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Submission to the NDIS Review Panel on a future model for NDIS that meets the needs of Aboriginal people with disabilities in the Northern Territory

Aboriginal Medical Services Alliance Northern Territory (AMSANT)

AMSANT is the peak body for Aboriginal Community-Controlled Health Services (ACCHSs) in the Northern Territory. The Not-for-Profit Aboriginal Community Controlled Health Services sector, as the largest provider of comprehensive primary health care to Aboriginal people in the NT, has been a primary driver of the impressive health gains for Aboriginal people in the NT over the last three decades.

AMSANT represents 12 full-member organisations and 13 associate members across all areas of the Territory from regional centres to the most remote communities. AMSANT aims to grow a strong Aboriginal community controlled primary health care sector by supporting our members to deliver culturally safe, high quality comprehensive primary health care that supports action on the social determinants of health; and represent our members' views and aspirations through advocacy, policy, planning and research.

Aboriginal Community Controlled Health Services (ACCHSs) in the Northern Territory

ACCHS are owned and governed by the Aboriginal communities they serve. ACCHS exist because Aboriginal people have exercised their *voice* and *choice* through establishing their own health services on their own terms. The ACCHS sector is the larger of the two providers of Aboriginal Primary Health Care in the Northern Territory and provides around two thirds of Aboriginal client contacts. Our sector is growing, with the recent transition of two health services to Aboriginal community control in Central Australia and two in the West Arnhem region in the last three years. More transitions from NT Government-run to Aboriginal community controlled PHC are planned in West Arnhem and there is also much interest from community about further transitions in Central Australia. The Northern Territory has an established and agreed commitment to transfer all Government run PHC services and clinics to Aboriginal community control over time.

ACCHSs deliver a range of services as part of a broader model of Comprehensive Primary Health Care (CPHC), aligned with the Alma Ata Declaration on primary health care which asserted that health care is a human right and should be based on community participation and the principle of equity. ACCHSs have been built on a holistic definition of health since their beginning where:

> *"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in*

> *which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community. It is a whole of life view and includes the cyclical concept of life-death-life.* (NACCHO)

CPHC is an intentionally broad understanding of primary health care that is reflective of a holistic understanding of health adopted by Aboriginal people. It includes a medical component however this should not imply that services are delivered through the lens of a medical model. ACCHS deliver a wide range of non-clinical services such as allied health, social and emotional wellbeing, psychosocial support, family support, youth support, early childhood development, education and care, health promotion, public health, aged care, and disability services. ACCHS are, by design, "complete and joined up ecosystem[s] of support" (NDIS Review What Have We Heard Summary Report, p.13)

The effectiveness of ACCHS model of community-controlled governance combined with this approach to CPHS is best summed up in the National Agreement on Closing the Gap:

> *Aboriginal and Torres Strait Islander community-controlled services are **better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people, and are often preferred over mainstream services**. Priority Reform Two received the strongest support in the 2019 engagements*
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> (National Agreement on Closing the Gap, 43).

The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is a crucial initiative aimed at providing support and services to people with disabilities across Australia. While the NDIS has brought about significant positive changes for many people living with disability, the unique challenges faced in the NT necessitate a different funding and service delivery approach for Aboriginal people. Aligning the funding approach of the NDIS with the community controlled model that has proven most effective in the delivery of Comprehensive Primary Health Care is essential to address the many challenges that the Scheme has posed for the delivery of high quality, continuous, and sustainable services for Aboriginal people in the NT. These challenges are outlined below.

In 2019, AMSANT's submission in response to the NDIS Thin Market Project Discussion Paper reported that "It is our members experience that many aspects of Aboriginal health and the wider human service delivery sector are not suited to the introduction of greater competition and user choice under a market-based system such as the NDIS". There are many reasons for this:

- **Community control is the ultimate expression of voice and choice**
  The model of community controlled governance that has been developed and underpins ACCHS and ACCOs is an expression of self-determination exercised by Aboriginal communities – they represent the **most significant expression of voice and choice of Aboriginal communities** who have taken control of their own health and human services, precisely because of the failings of privatised and government

systems. A market-driven competitive model has, in effect, put local Aboriginal owned and governed services in competition with a range of non-Indigenous non-government and privately owned businesses, creating fragmentation in both funding and service delivery.

