

CONSULTATION RESPONSE

Department of
Social Services



**Allied Health
Professions
Australia**

A new National Disability Strategy – Stage 2 consultations

October 2020

Submitted via email to: disabilityreform@dss.gov.au

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

Introduction

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback as part of the Department of Social Services (DSS) Stage 2 consultations on the National Disability Strategy.

AHPA represents 19 national allied health associations and collectively works on behalf of their 130,000 allied health profession members. Many of those allied health professionals are involved in providing services to people with disability, regardless of whether those people are participants in the National Disability Insurance Scheme (NDIS). Allied health professionals also work in a range of related sectors such as education, mental health and aged care where they may be involved in supporting people with disability. The role of allied health practitioners in working across schemes and sectors provides a unique insight into the challenges experienced by people with disability, particularly those that rely on the health and aged care systems for support. This provides both a strong foundation for our contribution to this consultation, but also a strong argument for better integration of the allied health sector in the implementation of the Strategy.

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. We welcome the development of a new National Disability Strategy as an important foundation for improving equity and access for all Australians with support needs.

This submission has been developed in consultation with AHPA's allied health association members. We encourage consideration of this response in conjunction with individual responses by our allied health peak association members, which provide additional detail in relation to their specific areas of clinical focus.

Responses to the questions outlined in the position paper

Question 1: During the first stage of consultations we heard that the vision and the six outcome areas under the current Strategy are still the right ones. Do you have any comments on the vision and outcome areas being proposed for the new Strategy?

AHPA broadly supports the vision outlined in the National Disability Strategy position paper. However, it is clear to Allied Health Professions Australia (AHPA) and its members that there are still significant gaps in access to disability services for some parts of the community, despite the introduction of the National Disability Insurance Scheme (NDIS). As such we argue that the new National Disability Strategy provides an important opportunity to address an ongoing lack of equity in the experiences of some people with disability. There are currently significant disparities between someone who acquires an injury in their early 60s and who is able to achieve entry to the Scheme when compared to someone only a few years older who misses that cut-off and must instead depend on the Australian health and aged care systems for disability supports. This disparity applies not only to people with disability over the age of 65. Instead, any person with disability that relies on our current health and aged care systems is highly limited in the extent to which they are able to

access person-centred, fully funded services that focus on helping them overcome any functional barriers arising from their disabilities. Access to assistive technology in particular varies very dramatically between participants in the NDIS and those outside the scheme, a point that has been clearly articulated as part of the Royal Commission into Aged Care Quality and Safety.

Similar issues also apply to a range of other consumer cohorts. There is clear evidence that there are significant barriers to entry and service access for people with disability located in rural and remote regions, First Australian peoples, people from culturally and linguistically diverse communities, people with communication disabilities, and people with psychosocial disability. While we recognise work is underway by organisations such as the National Disability Insurance Agency (NDIA) to address some of these barriers, we argue that Australian governments have a shared responsibility for ensuring that all Australians, regardless of their age, culture, or type of disability, can access the supports they need.

On the basis of these arguments, AHPA argues for an amendment to the vision to include several minor changes—the addition of the word ‘all’, and the addition of the phrase ‘regardless of their age, location or background, to access the support they need’. The resulting vision would be as follows:

An inclusive Australian society that enables all people with disability, regardless of their age, location or background, to access the support they need to fulfil their potential as equal members of the community.

We argue that these changes to the vision are needed to highlight the disparities experienced by some parts of the community and to ensure that all governments undertake strategic policy and program planning focused on the needs of their whole community. The Strategy should seek at all levels to emphasise the need to create a genuinely equitable system that supports all people with disability. While we note that the proposed guiding principles seek to identify and address barriers for priority populations, we argue that equity must be enshrined throughout, including in the vision for the Strategy.

AHPA supports the six outcome areas and believes that they remain appropriate for the new strategy.

Question 2: What do you think about the guiding principles proposed here?

AHPA supports the proposed guiding principles outlined in the discussion paper. We strongly acknowledge the importance and value of identifying an appropriate set of core principles to focus the development of policy and programs associated with the Strategy.

However, while we broadly support the principles as outlined, we note our concern that the intentions around engagement do not sufficiently call out the need to work with the allied health sector. While the allied health sector acknowledges the fundamental principle of ensuring that the Australian disability system is designed with, and for, people with disability, and that policy and

program design must engage directly with users of services, we strongly argue that providers should also be the focus of targeted engagement. It is not currently clear that the intention of the principles outlined involves genuine engagement and co-design with the allied health disability sector.

