions working within the health sector such as general practice through the General Practice Rural Incentives Program (GPRIP).

Finally, AHPA also argues strongly for the need to support practitioners to build skills in areas of skills shortages by developing programs that allow experienced practitioners to mentor and supervise less experienced practitioners from within their profession. For example, AHPA is aware of shortages in some rural areas of occupational therapists with experience prescribing complex assistive technology. The NDIS currently lacks the ability to connect and fund expert practitioners from other regions that could support local occupational therapists to build their skills and experience in this area, and it is not clear that any other government agencies are focusing on enabling skills improvements in this way.

Regulation issues

Are the registered/unregistered provider requirements effective and efficient? If not, why not?
What role do NDIS regulations play in your decision to be a registered or an unregistered provider?
What resources are required to comply with NDIS price and quality regulations?
What impact do differences in the requirements for registered and unregistered providers have on your sector of the NDIS and on the level and quality of supports for participants?
What impact does regulation have on innovation?

AHPA argues that the current registered/unregistered provider requirements are neither effective nor efficient. From the perspective of efficiency, AHPA argues that the provider marketplace should be as large and diverse as possible to ensure that participants can make decisions about the services that they access. We argue that it is counterintuitive to have the most expensive and complex registration requirements in areas of market shortage despite recognising the need to manage higher risk registration categories. This is the case with the certification requirements for behavior support practitioners.

AHPA further argues that while the foundations of the registration scheme provide the potential to be effective as an overall means of ensuring quality and regulating providers, this is undermined by the ability for providers to work within the scheme as unregistered providers. In arguing that current requirements are not efficient or effective, AHPA notes our belief that these issues do not result from any failures on behalf of the Commission. We also recognise the benefit of rigorous safeguards. However, we argue for the need to address the tension between a system based on an open market of providers opting in to provide services and the need to impose onerous requirements on registered providers.

It is clear from the work undertaken by AHPA on a registration support project funded by the NDIS Commission, that there is significant uncertainty among providers about the long-term value of registration in relation to access to a sufficiently large market of NDIS participants. Providers consistently report that the decision to register is based more on concerns around equitable access to their services than on concern about attracting clients, the exception being those areas of service delivery where registration is a requirement.

From the perspective of the sector, this is a concern as providers report significant investment of time and money is required to comply with registration requirements. While anecdotal feedback suggests that providers do benefit from the investment in more robust systems and quality processes as part of preparing for registration, it is not clear that this offsets the costs involved. The allied health NDIS provider sector consists to a very large extent of solo and small providers—COAG Disability Reform Council data suggests that just under half of all providers of therapy services are solo providers. For solo and small providers, staff resources consist almost exclusively of practitioners involved in delivering services and generating an income for the business. That means that any time invested in preparing for and complying with registration requirements directly impacts income for the business. Providers report that this can represent several weeks of work in total which can quickly represent $10,000 or more of lost income. This can then be further exacerbated by third party audit costs ranging from $1500 to $15,000 depending on location and registration category.

Given the relatively new nature of registration with the NDIS Commission, particularly in those jurisdictions that only joined the new regulatory scheme on July 1st, 2019, AHPA argues that it is not yet clear what long-term impacts registration requirements will have on the market and on the overall quality of services. Many of those providers choosing not to register are experienced practitioners who are able to attract sufficient demand for services on the basis of the quality of their services. However, this does not automatically have to be the case, particularly in areas of workforce shortage. We note that while the Commission is undertaking significant work to identify and support quality improvement in the sector, it is not clear to what extent providers will engage with this work where it is voluntary and not imposed through regulatory requirements.

Given the capacity to deliver services either as a registered or unregistered provider in most areas of allied health service delivery, AHPA is not aware of any impact (positive or negative) on innovation. We instead consider pricing constraints a much more significant factor in impacting innovation.

Regulation of prices

Is price regulation effectively and efficiently achieving its objectives? If not, why not? Is the framework for setting prices robust, transparent and accountable? What influence does price regulation have on the supply, types and quality of services/supports you offer? How does price regulation in the NDIS compare to other non-NDIS 'markets' that you operate in (such as non-NDIS disabled services, aged care or health services)?

Despite previous challenges in relation to NDIS price-setting, AHPA now considers the NDIS approach to price regulation is broadly achieving its objectives in ensuring participants are able to access appropriate allied health services. Prices appear to be sufficient to cover the provision of services at a rate that is competitive with other schemes and pricing issues generally appear to relate more to areas such as travel or non-face to face aspects of service delivery than hourly rates. AHPA considers the approach taken by the NDIA during the last two rounds of price-setting as close to best practice as we're currently aware of in any sector—price-setting is based on the real price of comparable services in the open market, consultation is undertaken with the provider sector to understand where NDIS services may attract additional costs or where other complexities may play a role, and prices are regularly reviewed.

