NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the National Disability Insurance Agency on the NDIS Quality and Safeguarding Framework

April 2015

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

Good health and wellbeing for rural and remote Australia

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About the Alliance

The National Rural Health Alliance (the Alliance) is comprised of 37 national organisations. It is committed to improving the health and wellbeing of the more than 6.7 million people in rural and remote Australia.

Members include consumer groups (such as the Country Women's Association of Australia and the Isolated Children's Parents' Association), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and Frontier Services of the Uniting Church in Australia). The full list of Member Bodies is at Attachment A.

Each of the Member Bodies is represented on the Council of the Alliance, which guides and informs policy development and submissions. With such a broad representative base, the Alliance is in a unique position to provide input on the broader issues relating to good health and wellbeing in rural and remote areas.

The Alliance is keen to provide input into the NDIS Quality and Safeguarding Framework. We believe that it is vital to ensure that all people, including those living in rural and remote Australia, have access to high quality disability services; the success of the NDIS largely depends on meeting this objective.

Introductory comments

To be effective in rural and remote Australia the NDIS will need to operate in a way that suits the circumstances of people living with a disability in those areas. In this regard there are some obvious challenges, including distance and isolation, which will need to be met through a general flexibility of service models.

Establishing markets for disability service delivery will be difficult in some parts of rural and remote Australia. For a market to exist, and be functional, there needs to be a minimum 'critical mass' of service capability within a community. Where this is not present, there may be the need for people with a disability and their families to have subsidised travel, for example to a regional centre. A hub and spoke approach would enable specialist staff based in a regional city to outreach to surrounding areas. Such a model requires higher staff-to-client ratios due to the time taken for staff to travel to more remote areas. Depending on the type of service required, there may also be a place for some 'fly-in-fly-out' services, although the Alliance's firm view is that such an approach is not suitable for the delivery of day-to-day services where a high degree of trust must be established between the client and the support provider.

Whatever models of service are adopted, there is a continuing call from rural and remote communities that services be provided as locally as possible. This will require an ongoing commitment to working with local people with the necessary expertise, including Aboriginal Health Workers and Community Workers. It will require investment in professional development for existing providers, and adequate support for new providers starting out in rural and remote areas.

In its submission to the NDIA, the NRHA has chosen to focus on three issues that have particular relevance to people in rural and remote Australia:

- Issue 1 – registering providers under the NDIS in rural and remote Australia;
- Issue 2 – implementing a system for complaints handling in rural and remote Australia; and,
- Issue 3 – ensuring staff are safe to work with participants in rural and remote Australia.

The Alliance's view on these issues and the options proposed by the NDIA are outlined below.

Issue 1 – Registering providers under the NDIS

The NRHA believes it is vital that the quality of services delivered under the NDIS is evaluated by independent assessors. As such, Options 1 and 2 outlined in the Consultation Paper would not provide adequate protection to NDIS participants in rural and remote areas.

The NRHA supports Options 3 or 4 because both of them guarantee an independent assessment of quality. To implement either of these options in rural and remote areas, however, the NDIA will need to give special consideration to what constitutes 'independence' in rural and remote communities. To be truly independent, it is likely that quality assessors will have to be sourced from other geographic areas, particularly for work in small, isolated communities.

If the NDIA decides to pursue Option 4, the NRHA believes it is vital that the accrediting organisation has 'teeth' – that is, it must have the authority to 'de-accredit' providers, or to make their ongoing accreditation conditional on remedying any problems identified.

The Consultation paper also states that special arrangements might be put in place for registered health professionals (for example, physiotherapists and psychologists) seeking to become providers under the NDIS. It explains that by complying with their own professional registration requirements, these health professionals may also be considered compliant with NDIS registration requirements. The advantage of such an option would be that it would reduce duplication and effort for health professionals that are working in private practice and are seeking to become registered providers under the NDIS.

While the Alliance supports this approach, it is important to note that not all health professionals who are likely to be seeking to become registered providers under the NDIS are members of registered health professions; some health professional groups are self-regulated (speech pathologists and audiologists are two examples). The NRHA is concerned that the arrangements outlined in the Consultation paper mean that self-regulated health professionals will face one of two unsuitable scenarios:

- they may be treated in the same category as other low-risk service providers (for example taxi services) and therefore required to comply with inadequate safety and quality standards; or,
- they may be expected to comply with particularly onerous registration requirements, similar to those of larger service delivery organisations.

In the absence of national registration, some health professional groups have formed a National Alliance of Self-Regulating Health Professions (NASRHP). The NASRHP has developed a National Framework for Self-Regulation for Health Professionals. Where possible, this framework mirrors the quality and safety requirements stipulated by the national regulation scheme for registered health professions.

The NRHA proposes that the NDIA examine the existing safety and quality arrangements used by self-regulated health professional groups. The NDIA may then be able to make a determination as to whether or not demonstrated compliance with safety and quality arrangements for self-regulated health professional groups could be considered equivalent to compliance with national registration standards for registered health professional groups. If so, members of self-regulated health professions would not be required to meet the same requirements as organisations when seeking to become registered providers under the NDIS, nor would they be subject to inadequate safety and quality arrangements required of non-clinical providers.

Issue 2 – Implementing a system for complaints handling

The NRHA supports the notion of an independent complaints assessor for the NDIS. We believe that the same arrangements should be in place for all NDIS participants and providers, regardless of where they are located.

Our view is that Option 1 would not provide sufficient protection for NDIS participants. We have mixed views on the merits of Options 2 and 3, but we are of the view that any complaints body must be:

- independent from government (that is, its role should always be to protect participants, carers and providers, not the reputation of the government or NDIA); and
- empowered to investigate, take action and make binding recommendations on providers registered under the NDIS.

If these two conditions are met, the NRHA believes that NDIS participants in rural and remote areas will have sufficient protection, even if markets are weak.

The NRHA also supports the notion of a community visitor scheme because such a scheme could play an important role in ensuring high quality services are provided in rural and remote areas. Once again, ensuring the independence of community visitors in rural and remote areas would be an important consideration. For the community visitor scheme to have the intended impact (a truly independent assessment of quality) community visitors should come from communities other than the one they are visiting. The NDIA would need to provide additional resources to community visitors in rural and remote areas so that they could travel long distances as part of their duties.

Issue 3 – Ensuring staff are safe to work with participants

The NRHA holds the view that no jurisdiction should be required to 'water down' its existing requirements. As a result, our preferred options are Option 3 and 4.

The NRHA believes that providers should be responsible for ensuring that their staff are safe to work with NDIS participants. However, responsibility for developing and implementing processes for how this is done should not be left to providers. We believe that NDIS providers should be required to get police checks on employees and maintain banned persons lists if they are providing certain types of care (e.g. personal care).

Conclusion

The NRHA will be closely engaged with the rollout of the NDIS, focussing on ensuring equity of access to high quality disability care in rural and remote Australia. While there are unique challenges associated with rolling out the NDIS in rural and remote areas, the NRHA is strongly of the view that these challenges should not have an over-riding influence on all decision-making regarding the roll-out. On some occasions, for example, it might be necessary for the NDIA to give special consideration to how the Quality and Safeguarding Framework might be applied in rural and remote Australia. It might require additional resources and investment from government, greater flexibility, or innovative thinking and models of care. At other times, however, national consistency should be the priority.

We welcome the opportunity to continue working with the NDIA as the roll-out of the NDIS progresses and are committed to ensuring the right balance between flexibility and consistency is achieved.

ATTACHMENT A

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)