Allied health providers are a crucial part of the disability sector with an important perspective that is frequently left out in the design of policy and programs for people with disability. Allied health providers are often smaller, specialised providers of niche services and these views and input in particular have often been left out of conversations in favour of very large non-government organisations (NGOs) and providers, who may have allied health professionals as employees but lack the perspective and understanding of the diversity and structure of the allied health disability workforce. This approach is resulting in avoidable design and implementation issues that arise from a lack of consideration of the needs, expertise and capacity of the allied health sector. This impacts providers and, in turn, access to services for people with disability.

While there has been significant work undertaken by some government bodies and agencies, particularly the NDIA, to increase engagement with the allied health sector, we argue that crucial areas such as workforce development continue to involve little real engagement with the sector or the peak associations responsible for Australia's allied health workforce. That continued lack of genuine engagement with the allied health sector can be seen in a lack of progress in addressing serious concerns raised by the allied health sector about the adequacy of the NDIS Workforce Plan. It can also be seen in the Commonwealth Minister for Social Services' determination that the allied health sector is not eligible for peak funding as part of the Department of Social Services' National Disability Representative Organisations funding program. The sector has very serious concerns about the Australian government's view that the allied health sector should not be supported to engage in representative a key part of the disability sector. This is despite funding being provided to other provider representative organisations such as National Disability Services and Mental Health Australia, which overwhelmingly represent large providers. AHPA also notes that Government funding for the allied health sector provided by the Department of Health excludes disability related activities.

Allied health providers are an essential part of the disability sector and a key partner in delivering on the National Disability Strategy. Significant policy and program work will continue to be required to address challenges such as access to services for people with disability, building sustainable and high-quality workforces, ensuring providers have the skills and expertise needed and more. Strong input from the allied health sector will be essential, particularly in light of the important link that allied health professions provide to closely aligned sectors such as education and health. Governments, particularly the Commonwealth, must commit to engaging with the allied health sector in its guiding principles and in doing so, needs to not only create opportunities for participation in working groups or committees but also provide the resourcing to support the sector in delivering on government programs.

Until resourcing of, and engagement with, allied health professions is addressed, program and policy design will continue to be poorly coordinated, particularly in relation to workforce development and support, and outcomes for people with disability will suffer. We note by way of contrast that no

health sector-led strategy would fail to acknowledge, or support, the vital role of medical professionals.

Question 3: What is your view on the proposal for the new Strategy to have a stronger emphasis on improving community attitudes across all outcome areas?

AHPA strongly supports an increased focus in the Strategy on addressing community attitudes in relation to people with disability. However, while we commend a general focus across all outcome areas on addressing stigma and attitudes, we argue that it may be more effective to focus in the development of the Strategy on specific outcome areas. This would allow specific issues and barriers to be more clearly articulated, as well as helping to identify audiences and outcome targets for engagement activities. For example, employment (particularly mainstream employment) is appropriately called out as an area of significant underrepresentation and one where community attitudes play a significant role in supporting access to employment opportunities for people with disability. Employment for people with disability straddles several outcome areas—economic security and inclusive and accessible communities—but if any activities arising from the Strategy focus on these broad outcome areas, they may not achieve the intended outcomes in relation to employment opportunities.

Addressing attitudes in workplaces is likely to require a multi-pronged approach that involves a dedicated focus on the attitudes of employers and may focus on areas such as highlighting examples of people with disability participating in workplaces. It is also likely to involve education about the supports that are available to employers to help them make their workplaces more accepting and appropriate for people with disability. These focus areas are likely to be different than other campaigns that may focus on other outcome areas or aspects of the outcome areas. As such we argue that focusing in the Strategy on specific areas of focus that align with, but may be different to the outcome areas.

AHPA also argues that people with different types of disability experience different types of discrimination and stigma. It would be beneficial to undertake work to identify the greatest areas of need and the most important areas of focus. AHPA argues that by doing so, effective outcomes are more likely to be achieved if there are specific priorities set in relation to community attitude activities. This would in turn allow different government and non-government agencies and organisations to be identified as responsible for delivering programs. It may also help other non-government stakeholders to support activities and programs focused on community attitudes.

Question 4: How do you think that clearly outlining what each government is responsible for could make it easier for people with disability to access the supports and services they need?

