University Department of Rural Health

The perspectives of National Disability Insurance Scheme service providers on student placements in rural Victoria

Dr Claire Quilliam
Professor Lisa Bourke

2019

Table of Contents

Executive Summary 3

Introduction 4

How was the study conducted? 7

Recruitment 7

Data collection 7

Analysis 7

What did we find? 8

Enablers to offering student placements 8

Barriers to offering student placements 10

Impacts of the NDIS on service 13

Impacts of the NDIS on student placements 18

Ways to support organisations to offer [more] student placements 22

Discussion 26

Recommendations 28

References 29

Acknowledgements 31

Executive Summary

The National Disability Insurance Scheme (NDIS) is transforming the way services are provided to people with disability in Australia. It is shifting part or—for some organisations—all funding from block to a fee-for-service model. There are concerns this shift may risk the financial viability of organisations and therefore service provision in rural and remote areas because there are fewer people with NDIS funding to purchase services. The impact of the NDIS on other organisational activities, such as the placement of allied health students, is largely unknown. Given the substantive role student placements play in securing the Australian rural allied health workforce, this study explored the perceived impacts of the NDIS on allied health student placements in NDIS funded organisations located in rural Victoria. Face-to-face interviews were conducted with 20 health professionals involved with student placements in NDIS-funded health and human service organisations in the Goulburn, Ovens Murray, Loddon, Central Highlands and Western District regions of Victoria. These interviews were audio-recorded, transcribed verbatim and analysed using enumerative and content analysis techniques. The study found the NDIS may have impacted rural health and human service organisations that previously relied on block funding and now heavily relied on fee-for-service NDIS funding, such as disability services and community health service organisations. Participants from these organisations described how the NDIS had impacted on organisational structures and processes, on the nature and types of services provided, on the service market, and on people with disability and their families. They described how these changes impacted on organisational capacity to conduct other activities, including hosting students on placement. Participants described how student placements provided a means for rural organisations to recruit allied health professionals, and to build the rural allied health workforce that is skilled in disability practice. However, participants also noted the NDIS presented new barriers to offering student placements. Many participants described ceasing to offer placements while their organisation transitioned to the NDIS. Many were concerned about their organisation's capacity to offer student placements into the future because of the long-term impact of the NDIS on the organisation and on service provision. Participants were also concerned about involving students in service provision within in a competitive service market, particularly given the risk that poor student practices may negatively impact on organisational reputation. These participants struggled to reconcile the costs associated with hosting students on placement. Overall, the findings suggest the NDIS could potentially change the nature and reduce the number of allied health student placements in rural Victoria. This impact on rural allied health student placements could diminish the rural allied health workforce, particularly in disability services and community health service organisations providing services to people with disability. The impact of the NDIS on rural health and human services means these organisations can no longer be expected to carry the responsibility of preparing students for the allied health workforce. It is recommended that state and federal government departments and agencies, including the NDIA, universities, and allied health professional bodies, accept more responsibility for enabling student placements in rural Victoria. These stakeholders need to work together to identify strategies that will lead to the provision of adequate funding and other incentives to rural health and human service organisations, so they can continue to offer placements to allied health students in the future.

Introduction

In 2013, the Australian Federal Government introduced the National Disability Insurance Scheme (NDIS). The NDIS is considered an important policy reform to support people with disability to have choice and control over day-to-day supports and to lead meaningful lives in the communities of their choice. At a cost of $22 billion, the NDIS is expected to be fully rolled out by 2020, and include approximately 475, 000 "NDIS participants"—or people with individualised support plans and NDIS funding (Productivity Commission, 2017). The NDIS signifies a major change to the way health and human service organisations receive funds and provide services to people with disability. "Block" funding previously provided by state governments to disability service organisations is being phased out for an individualised "fee-for-service" funding model (Carey, Malbon, Olney, & Reeders, 2018). Health and human service organisations wishing to receive NDIS funding directly are expected to register as NDIS service providers. In December 2018, there were 19, 075 registered NDIS service providers, including hospitals, community health services, disability services, and private allied health practices (National Disability Insurance Agency [NDIA], 2018b; 2018c). Further, there were 244, 653 people with NDIS funding to purchase services from service providers (NDIA, 2018c).

