Claire Hewat and Gail Mulcair, Allied Health Professions Australia

DR KAREN HOOPER:
Welcome back. We'll now move on to our second presentation in our program today from Allied Health Professions Australia. And I'd like to welcome Claire Hewat and Gail Mulcair, who are joining us from Melbourne today. So welcome Claire and Gail, I'm really pleased that you're able to join us. I'll hand over for you, to make your presentation. Before you do so, would you please identify yourselves, your name and your organisation for the transcript, thank you.

GAIL MULCAIR:
I'm Gail Mulcair, I'm the Chair of Allied Health Professionals Australia.

CLAIRE HEWAT:
I'm Claire Hewat, I'm the CEO of Allied Health Professions Australia.

DR KAREN HOOPER:
Thank you.

GAIL MULCAIR:
Thank you, Dr Hooper and commission members, for the opportunity to appear before you today to speak on behalf of Allied Health Professions Australia and the 130,000 Allied Health Professionals that we collectively represent. I'm here in my role as chair of Allied Health Professions Australia, and I'm also the CEO of Speech Pathology Australia. And I'm accompanied by the CEO of Allied Health Professions Australia or AHPA, Claire Hewat.

My intention is to provide a few opening remarks outline on the key issues identified by (INAUDIBLE) in its two responses to this inquiry. We welcome any follow up questions that you might then have. The introduction of the National Disability Insurance Scheme fundamentally transformed the delivery of disability services in Queensland. The addition of new funding and a new focus on participant choice has improved the lives of many participants, as well as providing new and expanded opportunities for providers.

The scheme has matured quickly, and many early issues are being addressed. We welcome the significantly improved level of engagement with the allied health provider sector over the last two years, which has provided increased opportunities for consultation in areas such as pricing and policy changes. Despite these positives, AHPA considers there to be several key issues that negatively impact the scheme.

These are: One, equitable access to the scheme for people with disability. Two, inconsistent and variable planning outcomes. Three, supply and workforce issues. And four, provider regulation and sustainability. And we were pleased to see the QPC addressed many of these issues in the draft report. So to expand briefly on each, firstly, equitable access to the scheme. AHPA welcomed initial proposals to introduce independent assessments as the entry to the NDIS. We remain cautiously supportive of a consistent NDIA funded assessment process to support access to the scheme.

However, under current proposals, there is a risk that access will not improve due to the the burden of proof that potential participants are required to provide before being eligible for the independent assessment. We're also concerned about whether the proposed new assessment process will

address the access issues experienced by Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, people with psychosocial issues and people with communication and cognitive disabilities.

Our view is that there should be capacity for a more flexible approach within a nationally consistent assessment process to consider varying participant capacity and be informed by continuing consultation with the Allied Health peaks. Secondly, inconsistent planning outcomes. The planning process is critical to the success of the NDIS. However, planning and the experience and knowledge of planners remains inconsistent, and continues to impact access to appropriate services and assistive technology.

AHPA has significant questions about the capacity of planners to provide coaching to participants while these inconsistencies have not yet been addressed. We remain similarly concerned about new proposals around independent assessments and flexible budgets that will create significant changes to the planning process. AHPA is concerned that there has not been sufficient testing and evaluation of the independent assessments to support a national rollout. AHPA particularly questions the current proposal to have independent assessments generate fixed plan budgets with limited capacity for these to be varied during the planning process.

And it's not at all clear how this process will support participant choice and capacity to have individual goals that may have significant impact on the necessary plan budget. Thirdly, in terms of supply and workforce issues. The Allied Health workforce is an important provider of services to people with disability. Yet, there's clear evidence that many participants experienced issues accessing Allied Health services, despite having those Allied Health services recognised within their plan and their budget.

Many of these barriers particularly impact participants and providers in Queensland, due to the proportion of people living in rural and remote areas where Allied Health workforce is particularly limited. While the need to expand the Allied Health workforce has been well established, current proposals such as the Department of Social Services-led NDIS workforce plan and proposals within the QPC draft report rely on the market to grow independently to meet demand. AHPA upholds a strong view that provide a market information to the provider sector will not be sufficient and that a dedicated multi-sector Allied Health workforce plan is required, which mirrors similar medical workforce plans.