AHPA believes that there is a real need to streamline access to information about the different services and supports available to people with disability. There is significant variation across different jurisdictions and different types of disabilities in terms of what services and funding people with disability can access, as well as range of ways in which services are accessed. We note that

disability supports and services straddle not only multiple levels of government, but also different government departments and schemes. Services may also be funded through non-government organisations (NGOs). Each of these may have different access methods, review and complaint processes, and eligibility criteria. Consistent feedback from providers involved in supporting families and people with disability suggests that navigating the range of services is challenging, particularly for those that have a newly acquired or diagnosed disability. Yet access to the right services can improve outcomes significantly. We note the additional complexity that arises due to the labelling of services as disability services and that some people may not consider themselves or the person with disability they support to 'be disabled'. This can further limit access to appropriate supports even where a person may be eligible.

AHPA recommends the development of clearer guidance for people with disability that makes it easy to understand which options are available in any given geographic region, what appropriate access points are for services, and what may be needed to demonstrate eligibility. We argue that in developing such guidance, consideration should be given to how that guidance is accessed and how it can support the role that medical and allied health professionals have in supporting families and people with disability as they navigate the system. Developing information will not be enough, instead we also argue for the need to map entry points to the system, to consider the roles of organisations such as the NDIA, and to plan appropriate development, rollout and implementation of guidance in conjunction with health professional bodies.

We note by way of example, the experience of a family who has a young child with developmental delay. That family is likely to initially spend significant time accessing services and seeking support from within the health system, often through the support of community based maternal child health services, and primary care allied health clinics. These may be further supported by referrals to hospital-based paediatric clinics and medical specialty services, which focus on diagnosing the child's needs and identifying the supports and services that may be required to address that delay. Each of these services often involves significant wait times as well as screening checks for eligibility along the way. At this early stage, particularly if there is not a clear diagnosis of significant disability, the family is likely to be relatively unaware of the supports available to them. Feedback from the sector suggests that outcomes for people with disability still depends heavily on a family's capacity to do their own research or connect with peers who can provide knowledge and guidance about appropriate services. Outcomes also depend heavily both on early intervention, influenced by the ability to purchase services privately, due to the significant gaps in funding for services such as allied health, outside the NDIS. It is common for families to choose to pay for a private autism diagnosis to streamline their funding application for services rather than waiting as long as two years in the public system.

Even if a child enters the NDIS, families are required to develop significant capacity to navigate access to services across health, education, and disability. The experiences of a person acquiring a disability later in life will differ but will also involve straddling medical, health and disability services, other services such as accident and compensation schemes, social services and more. Those services are likely to include not just direct government services, such as may be funded by the NDIS or Department of Education, but also services that may be funded indirectly through NGOs and other community-based supports. Supporting people with disabilities to access these requires a careful

approach that considers the many different access points and pathways and how best to provide targeted information where needed.

AHPA also notes the significant issues that people with disability continue to experience in relation to access to assistive technology. For participants in the NDIS, there continues to be significant variation in decision-making around access to assistive technology and allied health clinicians are experiencing higher rates of rejection by planners of the assistive technology they prescribe than under previous State and Territory schemes. One clinician reported:

One of our clients, a young girl with cerebral palsy, has had her NDIS application for an eye gaze system declined despite careful selection and trialing in conjunction with a speech pathologist. The girl had shown significant progress in using her eye gaze system for communication in just a few short weeks and has significant potential to continue learning and improving her capacity to communicate in relation to many of her daily activities. However, instead of approving the prescribed technology, the NDIS planner proposed adding an eye gaze camera to her very old system, something that is not technically possible as that system is now obsolete and no longer available or supported.

With the shift to the NDIS across Australia, funding and processes for accessing assistive technology outside of the Scheme have also changed and there is significant evidence of the challenges people with disability experience in accessing the assistive technology they require. Any work to provide greater clarity around the roles and responsibilities of different governments should seek to provide clear guidance about access to assistive technology as well as the clinical support services required to assess, prescribe and fit the equipment.

AHPA notes that the soon-to-be-introduced NDIS Independent Assessment process offers the potential to create greater consistency and equity in people's ability to determine if they are eligible for the scheme. It may also offer the opportunity to create streamlined processes for connecting families and people with disability to the information they need to navigate the range of supports and services available to them. AHPA recommends that the planning of any work arising from this recommendation, in relation to clarifying the range and role of government and non-government services for people with disability, should consider how the Independent Assessment process could provide a more streamlined means of accessing not only assessments for entry to the NDIS, but also a more streamlined connection to information about services.