The transition to a fee-for-service funding model presents new opportunities and new concerns for health and human service organisations (National Disability Services [NDS], 2017). The injection of funds into the disability services system suggests that service providers have the opportunity to attract new customers and develop new services. However, the NDIS fee-for-service funding model is more insecure than the block funding model used previously (Mavromaras et al., 2018). Funding for services is capped to the prices listed on the NDIA services price list, meaning service providers cannot charge fees exceeding those amounts. Service providers are expected to develop service agreements and invoice individual people with NDIS funding to generate income (NDIA, 2016b). The capped fees are expected to cover all costs associated with service provision, including overheads such as the establishment of new information technology systems required through the transition, marketing of services, and staff training (McKinsey & Company, 2018). The NDIA offers price loading for supports for particular people with NDIS funding, including people living in remote areas, people with complex support needs, and those requiring assistive technology. However, the NDS (2018a) State of the Sector Report found the NDIS prices did not cover the full cost of service provision. The respondents in the NDS study suggested the low prices impacted their capacity to provide staff supervision and training, and on work to recruit and retain qualified staff. A review of the NDIS prices by McKinsey and Company (2018) found the price loading was insufficient to provide services to people in remote areas.

The transition to the NDIS means health and human service organisations providing services to people with disability are now in a quasi-market, characterised by competition and consumer choice (Green, Malbon, Carey, Dickinson, & Reeders, 2018; Malbon, Carey, & Dickinson, 2018). The move toward a quasi-market is based on the idea that service providers will rise to meet market demands in efficient and innovative ways (Malbon et al., 2018). The final NDIS evaluation report by Mavromaras et al. (2018) demonstrated that many NDIS service providers have expanded to provide increased services to people with NDIS funding. However, quasi-markets are also expected to allow people with NDIS funding to move between service providers to receive services and supports of their choice. Health and human service organisations wishing to attract NDIS funding are therefore in competition, vying for the business of people with NDIS funding (Green et al., 2018).

The impact of a competitive quasi-market in rural and remote areas of Australia is yet to be fully understood (Dew et al., 2016). Roughly 30 per cent of Australia's population live in rural or remote areas of Australia (Australian Bureau of Statistics, 2017). These areas are likely to have fewer people with NDIS funding, less demand for services and fewer services available (Gallego et al., 2018; Gilroy, Dew, Lincoln, & Hines, 2017). These areas are at risk of experiencing 'thin markets' because they may only have a few NDIS providers servicing the area, or lack providers for particular services entirely (Carey, Malbon, Reeders, Kavanagh, & Llewellyn, 2017). People with NDIS funding living in rural and remote areas of Australia are therefore at risk of not receiving services, having little choice or control over the services they request (Gallego et al., 2018), and having their funding retracted because they did not use it (Warr et al., 2017).

The NDIS has the potential to impact on rural health and human service organisations in ways that reach beyond service provision. The quasi-market could impact on activities that these organisations previously considered as important aspects of their work, for example, activities that aimed at building inclusive communities (Brotherhood of St. Laurence, 2018; Jenkin & Wilson, 2009), or at supporting students on placement to build an allied health workforce capable of meeting the growing service demand (Flinders University, 2018). Considering the shortage of allied health professionals and increased demand for allied health services in rural and remote areas of Australia (Lincoln et al.,

2014; Mavromaras et al., 2018), it is important to explore and address the impact of policy reforms, such as the NDIS, on the rural allied health workforce.

Rurally-based student placements are considered crucial in the development of the rural allied health workforce (Department of Health, 2013; Humphreys, Lyle, & Barlow, 2018; Playford, Larson, & Wheatland, 2006). Rurally-based placements can expose students to positive aspects of working rurally, such as experiencing a broad range of clinical tasks, and to positive aspects of living rurally, such as low living costs and having the opportunity to develop close ties with other community members (Keane, Lincoln, & Smith, 2012). It is thought that students who experience rurally-based student placements may decide to work in rural settings, after completing their studies (Taylor, Maharaj, Williams, & Sheldrake, 2009; Webster et al., 2010). The number of nursing and allied health student placements in rural regions of Australia have doubled between 2004 and 2013, following significant boosts in funding (Lyle & Greenhill, 2018). In 2016 there were 7407 rurally-based nursing and allied health student placements (Australian Rural Health Education Network, 2017). Rural health and human service organisations play an important role in promoting rural practice opportunities to students, by offering a rural environment to experience work in their chosen profession (Barnett et al., 2008). It is unknown however, if the NDIS has impacted on the capacity of rural health and human service organisations to offer student placements in the future.

Concerns about how the NDIS may impact on the rural allied health workforce have been highlighted by state and federal governments, agencies and departments. The Victorian Government (2016) NDIS Workforce Plan highlighted the need to build the rural nursing and allied health workforce, and to meet additional demand for their services in the disability sector. It proposed the development a capability framework and educational resources to boost the number of nursing and allied health professionals, and allied health assistants in regional Victoria. The plan fell short of detailing how the Victorian Government would support rural health and human service organisations to offer student placements. The Australian Government Department of Social Services (2015) suggested particular attention and strategies were required to develop the allied health workforce in rural and remote areas of Australia. For example, the Remote and Rural Indigenous Allied Health Workforce Development Project funded through the Sector Development Fund, aimed to explore the development of the remote and rural Indigenous allied health workforce (NDIA, 2018a). The Disability Reform Council (2015) posited that all levels of government need to make a concerted effort to build a suitable service market and a sustainable workforce to match, and suggested block funding be considered, if necessary, to develop service provision in rural and remote areas.