Such a plan would need to be supported by a dedicated funding for a range of targeted initiatives to address workforce gaps. And those gaps include limited capacity to identify areas of workforce shortage due to a lack of workforce data collection by any government and lack of detailed reporting on unmet participant demand. Also, a lack of programs directly targeting workforce maldistribution, including a lack of scholarship or incentivisation programs to attract practitioners to rural areas. A lack of targeted engagement with the education sector to increase access to Allied Health university courses in areas of Australia with significant workforce shortages.

And also, a lack of student placement opportunities in private practice, particularly with providers of disability services. Barriers in funding structures that limit ability for early career graduates to be supported in developing disability specific experience and expertise through appropriate supervision

and mentoring. And lastly, limited current opportunities to use technology such as telepractice to address supply issues. So while we welcome the QPC recommendations around thin markets, our view is that more significant measures are required to address long term supply issues for people with disability and adjacent markets. And our last point is in relation to provider regulation and sustainability.

While the NDIS provides significant opportunities for Allied Health providers, it also provides significant regulatory barriers for those wishing to provide services as a registered NDIS provider. (INAUDIBLE) continues to receive feedback around high audit costs associated with registration, with these particularly impacting providers in regional and remote settings may pay higher overall rates and are required to cover flights and accommodation costs to the auditor.

AHPA understands that an increasing number of established providers are choosing not to register and to extend only provided services to plan-managed or self-managed participants. In addition to formal registration requirements, providers are also increasingly being expected to implement capability frameworks and other training outside of their own professions, continuing professional development requirements and regulation as health professionals. Allied Health providers also report significant uncertainty about their future in the scheme due to the high rate of change.

They also note the high administrative burden that arises from changes, and unintended consequences from NDIA initiatives. In many cases, providers need to do significant unpaid work with very little notice when the NDIA introduces policy changes and updated price guides, as examples. Currently, there's significant anxiety in the sector about current proposals around changes to early childhood intervention and the introduction of independent assessments and flexible budgets, which each may have significant ramifications for providers.

While the NDIA is increasingly consulting on changes and providing increased information to providers and participants, many changes do not provide the sufficient time and support to help the sector understand and implement these. AHPA welcomes QPC draft recommendation 15, proposing a provider guarantee as a means of increasing provider confidence about the scheme. AHPA will be keen to see a provider guarantee included commitment to provide clear information to peak associations, and providers about upcoming changes with an appropriate amount of notice to support providers and members to implement changes.

We would also like to see an increased focus on supporting providers to implement NDIA policy through expanded educational resources. Allied Health and other peak associations are underutilised and have a significant capacity to work with the NDIA and other government bodies to support providers. So in conclusion, the barriers and issues we've just outlined have a range of causes and the solutions to them will require a commitment and input from a range of government departments and agencies, including the DSS, the Department of Health, the NDIA, the NDIS Commission, and the Queensland Government. And it will require governments to assign clear responsibility to the Allied Health workforce, including responsibility for funding its growth to meet participant demand.

And this may require coordination across multiple governments and government departments and agencies. The recent appointment of a dedicated Commonwealth Chief Allied Health Officer, Dr

Anne-Marie Boxall, provides an opportunity to improve coordination and begin developing a fit-for-purpose solution. We're confident that there are achievable solutions to these issues, and look forward to working with governments to ensure a strong and sustainable National Disability Insurance Scheme for Australians with disability. Thank you, and we're certainly very happy to have any questions and respond to those.

DR KAREN HOOPER:
Thank you very much, Gail, for that oral submission. And we do appreciate the submissions that you've made to the inquiry today. And obviously, the issues that you've raised this morning are highly relevant to the inquiry. And as you've said, we've sought to address many of them through the draft recommendations in the report.

So I do have a couple of questions based on some comments that you did make, Gail, if I could just ask those. You mentioned some concern for providers in relation to budget flexibility. Just wondering if we could talk a little bit more about what those concerns are.

GAIL MULCAIR:
At the moment, with the proposal in terms of fixed budgets, there is concern that there will not necessarily be the flexibility to adapt budgets based on the participants needs. And I think we see that already where there are limitations in terms of the initial budget, plan budget, and therefore that leads to the increasing number of plan reviews that are required. Would you agree with that Claire?