Question 5: How do you think the Strategy should represent the role that the non-government sector plays in improving outcomes for people with disability?

AHPA argues that there should be careful consideration of the expected role of non-government organisations and providers in delivering on the Strategy and that this role should be clearly outlined in the Strategy.

The current approach taken by Australian governments, and by government agencies such as the NDIA and the NDIS Quality and Safeguarding Commission, is one that relies heavily on a free market

approach to meeting participant demand for allied health services. Both the Department of Social Services (DSS) and the NDIA have developed tools that seek to identify participant need and encourage investment by non-government providers in meeting that demand as a means of addressing demand for services. Their approach depends heavily on private providers having the capacity to use those tools and to respond to meeting market need through private investment with little or no stewardship of the market by Australian governments. This approach appears to apply not only to the NDIS market, and the availability of registered and unregistered supports, but also to services for people with disability who may fall outside the NDIS. In the latter case though, there appears to be little if any market information or other support to help address any demand for non-NDIS funded services and the needs of people with disability are broadly left to the health sector. Overall there appears to be little in the way of planning or oversight of service provision by Australian governments for those cohorts outside the NDIS and no clear initiatives to address the impact of competition for services in an environment where the NDIS market itself has created a demand for services that may outstrip supply and where NDIS funding provides a far more appropriate level of rebate and funding than available outside the NDIS.

AHPA has consistently stated its strong concerns that this approach is failing and needs to be changed in favour of an approach that focuses on more active stewardship of the allied health disability workforce. However, given the decision by Australian governments, particularly the Commonwealth, to rely on the private sector to meet need, we argue that this should be clearly articulated in the Strategy. The Strategy document should articulate which aspects of the Strategy the private sector is responsible for, how it will be engaged and supported to deliver on different areas, and how the effectiveness of that approach will be evaluated. We argue that mitigation strategies should also be articulated that might be used by different levels of government where a reliance on the non-government sector is ineffective.

AHPA notes its concern that workforce issues appear to be considered outside of scope for the Strategy. The discussion paper states that: ‘the Commonwealth, in conjunction with states and territories are currently developing a National Disability Insurance Scheme (NDIS) National Workforce Plan, which will outline a national approach to disability workforce development’, and that ‘the project aims to set out a cohesive, focused, national approach to developing the NDIS workforce and the care sector more broadly’. While AHPA acknowledges that work is being undertaken on a workforce plan, our own involvement in consultations with DSS suggests that there is little appetite to address the key barriers impacting development of the allied health disability workforce and there remain major questions about how effective the workforce plan will be. Current iterations of the plan show a strong and ongoing reliance on the health system and on new measures for the rural allied health workforce as a means of addressing long term supply gaps.

Given the gaps in the workforce plan, AHPA argues that the Strategy will need to address the supply of allied health disability services and how that will be supported by the non-government and government sectors. It may be that a clear, long-term commitment from the Commonwealth to supporting the growth and sustainability of the allied health disability workforce, as is done currently with the medical workforce strategy through a wide range of scholarships, incentive programs, and workforce plans, is the most appropriate option.

Question 6: What kind of information on the Strategy's progress should governments make available to the public and how often should this information be made available?

AHPA argues for the development of a clear set of outcome goals as part of the Strategy, based on the aim and guiding principles, with clear metrics and accountability for each goal. This would most likely involve identifying a series of goals, aligned with specific areas of focus or Targeted Action Plans identified in the Strategy, with clear assignment of responsibility for given goals by different governments or agencies. An example might be the development and implementation of an education plan for mainstream employers, run by the Commonwealth Departments of Social Services and Education, Skills and Employment, focused on improving attitudes and awareness in relation to employment of people with disability. Metrics might include both exposure to information and communications activities by employers as well as employment rates. These would then be reported on as part of an annual statement for the Australian public and for people with disability.

AHPA strongly welcomes the Council of Australian Governments (COAG) Australian Data and Digital Council commitment to developing a National Disability Data Asset (NDDA), to bring together de-identified Commonwealth and services data, NDIS data, and service system data from states and territories. The development of a data asset for disability services is something that AHPA and its members have called for as a vital foundation for understanding service gaps and workforce shortages, supporting better understanding of outcomes, and understanding access to services for people with disability. We argue that the development of the data asset will be an important tool to support reporting and measurement of activities and programs developed as part of the Strategy.