The NDIA's (2016a) Rural and Remote Strategy 2016-2019 demonstrated an awareness of the significant task required to build service provision in rural and remote areas of Australia, and meet service demand in these areas. The NDIA acknowledge the need to boost the number of rurally-based allied health professionals (NDIA, 2018a), and identified their role in supporting NDIS service providers to continue to offer allied health student placements (NDIA, 2017). The NDIA provided NDIS service providers with guidelines for hosting allied health students on placement. These guidelines stated that students on placement could provide services to people with NDIS funding, if supervised by a suitably qualified health professional. The guidelines also stated NDIS service providers could provide student-led services, free of charge, to people with NDIS funding (NDIA, 2017). However, these guidelines failed to address why people with NDIS funding would want to receive or pay for student-led services rather than services provided by qualified allied health professionals. The guidelines also failed to address how providing free services would incentivise health and human service organisations to supervise students, within the context of a fee-for-service funding model. Researchers from Flinders University (2018) highlighted concerns about the potential impact of the NDIS on the capacity for health and human service organisations to offer allied health student placements. These researchers are currently trialling a model of allied health student placements in one metropolitan region of South Australia, with the aim of meeting the requirements of all stakeholders involved, including NDIS service providers, people with NDIS funding, students, and allied health professional bodies.

The impacts of the NDIS on activities undertaken by rural health and human service organisations to offer student placements and to build the rural allied health workforce, are largely unknown. Given the substantive role of nursing and allied health student placements in securing the future rural allied health workforce in Australia (Department of Health, 2013), further work is required to understand if and how the NDIS has impacted on the capacity of rural health and human service organisations to offer nursing and allied health student placements. This work could identify potential strategies for government, universities, and allied health professional bodies to support rural health and human service organisations to continue their role in building the rural allied health workforce as the NDIS is

implemented. This study aimed to explore the perceived impacts of the NDIS on nursing and allied health student placements among staff in organisations funded at least partly by the NDIS, located in rural areas of Victoria.

How was the study conducted?

This study was conducted between February and November 2018. The University of Melbourne, Department of Rural Health Human Ethics Advisory Group provided approval for the researchers to conduct the study (ethics application ID: 1750733.1, 1750733.2). The study adopted a qualitative research approach because this allowed the researchers to investigate the perceived impacts of the NDIS on nursing and allied health student placements in rural health and human service organisations in an exploratory way (Crotty, 1998).

Recruitment

A total of 20 health professionals participated in the study: nine community health service employees, four disability service employees, four private practitioners and three hospital employees. These professionals worked in six community health services, four hospitals, three disability services and three private practices located in the Goulburn, Ovens Murray, Loddon, Central Highlands and Western District regions of Victoria. To recruit participants, the first author telephoned health and human service organisations that had advertised on the internet as providing NDIS funded services in these regions. This author asked to speak with an individual involved with facilitating student placements, employee professional development or with NDIS transition. Once contact had been made with the suitable individual, the author used the plain language statement to verbally introduce the study and invite them to talk further, face-to-face, about the study. The first author met face-to-face with all interested individuals, explained the study in detail and invited them to ask questions about the study. This author asked individuals to sign the consent form if they decided to participate in the study. No more than two health professionals from each organisation participated in the study.

Data collection

The first author conducted face-to-face interviews with 20 health professionals. The interviews ranged between 25 minutes and 1.5 hours in length. Interviews were semi-structured, and included questions regarding experiences with the NDIS, student placements and strategies for supporting rural health and human service organisations to offer student placements. These interviews were audio-recorded with participant permission and transcribed verbatim. All identifying data were removed from the transcriptions prior to analysis.

Analysis

The first author analysed the transcripts qualitatively for content relating to five key discussion points: enablers to student placements, barriers to student placements, impacts of the NDIS on service, impacts of the NDIS on student placements, and ways to support organisations to offer student placements. The author used enumerative content analysis techniques to identify the number of participants who perceived the NDIS as having had a significant impact on services, no impact on service provision, and the number of participants who were unsure if the NDIS had impacted on service provision (Grbich, 2013). The same technique was used to identify the number of participants who perceived the NDIS as having had a significant impact on student placements in their organisation, no impact on student placements, and the number of participants who were unsure if the NDIS had impacted on student placements. The author used content analysis techniques to code data within the five key points of enquiry, and organise these codes to identify mid-level categories (Hsieh & Shannon, 2005). The first and second authors reviewed and organised the mid-level categories to ensure they reflected participants' perceptions of the impact of the NDIS on student placements. Along with the enumerative data, the key points of enquiry and mid-level categories form the basis of this report.