CLAIRE HEWAT:
I would. And there's also the other, the flip side with flexibility of budgets is that if the quantum is insufficient for the person's needs, then there's the robbing Peter to pay Paul situation, where we will just take a bit from there to prop up this, and in the end, you don't get enough of anything, and the participant ends up being short-changed. So while flexibility might sound great, if it's flexibility within a straitjacket, that actually makes life a bit difficult.

DR KAREN HOOPER:
Thank you. You also made a point around thin markets, and you thought, perhaps our draft recommendations just don't go far enough. And you're suggesting that more significant intervention is needed, Be interested in any ideas around what those interventions might look like.

GAIL MULCAIR:
Yeah. It was certainly, we're very open to working with both the NDIS, and NDIA and the Commission, obviously, in terms of some key strategies. We feel that one of the suggestions in the report, the QPC report is to provide market information. And while that is a positive in itself, we don't feel that it's necessarily going to address the intrinsic needs in terms of building an appropriate and sustainable Allied Health workforce. So, providing information around where there might be gaps in terms of a certain profession services in terms of participant demand or needs, it's not necessarily going to drive an Allied Health professional to go to that location, as an example.

So within our opening statement, and certainly expanded within the most recent response to the draft report, we've listed a number of areas. So again, just to recap, we strongly feel that there

needs to be a comprehensive Allied Health workforce plan, which collects appropriate data in terms of services available across the different professions, as well as across different locations that the geography services that are being provided, but importantly, the gaps in demand of services.

But also, that needs to be backed up with appropriate supports and funding such as incentivisation programs to encourage Allied Health practitioners to go to areas where there are high need, but where, currently, there's maldistribution. Currently, there's no scholarship programs, as example, or there's no additional sort of funding programs as incentives to attract practitioners to rural areas.

And the flip side of that is that the cost for registration, which we've mentioned, is even higher. Generally, it's higher for rural Allied Health providers because of the need to be able to, or the need to cover the costs for travel and accommodation of auditors, for example. So in fact, there's decentives, de-incentives, if that's a word, for people to go to rural areas.

Some of the other things we've suggested is the need to look at the overall pipeline in terms of building the knowledge of working in the disability sector amongst students of Allied Health professional courses. And then, as graduates come into the field, ensuring that there is appropriate supports by experienced disability Allied Health professionals to provide supervision, mentoring, coaching to new graduates or early career Allied Health professionals coming into the disability sector. There are probably a few of the initiatives.

CLAIRE HEWAT:
Yeah. I think one of the key things is to... there's a tendency and it happens everywhere, to silo. Like this is Allied Health and disability and there's Allied Health here. Allied Health work across a vast range of areas, and particularly the rural and remote areas, they often, in individual works across a vast range of areas. So, it's not just a matter of the NDIS or the IA, looking at how they might expand markets.

One of the most important things is the cross-departmental, cross-sector collaboration. Because it needs to be a whole of Allied Health workforce approach. It cannot just be an Allied Health disability workforce approach. Because no one is going to go to those rural areas that are prepared to see if there are five people with disability needs, that is not going to put food on the table. They need to be able to do disability, they need to service the local aged-care home, they need to probably provide outpatient services to the hospital.

And so, it addresses thin markets, particularly in rural and remote areas, and also, I would say, in areas that are less attractive, such as the lower socioeconomic areas of major cities. It's not just about the NDIA, and that's one of the most important, or even people just working in disability, I think that's probably one of the most important things that needs to be done. And one of the underlying factors with Allied Health workforce is the lack of data. We don't know who they are, we don't know where they are, we don't know what they're doing.

And when you don't actually, if you're wandering into a dark room, it's really hard to tell where everything is. And that's really where Allied Health is at the moment, in all areas, but particularly in disability. And I think, the NDIA, I know it's an NDIA decision, but I think the NDIA needs to be encouraged if it's going to look at regulatory processes, that the regulatory processes apply to

everybody providing services within the NDIA, not just people who have plans managed by the NDIA. Because, why would you spend all that money to be a registered provider, when you can service disability clients without doing it, and you just cherry pick what you want. It's not a system that's going to be effective for people with disability in the long term.