The overall price setting process process is considered reasonably transparent and accountable, though AHPA notes that at times the NDIA and or Australian government appears to make decisions without the same level of accountability or transparency as the annual price review itself. Recent

examples include the decision to provide a transition process for the funding of group supports provided by non-allied health providers, and the decision to provide Personal Protective Equipment (PPE) funding via participant plans for core supports but not for therapy supports. Even more significantly, the NDIA continues to set a different rate for Exercise Physiology, despite similar education and experience requirements, and pricing rates in other schemes or on the open market being broadly consistent with other allied health professions.

Engagement with a wide variety of allied health providers in preparation for the most recent annual price review suggests that price regulation in relation to travel is significantly impacting the capacity of providers to deliver supports to some participants. While the sector recognises the complexity of setting travel provisions, and the need for these to be shared between participants, the impact of these provisions on providers is that service delivery can become unviable and/or so administratively complex as to make it untenable for providers. This impacts access to services for participants.

AHPA strongly supports the approach taken by the NDIA in determining prices and contrasts this with the seemingly arbitrary nature of cost-setting for allied health services under Medicare and a lack of price adjustment in many schemes in response to inflation. The allied health sector has undertaken significant advocacy work with government funders and statutory agencies to address low rates of pay, particularly in schemes such as DVA. There is significant concern in the sector that rather than emulating the approach taken by the NDIA, other schemes may be seeking to encourage lower rebates under the NDIS to reduce pressure on their own schemes.

Regulation of quality

What are the trade-offs between quality regulation and prices/price regulation? How well aligned are price and quality regulation?
How might the quality of provider services, and the management of risks to participants, be better regulated?
How do the regulatory requirements for quality in the NDIS compare to other non-NDIS 'markets' that you operate in (such as aged care or the health sector)?
How does quality regulation affect your ability to provide innovative services?

AHPA does not consider that there is good alignment of price and quality regulation or alignment between the work of the NDIA in relation to pricing, and the NDIS Commission in its role as regulator. While AHPA recognises that the two agencies can and should focus exclusively on their individual remits—that is paying the cost of appropriate services, and ensuring that services are safe and of an appropriate level of quality—the current structure does not reward or acknowledge quality in the remuneration providers receive. In a mature scheme, this regulation of quality may be driven to some extent by participant choice and a willingness to pay higher prices for higher quality services, however this is heavily dependent on highly informed and experienced participants. As such it may not ever be realistic to expect price and quality regulation to align.

AHPA instead argues for a re-think of quality regulation more generally, particularly in light of the NDIS workforce and the needs of the broader community. While we broadly support the work of the NDIS Commission to regulate quality, and recognise the value of having an organization that can lead sector-wide quality improvement programs, we continue to argue against quality regulation of providers on the basis of the funding scheme that pays for those services. Many people with disability access services outside the NDIS, while other cohorts of consumers, including older Australians or those with complex mental illness, may equally benefit from appropriate quality and safeguarding frameworks in place.

As such we argue for an approach that works within the framework of health practitioner regulation, and uses the structures of the National Registration and Accreditation Scheme (NRAS) as well as those regulatory services provided by self-regulating professions to manage their health workforces. This has the benefit of ensuring that regulation is provided by those organisations with the best clinical understanding of their professions. It also ensures that responsibility for regulation sits with a single body, which reduces the likelihood that issues are overlooked due to uncertainty about where responsibility sits, is attached to a practitioner's registration, and provides a clear regulatory processes for consumers who may otherwise be unsure where to raise complaints and concerns. The latter is particularly beneficial given that consumers with more complex needs may access services that are currently regulated by a range of different bodies.

This would also ensure that the regulatory requirements of the NDIS better align with those of other systems and schemes. We note that participation requirements for other schemes and funders such as Medicare, the Department of Veteran's (DVA) affairs, Workcover Queensland and private health insurers typically require only the completion of a registration form and evidence of registration with the Australian Health Practitioner Regulation Agency (AHPRA) or the relevant self-regulating health profession. Both Medicare and DVA provide additional support for practitioners starting in their schemes through online training resources that provide advice in relation to the requirements for practitioners.

Even where funders require additional checks, such as is the case in aged care, requirements typically do not go beyond evidence of registration as a health professional, a police check, and adherence to the Charter of Aged Care Rights. Of note is that while the requirements for registered NDIS providers are far more rigorous, unregistered NDIS providers may choose not to even register with their health profession as the NDIA/NDIS Commission do not require this of self-regulating health professionals such as speech pathologists. As a result, those health professionals have no requirements for ongoing continuing professional development and are not bound by any other requirements imposed by their health profession such as profession-specific codes of conduct.

AHPA is not aware of any way in which quality regulation directly limits innovation, though we note that working with self-managing participants, and thus broadly outside the NDIS regulatory framework, provides additional flexibility for providers and families and may in turn better support innovation.