What did we find?

Many participants perceived student placements as an important organisational activity. They saw student placements benefitting students, service users, allied health professionals, rural health and human service organisations, and the rural health workforce more generally. They emphasised the important role student placements play in promoting rural health careers to students: "If they [students] weren't having opportunities to come to rural health settings to do their placements, they might not want to work in rural health." Many believed rural health and human service organisations had "a responsibility to the community to help people learn and grow," and saw student placements as a means to contribute to the work of building the rural allied health workforce in Victoria. However, participants offered placements to local students before offering the same opportunity to students from other regions. They encouraged "kids to do placements in their own regional backyard," to help develop the skills of students who they believed were likely to work locally after graduating. Student placements also provided an opportunity for organisations to draw students to their region where there were few or no locally-based allied health students: "There are not as many students on this side of the state wanting to take up a placement." Student placements were considered a "useful investment" and "a vital part [of] workforce planning" for rural organisations: "One of the ways to ensure yourself against workforce issues is to have students." Placements allowed rural organisations to "trial" students as "potential employees." One participant explained:

> Student placements allow us to a—support a person in their studies, but b—to give us time to see how a person fits. And to show them what the organisation's like, and maybe, instil a desire to come here [to work].

Participants described a number of enablers and barriers to offering placements to nursing and allied health students. They also described the impacts of the NDIS on service provision and on student placements, and offered strategies to support rural organisations to offer student placements. These points will now be discussed.

Enablers to offering student placements

Participants described a number of enablers to rural health and human service organisations offering student placements, including having basic resources, support from external stakeholders, working well with other stakeholders, stable team conditions and organisational placement champions, consistent and productive organisational practices, having or generating funding for student placements, capable students, and organisations choosing to offer quality student placements.

Basic resources

Participants described how having basic resources enabled organisations to host students. Having physical resources such as student accommodation and designated student spaces with computers "where students can leave all of their belongings… and complete notes or do any assignment work", were considered particularly helpful. Time for supervision was another basic resource: "To offer quality placements you need to have time… to see a patient with you of course, and then to debrief afterwards."

Support from external stakeholders

Good support from external stakeholders enabled organisations to host students. When universities led the work of organising placements rather than expecting students to contact organisations, it streamlined the communication process and the task of organising placements for organisations. Participants described how University Departments of Rural Health [UDRH] student support scheme teams provided a range of services that enabled organisations to host students. These included the provision of external and paid supervisors for organisations that lacked suitable health professionals for student supervision, and accommodation and other financial support for students living away from home: "If you're still a student and you're renting wherever you're at uni, you can't then afford to pay rent somewhere [else] for a week. …The Going Rural Health [UDRH student support scheme team] money makes a huge difference." Supportive service users also enabled organisations to confidently offer student placements: "They [practitioners] go [say to service users], "look, I've got [-] with me today. She's a student. Are you happy for her to sit in with us for your consultation today?" We've never had someone say… 'No.'"

Working well with other stakeholders

Many participants described how working well with other stakeholders enabled organisations to host students. Participants described having strong "connections" with local universities that facilitated the organisation of placements: "We've always had a really good rapport with them [one university] and we take a lot of students [from the university]." Good working relationships between organisations and universities buffered logistical issues around organising placements, such as booking placement dates: "Having relationships with the universities—that's integral, because you need to have those discussions with them… Making sure that [organisational] departments are able to take the placements." One participant explained that rurally-based universities and organisations maintained these relationships more effectively than their metropolitan counterparts: "Rural communities, relationships tend to be stronger and easier." Alliances between community health service and disability service organisations enabled organisations to work collaboratively to offer student placements. Participants described pooling administrative resources for hosting students, and using "buddy up" systems, which allowed individual organisations to host students for part of their placement where it was not possible to host for the entire placement duration.

Stable team and organisational champions

Participants described the importance of hosting students within a "stable" team environment with minimal staff turnover and where staff had a "reasonable depth of experience." Skilled and experienced supervisors were considered important: "You need to have staff here who… can actually teach the students." Supportive managers were important because they encouraged student supervisors by "build[ing] their confidence" and providing supervisor training. Many participants highlighted the benefit of having a key person for students to contact: "You really need to have someone designated to be the primary responsible person. I think that's good for the student." Others suggested having multiple supervisors per student helped organisations sustain their commitment to students and to provide students with broad experiences. Participants described the importance of having placement "champions" in the organisation, including members of senior management, allied health professionals in other teams, human resource staff and placement coordinators. The placement coordinator role was considered a particularly important enabler to student placements. Placement coordinators maintained relationships with external stakeholders such as universities, and completed administrative duties relating to placements. This work reduced the administrative workload for supervisors and allowed them to focus on supervising students: "The only paperwork that the staff actually have to do for a student placement is signing off the competencies. [It] stops them having to worry about all the small stuff." A number of placement coordinators described selecting high-performing students so their organisations were less likely to host underperforming students: "We don't have many problem students—I deal with recruitment and the planning of it all." Many participants believed students gained broader experiences when placement coordinators were responsible for organising staff education, because the coordinator supported students to participate in professional development activities.