- **Competition undermines collaboration and partnerships**
  The notion that competition will promote greater 'user choice' is misaligned with a key principle of community control – **collaboration and partnerships**. If we are to truly put the person at the centre of support, services need to complement each other, not compete. Given the range of supports that people with disability require, ACCHS are not aligned to deliver them all. However, the duplication of some services via a competitive model, while significant service gaps still exist in other areas, is counter to the interests of Aboriginal people with disabilities. A collaborative effort is required to ensure that all the supports Aboriginal people with disabilities may need are available. Partnerships are also a very effective way to manage conflicts of interest, noting that a competitive business model is an enticement for disability service providers to become supports coordinators with a motive to generate more business, as opposed to focusing on participants' needs and choices.

- **ACCHS are subsidising the Scheme**
  The rates set by the NDIS for remote service delivery significantly underestimate the cost of remote service delivery. ACCHS in the NT that are delivering NDIS services are reporting a loss and subsidising the service with other funding. The effect is that while NDIS participants are receiving the services they need, it is at the expense of others who also have significantly high needs whether this be chronic conditions management, early childhood development, social and emotional wellbeing (inclusive of mental health and alcohol and other drugs) therapy and rehabilitation, etc. The less care and support ACCHS are able to provide in these areas, the higher the rates of disability Aboriginal people are likely to experience in the future (for example, Fetal Alcohol Spectrum Disorder and diabetes related impairments, etc)

  Most NDIS Planners and private Supports Coordinators lack cultural understanding generally and in community-specific contexts. Further, the virtual/telephone planning model and FIFO model of supports coordination that has emerged, mean they also lack relationships with potential clients and families. As a consequence, it is ACCHS staff, usually Aboriginal staff, who are left to advocate for participants, leaned on to organise and facilitate planning and support coordination meetings, act as interpreters (whether this be in local language and/or the translation of complex and bureaucratic concepts), provide transportation for participants and the visiting NDIS service providers, and provide the clinic space for the meeting or the phone to make the call. Further, frequently it is the ACCHS that is left to coordinate and deliver the services on the ground.

  The same is true for the provision of medical and allied health services. In the first instance, NDIS requires a diagnosis, and it is ACCHS GPs, Aboriginal Health Practitioners, nurses and allied health professionals who must carry the weight of this role, even when it is clearly apparent that a person has disability. The long delays in

accessing the assessments required by the NDIS mean that ACCHS are relied upon to continue to support potential participants indefinitely.

Further, it is ACCHS allied health professionals who typically provide the therapy services for NDIS participants. However, the NDIS funding model presumes a mainstream 'appointment-based' model which is ineffective in many remote and regional Aboriginal community contexts for a variety of reasons. Further, in the NT, there is significant transience of Aboriginal people between remote communities and regional centres, and ACCHS, particularly in regional centres, are often providing these services with no knowledge of whether a person has an NDIS plan and, therefore, no capacity to draw down on it.

- **Workforce challenges are exacerbated**
  The NDIS presents a significant job creation opportunity for Aboriginal people in the NT. However, with the challenges accessing the scheme - by way of lack of diagnosis and/or significant barriers stemming from a culturally unsafe and overly bureaucratic process - and the small populations on remote communities, there is not a "critical mass" of participants to create the economies of scale required to effectively train, support, and sustain a local disability workforce. The funding-related challenges of supporting a community-based Aboriginal workforce is much like those associated with Supported Independent Living (SIL) where it is not as simple as one support worker – one participant ratio. Teams are required and supporting and sustaining teams require local coordination and management.

  There is an allied health workforce shortage in the NT and, for reasons cited above, the NDIS fee for service model is not aligned to support the employment of allied health in stable regionally based roles. The transition of the NT PHN funded Medical Outreach Indigenous Chronic Disease program from an 'drive-in-drive out' or 'fly-in-fly-out' contracted outreach model to one that has enabled ACCHS to employ allied health directly. This has resulted in the significant cost efficiencies while simultaneously achieving significant improvements in quality and continuity of care. Most importantly, allied health staff are able to work more closely with local Aboriginal staff, thus delivering a more culturally safe and effective service; for Aboriginal people with chronic conditions as well as significant cost efficiencies.

- **Participants are charged more than necessary**
  While the NDIS significantly underestimates the cost of remote service delivery, the FIFO model it promotes in the NT is excessively expensive with participants being charged for charter flights for the purpose of a meeting with a supports coordinator or the delivery of equipment. The aviation industry has arguably been the most significant benefactor of the 'market stimulation' that has resulted from the NDIS in the NT.

A solution for the NT

AMSANT and our member services have been advocating for change to address the failings of the NDIS model for Aboriginal people in the NT for many years. The solution, at its core, lies in alignment of decision-making about the future design and funding model that will

support the best outcomes with the National Agreement on Closing the Gap Priority Reform One – Formal partnerships and shared decision-making.