GAIL MULCAIR:
It's not providing an equitable service or access to services for participants. The other point I'll make, just adding to Claire's comments around the different strategies needed to be across sectors. This is spoken about through the National Rural Health Commissioner's report. So not specific to disability, but there's a range of strategies that is in that report which has not yet been actioned, which will certainly impact on the disability workforce.

Again, it's around data collection, and it's around looking at providing supports and hubs, potential sort of hubs of Allied Health providers across different sectors. So, looking at how you can attract someone to work, perhaps part time at the local hospital, part time in private practice seeing clients under the NDIS, but also other private clients or in aged care. So, there's some good ideas and strategies within the National Rural Health Commissioner's report that I think would lend itself to this work as well.

CLAIRE HEWAT:
And I would also add, in terms of student training, there is a huge reliance on students being trained within the public hospital system. And now that disability has largely disappeared from the public hospital system, they're not exposed to that, they don't get that kind of training. And there is a reluctance on the part of the NDIA to recognise that there is a responsibility for actually supporting student training although they come out of the pipeline. Well, they might come out of the pipeline, but there's no incentive for them to go and work in disability.

They've not experienced it, they don't know anything about it, and there's not necessarily any support for them to actually get that experience. And the funding, at the moment, the funding to have a new graduate is basically the expectation is well they know as much as somebody who's been in there for 10 years, there's no funding for them to be supported or nurtured through the NDIA, unless the participant is happy to pay for it, which doesn't seem very reasonable that the participant should be supporting students.

GAIL MULCAIR:
And it's not part of, I guess, it's not part of the funding model. It's an important strategy. And anecdotally, we hear all the time from our different organisations members across the different Allied Health professions that experienced people, experienced clinicians are either in their own solo practice or in group practice, and half the time, there isn't the funding to be able to support the level of supervision, and support and mentoring for three-year (INAUDIBLE) practitioners coming into the disability field, particularly when they're dealing with very complex clients. As many within the NDIS, many participants of the NDIS are, they've got complex needs.

And so, an early career, whether it's a speech pathologist, or a physiotherapist or occupational therapist, they really need that support to be able to build their skills, build a capability and their knowledge base, and provide high quality services. That comes at a price for any private practice or

even for the NGO providers. And unfortunately, we're seeing that there is a reluctance to take on students, as Claire said, but also early career graduates for those reasons.

On the other side of things, we are seeing early career graduates across the different professions moving into private practice themselves, and setting up practices. And that's where, I guess, we also have some concerns that they may not be necessarily building the skills and having the supervision that they require, particularly to deal with complex clients.

DR KAREN HOOPER:
Thank you. Obviously, workforce issues are a critical issue and highly relevant to thin markets in Queensland. Just touching on another thin market-related issue, and that's around the pricing guide. And whether there's adequate funding, or is the pricing guide adequate in terms of covering the costs of service provision in regional and remote areas for Allied Health professionals. Be interested in your view on that.

GAIL MULCAIR:
I guess I mean, some of the issues we've just spoken about come into that. Because it's not just the price to be able to deliver a one-on-one service, it's all of the other client related non-chargeable services that goes along with providing a quality service. Plus the broader capacity building of that particular provider, business private practice, in an overall sense, and all of the costs associated with registration and auditing. So, I guess, largely, we hear that it's not sustainable. And that pricing is an issue for why people may not certainly register, that the NDIS (INAUDIBLE), but also why some people are opting not to provide services to people with disability.

CLAIRE HEWAT:
And I don't necessarily think that's entirely related to rural and remote areas, either. I think it's across the board, it's probably more difficult in the rural and remote areas. But certainly, it's the actual pricing for that face-to-face and some of the, the write up and report writing is probably not unreasonable, but there is a great deal beyond that. That it basically has to be covered by the provider themselves.

DR KAREN HOOPER:
And you mentioned...

Sorry, Gail.

GAIL MULCAIR:
I was just going to say (INAUDIBLE) I was just going to mention that Allied Health Professions Australia have been involved in some of the discussions with NDIA, around pricing and we welcome that. But we do feel that there needs to be continued dialogue with Allied Health Professions Australia and our member organisations to really get to the, I guess, the the nub of what the issues are, and this is definitely influencing thin markets as well, as we've said.