Consistent and productive organisational practices

Participants described how using consistent processes to organise placements, clarify expectations, and assess students prior to placements, helped reduce confusion about placements among organisational staff and students. Hosting students regularly helped staff to remain "in the flow" of having students, and in particular, enabled supervisors to remain familiar with student assessments. Participants described organising placements in advance by noting staffs' planned leave and using the online platform "Placeright." They described hosting students in pairs, so students could support each other throughout placements. They also described offering placements within the "core business" of the organisation so they could "supervise students with the appropriate resources and knowledge." Participants only offered placements that were an achievable length for the organisation, and used flexible placement arrangements that benefited the organisation: "They've [students have] been able to come in and do their hours across two or three school holidays… It's almost like having volunteers."

Having or generating funding for student placements

Many participants described how having or generating funding enabled organisations to host students. Secure funding for service activities certainly enabled organisations to offer student placements, as one participant explained: "We've had early intervention which was government funded and block funded. So we've been able to have students come and be involved in the program and running alongside our therapist there." Organisations sometimes generated revenue through student work: "We charge a fee for people to see our [students]." Some organisations charged universities to cover the cost of hosting students: "We now charge fees [for students] to the level that is appropriate

according to the guidelines. …I don't think they [the organisation] really wanted to do it, but you've got to run these things as a business."

Capable students

Participants described how students enabled their own placements by being open to learning, and competently completing tasks from the beginning of the placement. One participant noted that capable students could be distinguished early and were easier to supervise: "In a 10-week placement, particularly the first five weeks, if they … are on track and going to pass the placement as such, then your last five weeks are much easier." Participants described how students added value to organisations, by bringing "energy and enthusiasm" to the organisation, enabling organisations to explore new ideas and prompting a sense of accountability:

> That's the epitome of having a student. You've got someone who is really good, willing to learn, eager... The student challenges you to think about why you're doing something: 'Why do you do it this way?' … Having to explain it to someone else makes you have a look at a process … and [ask]… 'Is there a better way?' So, it does challenge you; having students.

Participants described how students completed important work for organisations while on placement. Capable students conducted research projects, wrote reports and developed resources on important topics. Their contributions were particularly valuable when there were gaps in funding or when staff were "quite busy" with their day-to-day tasks. Students also provided allied health professionals with an opportunity to "earn" professional development points through supervising students.

Organisations choosing to offer quality student placements

Organisations enabled student placements when they chose to offer students quality experiences. Participants described how rural organisations "looked after" students placed some distance from home, particularly by providing opportunities to make social connections: "[I] say to them, 'Come on, I'm going to yoga tonight' ...Those offers are there.'" Some described treating students as valued staff members, by including them in team activities, staff discussions, and extending employee support programs to students. They described providing students with interesting work tasks and experiences: "[It's] not a huge town, but we do have lots of really good programs as well, so there's variety [of experiences]—it's not like the students are just getting stuck with the same thing." Many participants described only offering good quality placements to students: "We won't take [students on] placements if we don't think we can offer quality [experiences]."

Barriers to offering student placements

Participants described a number of barriers to rural health and human service organisations offering student placements, including difficulties working with distant universities, mismatching placement expectations, difficulties recruiting distant students, organisational changes and disruptions, having finite resources, needing to prioritise service user and organisational requirements over placements, and student capacity.

Difficulties working with distant universities

A number of participants noted difficulties working with universities that were located some distance away: "The location of the universities can be a barrier… We don't have face-to-face or direct ability to communicate with them—they're always at a distance." Participants described having to negotiate overly complicated university processes to organise placements. One participant noted ongoing barriers to maintaining communication with distant universities: "Some of the administrative areas at the universities have a lot of turnover in staff, so you might be used to connecting with somebody but then all of a sudden they're no longer there." Poor communication with distant universities made it difficult for rural organisations to ascertain the quality of student work before offering placements to students. Inflexible administrative processes meant placement coordinators spent additional time organising placements: "The smaller kind of boutique-y sort of training providers… don't want to sign our partnership agreement and that can get really difficult."