Working in the NDIS

What are the barriers to workforce development? What are the key challenges facing the industry in attracting staff? What developments in the labour market have affected your ability to find and retain the workers you need to support service delivery into the NDIS?

The AHPA submission has outlined what we consider the most significant barriers to allied health workforce development—insufficient and incomplete workforce data to support understanding where workforce development initiatives are required, misalignment of education program locations and workforce shortages, a lack of programs to address workforce issues, a lack of clear accountability for the funding and oversight of a national workforce strategy, and a lack of focus on supporting providers to enter the scheme as well as high costs of registration. In addition, AHPA also argues that one of the most significant barriers is the high cost of providing student placements and supporting early career development in private practice in the disability sector.

One of the challenges inherent in the structure of the NDIS is that funding is paid from a participant plan for the delivery of services that meet the needs and wishes of the participant. That structure has major limitations in that it only funds direct service provision and limited additional non-face to face services such as reporting where these are agreed by participants in service agreements. As a result, the system currently relies entirely on the provider being able to self-fund training of staff. Feedback from the sector suggests that this is often not realistic and not sustainable given the cost of training and the impact of workforce demand even on wages for newer graduates. If providers cannot earn the margins required to support appropriate training and supervision, they are left with either the option of reducing the level of support and supervision they provide, which results in less well-trained staff, or ceasing to provide entry-level employment. Neither option best supports participants and participant outcomes.

Many of those same issues also impact the availability of student placements. While participants can agree to having services provided by students, there is not necessarily any incentive for doing so without some reduction in costs or other benefits offered by the provider. From a provider perspective, there may be significant costs associated with negotiating service agreements and any changes to the cost of service provision impact their own incomes. We note that current NDIA guidance states: *consent should be documented in the service agreement between the provider and the participant, and the arrangement results in added flexibility (e.g. lower hourly rate or additional hours of service) for the participant*[iii]. Given the short duration of most student placements, this is a significant administrative barrier that carries financial penalties for the provider.

Good student placements also involve significant time preparing the student and then providing feedback before and after a consultation, time that is not likely to be balanced out by any reimbursement afforded to the provider by a university. This is contributing to the limited nature of student placements in private practice disability settings and more broadly in other private practice settings, with the result that students are increasingly dependent on hospital-based placements that do little to provide exposure to the areas of practice in which they are most needed. This is particularly frustrating given evidence showing that the right student placements in the right settings can be an important means of attracting the future workforce to areas of work and geographic settings that those students may not otherwise consider.[iv]

AHPA argues strongly for the development of coordinated government programs that identify ways to ensure that the disability funding system can support both student placements and early career development of the workforce with a focus on appropriate supervision and mentoring. We argue that this should be developed separately from the funding of service delivery through the NDIS and instead be seen as an investment by government in the long-term development of the disability workforce. We propose that this arrangement would see funding for providers that opt in and meet program requirements by making a commitment to providing targeted on-the-job training and development for new graduates.

Such a program could be designed so as to also allow targeting of training where skill gaps are identified. For example, AHPA understands that there are significant workforce shortages in relation to allied health professions with the skills to support behaviour management or prescription of complex assistive technology. Both of these skills shortages will only be resolved by ensuring that allied health professionals with the necessary base skills and qualifications are able to gain on-the-job experience through strong supervision and mentoring arrangements. The proposed approach would be an effective way of supporting a flexible and sustainable approach to workforce development, focused around that practical, workplace training. Should government consider implementation of such a program, we encourage consideration of whether it is appropriate to do

so in conjunction with other initiatives being considered to increase access to student placements, such as the current work of the National Rural Health Commissioner highlighted previously.

AHPA notes that demand for allied health services is increasing across all sectors including health, disability, and aged care. This is impacting the availability of allied health staff, particularly where other sectors may have lower barriers to entry or better remuneration. While the NDIS offers competitive remuneration rates, disability is not always recognised as a potential area of work for graduates and is likely to compete with what may be considered more prestigious options such as elite sport. For providers seeking to establish a business, there can be a perception of higher barriers to entry as well as higher transactional costs compared to other sectors. This view is reflected in the Australian Government's *Growing the NDIS Workforce and Market*[v] report, which found that barriers associated with attracting people into the NDIS workforce include low public awareness of NDIS job opportunities, misperceptions about working in the sector, and competition from similar sectors.

---

[i] https://blcw.dss.gov.au/ndis-demand-map/

[ii] https://www.ndis.gov.au/providers/working-provider/market-information/market-position-statements

[iii] https://www.ndis.gov.au/providers/working-provider/allied-health-professionals/allied-health-practitioner-students-and-provisional-psychologists

[iv] https://www.saxinstitute.org.au/wp-content/uploads/The-costs-and-benefits-of-providing-undergraduate-student-clinical-place....pdf

[v] https://www.dss.gov.au/sites/default/files/documents/03_2019/220319-ndis-market-and-workforce-strategyacc-ij5665.pdf