The recent Productivity Commission's *Review of the National Agreement on Closing the Gap Draft Report, July 2023* states that "It is too easy to find examples of government decisions that contradict commitments in the Agreement, that do not reflect Aboriginal and Torres Strait Islander people's priorities and perspectives and that exacerbate, rather than remedy, disadvantage and discrimination" (p.2).

AMSANT and our members would like to work collaboratively with the National Disability Insurance Agency to design a model for the NDIS that delivers the best outcomes for Aboriginal people with disability in the NT.

Our proposal is to establish an alternative funding arrangement for an integrated NDIS model of service within the NT Aboriginal Community Controlled Primary Health Care Sector. This is by adopting the funding model that has already proven effective in the delivery of CPHC in the NT (and nationally) under the Indigenous Australians Health Program. This model includes:

- Core flexible Primary Health Care (PHC) funding that enables ACCHS to design service models that best meet the needs of communities and provides a stable foundation for employment and operation of a service that is not dependent on achieving economies of scale. An annual Activity Work Plan and reporting to agreed National Aboriginal Health Key Performance Indicators is the means through which outcomes are monitored and ACCHS are held to account.
- Individual Medicare claims for the delivery of Medicare eligible services (in the same manner as mainstream PHC services are funded).

This funding model could easily be replicated with core flexible NDIS funding combined with the capacity to draw down on participant's individual plans for specific services. We believe it is already being implemented in the Kimberly region by KAMS but just for children - AMSANT supports this holistic model becoming available to all Aboriginal people.

For core flexible NDIS funding, AMSANT proposes that each NT region is funded sufficiently for an allied health team with support from Allied Health Assistants, Aboriginal health coordinators and community-based coordinators. Regional allied health teams can operate and serve their regions through a visiting hub and spoke model to overcome the challenges with remote recruitment and accommodation. NT ACCHSs are already providing such regional services through a hub-and-spoke approach to the Tackling Indigenous Smoking program. Some ACCHSs would be large enough to be funded to employ these teams while other smaller ACCHSs might need to form collaborative relationships with larger ACCHSs in their region. Communities serviced by NT government clinics could also be serviced by a regional ACCHSs team by arrangement with Northern Territory Government, noting that people with disabilities in these communities will be facing the same issues as outlined in this submission. In areas of the NT where there is no regional ACCHS, another Aboriginal organisation could be supported to deliver a regional approach so that there could be one system across the NT. (Note, a commitment to, and investment in, training and development of the local Aboriginal

disability workforce (e.g., facilitating entry through the provision of Cert II training on country) is necessary to provide the foundations).

A blended funding model combined with a regional approach led by ACCHS will:

- Enable cost efficiencies through the development of economies of scale, improved coordination of services and decreased transport costs.
- Increase the consistency, fairness, and quality of plans for participants. This will include the right supports for families to help children reach their goals.
- Increase the Aboriginal disability support workforce as key to improving the accessibility of the scheme, culturally safe delivery of disability support services, and ongoing daily support to clients, supplemented by visiting specialist staff.
- Enable improved coordination and delivery of training, workforce development and promotion of career pathways for the local Aboriginal disability support workforce and emerging leaders, through replicating AMSANT's regional model for the delivery of Social and Emotional Wellbeing (SEWB) training and workforce development. This model includes two SEWB Regional Leads for each region across the NT, who stay abreast of workforce trends and needs, and training and workforce development activities are tailored to those needs.
- Enable the replication, adaptation and development of new sustainable and cohesive programs that are targeted to the priority needs of communities. For example, the Central Australian Aboriginal Congress' (CAAC) Child & Youth Assessment & Treatment program, a multidisciplinary allied health service which assesses, diagnoses and treats Aboriginal children and youth, aged 0 – 18 years, with neurodevelopmental, speech and language development disorders, including Foetal Alcohol Spectrum Disorder (FASD). This service needs to be made available NT wide.
- Facilitate a focused sector-wide effort to ensure that participants' are provided with opportunity to provide informed consent for sharing their NDIS plans through My Health Record (or other means) to ensure they are supported when they travel to a different community or a regional centre.

Next steps: AMSANT and our members are seeking a recommendation from the review committee that the NDIA work with AMSANT and our members to co-design a funding and service delivery model for the NT, with the concepts described above providing a broad framework for this work.

Thank you for considering our submission and your dedication to improving disability support services in the Northern Territory. We look forward to the opportunity to further contribute to the review process and the ongoing improvement of the NDIS for Aboriginal people in the Northern Territory.