Mismatching placement expectations

Participants described how university expectations for student placements sometimes mismatched organisational expectations. These expectations sometimes related to the timing of placements. Universities tended to organise placements for the second half of the year, although this did not always suit organisations because they became

"stacked with students." The nature of activities that universities expected students to undertake on placement sometimes mismatched with the activities that organisations offered: "The student might have projects they've got to do or, requirements set by the institute that are actually really challenging to even get them to do because it's not quite what we do, or it doesn't quite fit." Expectations surrounding workload during placements concerned some participants, and the length of placements also acted as a barrier to organisations offering student placements. Short placements did not always offer enough opportunity for students to learn: "One week … doesn't really give you the greatest opportunity to experience the setting." However, longer placements demanded significant organisational resources. A number of participants explained their organisations did not have the means to match placement expectations set by allied health professional bodies, such as the Australian Association of Social Workers [AASW]:

> We don't have enough qualified social work supervisors on staff … social work students [require] a 70-day placement—it's huge… Most of our staff, particularly our social workers, don't even work five days a week. So for us to have that supervision provided at the level they require from within [the organisation] can be very difficult, and we often have to request external supervision.

Difficulties recruiting distant students

Being located some distance from metropolitan-based universities made it difficult for organisations to recruit students. Rural placements often required students to move away from family or friends for a period of time. Participants saw this as "a real chore" for students who had invested time and developed connections elsewhere. They were also cynical about offering placements to distant students because previous attempts to entice these students to the rural community had been unsuccessful:

> Even if you get the students to the country, they don't want come back. They just want to do their placement and go. … I don't think it's a reflection on our practice. They like us but, yeah, their life is in Melbourne. That's where they've gone to uni. And they've got their friends. Not necessarily their family, but they've got their friends there. …that social network. So they don't want to start that over again.

Organisational changes and disruptions

Many participants described health and human service organisations as "changing spaces." Organisational restructures, service redevelopment, changing physical office buildings, and staff turnover all impacted on the capacity of organisations to offer student placements. Staff turnover was as a prominent barrier: "We have to adapt at the time. So, I have had to call up education providers and say, 'Look, we've had a massive staffing change. We actually can't take two students. We can only take one.'"

Providing placements within the resources available

Participants noted that organisations had limited resources, and this impacted on their capacity to offer student placements. Organisations often lacked the physical space required to place students: "Next year, we're not sure whether we'll take on students or not—that's only because of room availability. That's not because we don't want to. It's just [hard] finding a room." They described how organisations received limited and varied funding to place students. This was compounded by the lack of secure service funding for smaller services: "I'm not always the first person to respond to the email from [one university that] says 'can you take students?', and it's often the uncertainty with what's going on from year-to-year with contracts." Participants had difficulties finding short-term accommodation for students. One highlighted how students found it difficult to navigate rural towns with poor public transport: "There's definitely no public transport at night and when we get students down from metro areas who don't have their own mode of transport—that's definitely a barrier."

The lack of nursing and allied health professionals working in small rural organisations and areas made it difficult to host students on placement. Many participants described not having enough allied health professionals in the organisation to offer consistent supervision to students: "You can go talk to any of the agencies in town and have a conversation with them about trying to get qualified staff, and they are all screaming for people who have got any kind of experience or qualifications." Some highlighted that the part-time nature of the nursing and allied health workforce limited the capacity to offer student placements: "We had some maternity leave and things with our occupational therapists, so we weren't putting the pressure on them. We were asked to do occupational therapy placements this year, but we had said 'no' to that." Supervisors' lack of training, confidence or skills to supervise students limited their capacity to supervise students on placement. Participants described how they refrained from

loading supervision responsibilities onto new graduates: “We’re not taking students this year because we’ve got two new grads... We didn’t feel it’s appropriate to have new grads supervising students, so we’ll wait until they’ve had some more experience and done a bit more training.” Some allied health professional bodies required professionals to have particular experiences and qualifications to supervise students. This requirement also acted as a barrier:

> [Social workers] need to have a qualification that is acceptable for registration with the AASW, and they need to have two years full-time equivalent experience as a social workers [to offer student supervision]. … We’ve got a few staff at the moment who are completing their qualification... But at this point in time we’re a bit under-resourced.

Participants explained how organisations sometimes absorbed costs associated with hosting students on placement. The main cost came from a lack of income while supervising students: “It's taking time away from [the practitioner’s] earning capacity and she's not earning anything for the supervision. Because [she] doesn't charge the students for supervision.” Other costs came from time spent on organising placements, including the completion of administrative tasks to satisfy risk management requirements prior to hosting students. Being located near state borders required organisational staff to complete extra paperwork, such as history checks, for multiple jurisdictions prior to offering placements to students. Because organisations made very little or no money from hosting students, nursing and allied health professionals were often required to provide supervision to students “on top of their workload.” One participant highlighted that supervisors “struggle[d] to sort of supervise as well as they possibly should because of the commitments with their jobs.” Another explained how this additional supervisory workload resulted in “hosting fatigue.” They described how difficulties between supervisors and students led to supervisors feeling fatigued: “Hosting is always going to have a significant impact on somebody’s workload because they are with another person for three weeks and that can be challenging, particularly if you’ve got a student who ‘knows everything.’” When staff were fatigued, they looked for opportunities to drop unnecessary activities and responsibilities, such as supervising students on placement:

> Every time the pressure’s on is when we’re less likely to take students. So it’s not like, ‘Can we have more hands on decks? Get us some students.’ It’s absolutely the opposite. Like, ‘For goodness sake, don’t give us a student because we just can’t cope.’