DR KAREN HOOPER:
You mentioned pricing as being one of the disincentives for Allied Health professionals to register. And in your opening comments, you did talk about audit costs as well, as being another disincentive.

Are there any other disincentives that you haven't raised, that cause Allied Health professionals to either deregister or not to register?

GAIL MULCAIR:
..but there are, I guess, broader impact on costs for providers. So there is... ..associated with the constant changes in policy or pricing, it all adds to the organisation (INAUDIBLE) systems (INAUDIBLE)

DR KAREN HOOPER:
Sorry, Gail, I think you're breaking up. We might just take a short break and see if we can get the stream working again. Thank you.

GAIL MULCAIR:
(INAUDIBLE) We are breaking up. But yes, so there's sort of a bureaucratic components of the system and to those costs, imposts.

DR KAREN HOOPER:
Thank you. And just touching on your submission, which was very useful in terms of providing us with some very direct feedback around our recommendations. I just wanted to ask you for a little bit more detail around your concerns with our recommendation around establishing a price comparator website?

CLAIRE HEWAT:
Well, I think we can both speak to that. (AUDIO CUTS OUT) ..in terms of doing, it sounds like a great idea. But you really have to... (AUDIO CUTS OUT)

And it's, it's very difficult to make that comparison. You would have to do an enormous amount of research, consultation. Because what might appear to be the same service is... (AUDIO CUTS OUT) And it depends on the location, it may well depend on the location, it may depend on the experience of the provider. (AUDIO CUTS OUT)

DR KAREN HOOPER:
Sorry, you're breaking up again. We're struggling to hear you.

CLAIRE HEWAT:
(AUDIO CUTS OUT)

DR KAREN HOOPER:
OK, I can hear you now, Gail, you're back. So the price comparator website concerns really rests around the fact that price might be looked at independently of other non-price attributes in terms of selecting a provider. That's your key concern.

GAIL MULCAIR:
Yeah, and as Claire said, hopefully you heard some of that, but there's many different features around what is important in delivering a good quality service. And so, it's very hard to see, at this stage, but we're open to being consulted on this. But it's very hard to see how a pure sort of pricing

comparison will actually add value or add knowledge to a participant's choice other than purely picking on the cost itself.

But it won't necessarily provide information around the experience of the practitioner, the different types of specialisation of services that practitioner might have. The quality, as Claire said as well, depending on the complexity of the client's needs, that may impact on the charge, on the price itself. So all of those things would not necessarily be well captured in terms of any kind of, I guess, website comparator.

Also, in the recommendations, it includes talking about quality of service and having some sort of website that might, whether it's going to be testimonials or other sort of information, again, were cautious about anything that may misrepresent a provider in terms of the types of services and the quality of service that they're providing. So, we have, I mean, there are a range of different sites that we know have been developed within the health sector, as an example, making comparisons of different practitioners and with testimonials, and they are very problematic.

And it's very problematic for the provider if a poor, for whatever reason, if there's some sort of poor comment or remark, the provider has no means of being able to address that. So it is open to misuse. So on the surface, it sounds like a good idea, but we would welcome input to that to see whether there is an opportunity to have something which would be able to provide some appropriate information, but at this stage, we are very cautious.

CLAIRE HEWAT:
And we've also had examples, not so much as a price comparator, but certainly with the NDS, that new young graduates trying to establish their businesses will bulk bill. They do not necessarily afford to bulk bill, but they do, because it's a way of just getting people through the door. And if you look at a price comparator, you've got a very experienced person doing a really outstanding job who's charging double that amount.

And the new graduate, who may be OK, but is not necessarily, doesn't have that experience will be charging less. All you got is a price comparator. What do you... Who do you - how do you decided? It's like doing three painting quotes. The cheapest is not always the best. And I think that's the risk of price comparators.

GAIL MULCAIR:
And I think it's also a danger in terms of that information potentially being used by planners. Because we know that planners, and as we've said, they vary considerably in terms of their experience and may not have a health background at all. And we know, again, from both our members and also from participants, many stories are being told by their planer to go down XYZ pathway because it's cheaper.