AHPA argues that the annual reporting should be tied in with the proposal below (Question 8), in relation to the development of an engagement plan and the involvement of the disability community in monitoring the implementation of the strategy. We argue that a steering group consisting of representative participants and providers should be established which both monitors the implementation of the strategy and informs the development of the Annual Statement.

AHPA further argues that in addition to an annual statement, a public-facing website should be developed that provides the public and the disability community with information about any programs, policies and Targeted Action Plans that are being delivered under the Strategy. The intention would be to give the community a simple, accessible reference point that outlines the status and timelines of current activities being undertaken as part of the Strategy, outlines any opportunities to participate or provide input, and provides information about evaluation such as access to metrics and outcome measures.

Question 7: What do you think of the proposal to have Targeted Action Plans that focus on making improvements in specific areas within a defined period of time (for example within one, two or three years)?

AHPA strongly supports the proposal to include within the Strategy a series of Targeted Action Plans with clearly articulated outcomes and timelines, focused on achieving particular improvements

identified as priorities. In stating our support for these, we reiterate our view that the Plans will need to clearly identify accountability for the implementation of any activities, programs or policies that fall within them. From the perspective of the non-government sector, one of the key weaknesses of high-level strategies developed by governments is that they can lack clearly identified activities and accountability for specific outcomes.

We would like to see a series of Targeted Action Plans that build on one another in key areas of need, such as data gathering and workforce development. Many of these activities will require significant investment and time and this has often acted as a barrier to progress. AHPA argues that an approach built on Targeted Action Plans with short- and medium-term timelines would allow governments to set out multi-stage implementation plans that may start with locally-targeted pilots and then seek to scale those up appropriately. These plans may also include multiple distinct but complementary approaches.

A concrete example proposed by the allied health sector is around service gaps for allied health services in areas with thin markets. Initial, short-term Targeted Action Plans might involve working to identify and quantify thin markets for particular professions and to put in place short-term funding solutions to address service shortfalls. AHPA is aware that some of this work is currently being undertaken by the NDIA Thin Markets team in areas such as north-western Tasmania, though this focuses only on meeting the needs of participants in the NDIS. A medium-term approach might seek to build on that by undertaking additional work to identify any barriers to market growth that exist in that region. It would also fund initiatives targeted at overcoming those barriers with the aim of developing a market that can exist independently of market interventions, perhaps through improved education and training options in that region.

We argue that it is essential that any work in relation to the allied health services required by people with disability addresses the needs of Agency-, plan- and self-managed NDIS participants as well as those outside the Scheme.

Question 8: How could the proposed Engagement Plan ensure people with disability, and the disability community, are involved in the delivery and monitoring of the next Strategy?

AHPA argues for the need to develop a broad, multifaceted engagement plan that ensures that people with disability and providers are able to contribute to the delivery and monitoring of the Strategy. In doing so, we encourage a broad view of disability, given the particular needs and gaps that exist for people that fall outside the eligibility criteria of the NDIS. We note in this context that the Royal Commission into Aged Care Quality has called for equivalent services and supports available to older people with disability who are not eligible for the NDIS. We also note that there are important intersections with the mental health sector and the needs of people with psychosocial illness should very much be integral to this work. By engaging with consumers and their representatives from all relevant areas—that is, from disability, health, mental health, and aged care—the National Disability Strategy Engagement Plan could improve the effectiveness and coordination of different programs and policies for people with disability. We also consider there to

be important opportunities to involve people with disability in particular initiatives such as those outlined earlier in relation to community attitudes.

We reiterate our view that providers are an important part of the disability community and, as such, many of the arguments that support the involvement of participants also apply to representatives from the allied health sector. Allied health providers frequently work across multiple sectors and act as an important link and navigator for people with disability. Those providers are likely to play a significant role in the rollout of many aspects of the Strategy and will also be well-placed to support the monitoring of the Strategy's implementation.

We consider that a proposed engagement plan should involve the development of the following:

- A steering committee with consumer and provider representatives, which supports evaluation and annual reporting for outcome areas and/or Targeted Action Plans.
- A public information and engagement plan is developed, based on Targeted Action Plans and/or programs and activities arising from the Strategy, and which is built around a dedicated website. This site would then function as a means of providing the disability community with detailed information about initiatives, opportunities to engage and support activities, metrics and evaluation information, and copies of annual statements about performance against the outcome areas of the Strategy.

In addition, we strongly argue that there needs to be targeted engagement of the allied health peak associations as part of broader engagement of allied health providers in order to provide dedicated input and support in relation to any activities relating to the allied health disability sector.