Participants explained that organisations were unlikely to offer placements that would offer students a “half-baked opportunity” or poor-quality experiences:

> If we feel that the placement might be a bit tacked together because of our changing staff or if we’ve got quite a few new grads on at the time—and at times we have had that, then we’d be reluctant to offer a placement. Because we don’t think it would perhaps give the student enough.

Needing to prioritise service user and organisational requirements over placements

Organisations made careful decisions before offering student placements, and prioritised service users and the organisational requirements over student requirements. Participants described how they considered the potential impacts of having students present during service provision: “How many families can you impose on to have students involved in sessions? …We always have to weigh-up those options.” They noted the difficulties with involving students in complicated service provision, and described reducing student involvement in some areas: “We also don’t tend to put our students in our early childhood intervention services… We’re very aware of family’s privacy with very young children and families are still perhaps working through a grieving process.” Participants described how supervising students detracted staff from making organisational service “targets.” Staff prioritised meeting organisational targets over placement requirements because their roles depended on it:

> We have certain targets we need to meet for our funding… Each department has targets they have to achieve each month—try to achieve. So, obviously if we’re blocking out large amounts of time just to work one-on-one with the student, that then could have an impact on whether we’re achieving our targets. And our targets, is what our jobs are based on.

Student capacity

Student placements were sometimes limited by students’ own scope of interest, financial position, preparedness to adapt to the workplace environment, or capacity to undertake the work required during placements. Several participants described hosting students who lacked interest in completing placements involving particular groups of people, such as people with disability. Placements created additional financial stress for students who were covering

housing and other living expenses. Participants did not expect students to have developed professional competencies prior to completing study, although noted that supervisors had "a lot of hard work" to do when students were not able to undertake the work required during placements: "When you have a struggling student the workload increases because you're spending a lot more time trying to get them to pass the criteria of their placement." They described assessing students' skills prior to providing them with any tasks directly involving service users: "It's about our responsibility; about what [tasks] we can give students. …We have to make sure that they have a level of expertise before they can undertake some case work." When students were unwilling to learn new skills, or practice in-line with the organisational approach, they terminated placements:

> We've had a few students who come in here with their own agenda, and that doesn't work. [I say], 'I'm sorry, you're here for these clients'… And that comes as a really harsh learning curve for them. …I don't have a problem with bringing a placement to an end if I can see that the student is not a good fit.

Participants described how underperforming students could jeopardise the reputation and future business prospects of organisations. This was of particular concern to rural organisations, where poor reputation could significantly damage organisational viability: "If someone's paying privately, you're only as good as your last session, really… So if you've had the student and it's been a particularly bad session, they [the service user] might go, 'Oh…we can't rebook.' I've had that happen."

Impacts of the NDIS on service

Of the 20 participants, 10 perceived the NDIS as having had a significant impact on service in their organisation. Five others perceived it as having no impact on service, and the five remaining participants were unsure if the NDIS had impacted on service. Of the 10 participants who perceived the NDIS as having had a significant impact, seven worked at community health services and three at disability service organisations. Of the five participants who perceived the NDIS as having no impact on service, two worked at community health services, two at private allied health practices, and one at a hospital. Of the five who were unsure if the NDIS had impacted on service, three worked at hospitals, one at a private allied health practices, and one at a disability service. At the time of data collection, the NDIS had been rolled out for between six and nine months in all but one region of Victoria included in the study. This meant that the organisations in these regions were in the process of transitioning to the NDIS, as one participant explained: "It hasn't rolled-out completely. We're sitting in three-quarter-land." Some participants described the NDIS being a positive change for people with disability because "they now have a lot more help" to lead meaningful lives. However, many described the transition to the NDIS as a "work in progress" and highlighted that it had impacted on rural health and human service organisations and their service provision in several ways: by presenting a difficult period of transition, challenging existing organisational processes, creating changes to service provision, to the way people with disability and their families experience and receive services, to the service market, and to the rural workforce.