And in fact, we often hear that a participant or their families directed to only take on assistance, as an example, because that's going, or a student, have a student deliver your speech therapy program, because that's much cheaper. So I guess, we are very concerned that if there is a, I guess, a model where price is being used as a way of identifying a provider, we would be concerned that that's not

necessarily going to identify the right provider for that participant in terms of the type of quality and experience they need for their particular problem.

DR KAREN HOOPER:
But can I just, you agree with the general premise that more information is required for participants to be able to exercise informed choice, and control and selection of Allied Health professionals?

GAIL MULCAIR:
I don't think we can dispute that at all. I wouldn't necessarily dispute that it makes sense. But I guess we are very concerned around how that information may misrepresent what's available for...

DR KAREN HOOPER:
Can I just go back to a comment you made earlier, Gail, around limited opportunities to use technologies such as telepractice. What's the main concern or impediment there?

GAIL MULCAIR:
Well, again, this is not necessarily the funding provided. I've got some notes on there. There's not the funding for, there's funding for face-to-face, one-on-one, not face to face. There's the one-on-one consultation through telepractice that's available. But there's not necessarily anything for the participant to be able to have the appropriate IT infrastructure that they need.

It's not necessarily the additional support that have that appropriate systems that will provide quality telepractice. And I guess, again, there's not necessarily the funding that will provide more of a broader capacity building with the participants, (INAUDIBLE) and family through the use of telepractice.

CLAIRE HEWAT:
And there's also no, necessarily, funding. Because sometimes, if you're going to be doing telepractice, just working with the person at the other end is not going to work. You may need, for example, to have an Allied Health assistant at the other end. Well, that is an extra cost, they don't come for free. So, those sort of things are not necessarily factored into each of the funding.

GAIL MULCAIR:
But we strongly support these telepractice. Obviously, through COVID-19, it's been a necessity, and Allied Health professionals have utilised telepractice extremely well. And we've got strong research around the effectiveness and efficacy of telepractice. So we're certainly strong proponents, but again, it needs to be funded appropriately.

DR KAREN HOOPER:
And earlier, you mentioned some concerns around proposed changes in relation to early childhood intervention. I'd be really interested in learning a little bit more about what those concerns are.

GAIL MULCAIR:
We know that there's a separate consultation process occurring, so we'll be feeding into that. And we're certainly be very happy to supply our response, which I think is draft at the moment, in the end of February. I think there are still lots of unknowns. Broadly, we support that there is an increase

in the age range. So we do support that early childhood supports should increase to children under nine as against seven.

And we certainly support that there be a clearer... a review and a clearer definition around developmental delay, as an example. So there's a number of features that are key questions in that consultation that we do support. But we are concerned around the potential changes to do with the assessment of children through the independent assessment process, which, at this stage, looks as though that would be different to how the independent assessments are going to operate for adults, that those assessments would occur through early childhood providers. But at the moment, we've got very little information about that.

We don't know whether those assessments would be conducted by Allied Health professionals, as is the case in terms of the adult independent assessments. We have some concerns around the assessment tools that have been identified in early childhood space, because we're concerned that they're not necessarily going to highlight the, I guess, the full profile of that child's disability. It won't necessarily give you some of the profession-specific information, so the detail around child communication difficulties, as an example, or their behavioural needs. So we feel that there's not yet sufficient information to know whether those assessments are going to be comprehensive enough.

And also, how that will tie in with the knowledge and the reports from Allied Health practitioners who may already be dealing with that child. How will the knowledge of an occupational therapist or a speech pathologist working with that child, perhaps, since they were two going to be brought into that independent assessment process? And so, there's concerns around that. They're similar concerns as we have in the adult space. But there seems to be less known about how this is going to roll out in the early childhood area at this stage.

DR KAREN HOOPER:
Well, thank you both, for your time this morning. We've learned a lot about the challenges that Allied Health professionals are finding in relation to the NDIS, and particularly, I was interested in your earlier comments around the policy changes and the support that you gave for the provider guarantee. So thank you for joining us from Melbourne today. And again, thanks for the written submissions that you've provided to the inquiry today. So, thank you.

(CROSS TALK)

Thank you.

GAIL MULCAIR:
(INAUDIBLE) the internet.

DR KAREN HOOPER:
It's alright. Thank you, bye bye. So we might break now, for 15 minutes, and we'll come back at 11:15 Thank you.