A time-consuming and confusing transition period

Many participants perceived the transition to the NDIS as a confusing period for their organisation. Several explained how their organisation had "been preparing" for the transition to the NDIS for years, and staff had been "living and breathing the NDIS": "They just used to have lots of staff meetings …they would always be talking about the implementation of the NDIS and the work that's been going into it." Participants noted the processes involved with registering organisations as NDIS service providers were difficult to navigate:

> It was just so much [work]. You've got to get a PRODA user name—you have to go online, fill it all out, like literally have your Medicare, birth certificate, driver's licence, passport to get your user name. From there, you then had to be able to get online and then we had to have [the practice] added to the NDIS list. It was just a nightmare. …That three months, and getting it out there to NDIS clients that we were actually NDIS providers; that, by far, was the hardest thing.

Participants recalled reaching out to NDIA staff and contracted staff at the Partner in the Community organisations for guidance around NDIS service provision. They explained how these staff sometimes provided helpful information, although at times they found it difficult to make contact or receive consistent information: "Dependent on who you ask, you can get different answers." The lack of contact with NDIA and contracted staff made it difficult for organisations to ensure they were properly registered, but also made it difficult to promote their services to people

with NDIS funding. The competitive nature of private practice meant private allied health practitioners did not work collaboratively to problem-solve in the transition period. However, one participant recalled a rare occasion where they had supported a close friend working at another private practice to register as a NDIS service provider:

> I had a practice manager from a clinic call me the other day and [she] said, 'This NDIS…' And I said, 'Wait. Just before you go any further,' I said, 'Call me back when I've got time to talk. Because it will be a long conversation.'

Challenging existing organisational processes

The introduction of the NDIS challenged existing organisational processes, to varying extents and in different ways. Participants from health and human service organisations with complex funding or those already working in a fee-for–service model, described the NDIS as having a negligible impact on services. Participants working in hospitals were largely unaware of any impacts of the NDIS on service, with the exception of it leading to new service opportunities: "We might start getting more referrals, seeing people that previously didn't have opportunities [for services] as well. But given that we are a public health service as well, it's not like we're going to start doing weekend [work]." Participants who worked at organisations that were familiar to the fee-for-service model, such as private practices, described the NDIS as having a negligible impact on service. They considered NDIS funding as just another "third party organisation" to engage with: "Instead of sending it [an invoice] to [one party], you're sending it to [another party]. That's it." These participants also described choosing to offer a narrow range of NDIS services to reduce the impact of the NDIS on the organisation: "We only offer one NDIS service... We don't offer specialist behaviour support or any of the others [services] that psychologists are allowed to offer. We chose not to offer them." One participant who worked at a disability service noted the NDIS had a negligible impact on the organisation and services because they were accustomed to a fee-for-service model: "I don't feel our day-to-day work has had to change drastically."

Participants who worked at organisations that were transitioning from block funding to a fee-for-service funding model, and that now heavily relied on NDIS funding, perceived the NDIS as having had a significant impact on service. The transition to the NDIS required these organisations to adopt a "different way of thinking" and embrace more flexible processes within service provision. This was not easy for some organisations, as one participant explained: "Agencies like us aren't set up to be invoicing individual clients. We've never done it." Participants in these organisations highlighted that fee-for-service funding was more insecure than block funding, and this made it difficult to organise employees for future work:

> When you're holding onto grant funding, you're guaranteed funding up front, so you can plan your workforce through for the whole year and you can make sure that you've got adequate staff who can cover the grants that you hold. When you're looking at a fee-for-service world, that's a lot harder.

The transition to a fee-for-service funding model resulted in a number of rural organisations losing block funding previously used to carry out range of different organisational activities: "There isn't any fat." For some organisations, this meant a loss of funding in a short period of time: "As we go along, DHS is taking funding out of our block funding for every child who is going across to the [NDIS]." During the transition, organisations supplemented NDIS services funding with other funding, although participants conceded that it was a short-term solution: "Our HACC funding–we can still use that, but that is going to go. So that's going to be a very different world when we can't fall back on that." Many described how the change in funding model had "changed our whole organisation" and created losses in personnel and "intellectual capital." One participant explained: "Our service [valued at a six-figure amount] went down to [approximately half this amount]. …We had to make people redundant and [the service team] halved."

The change in funding model cut into planning and administration funded activities: "With NDIS, there's no admin time paid." This concerned participants because organisations providing NDIS services required additional time to plan individual services for people with NDIS funding and report on service provision. One participant from a community health service explained how allied health professionals resorted to completing planning and reporting work in the time allocated for therapy:

> There is no money in the NDIS for planning, for administration, for office [work]… none of that back of house stuff is funded at all. We're going to have staff who have to figure out who this person [the service user] is, what they need and all that sort of stuff on the fly.

When allied health professionals did not remind people with NDIS funding to request allied health service funding in their NDIS plans, organisations lost business because they could not provide services without approved funding: "The

first couple of months that the NDIS was here, our podiatry rates plummeted because people didn't realise it had to be in their plan." Participants described not being able to spend time developing new resources and programs: "When you are running a program for the first time, it takes a lot longer to get that up and running. …Developing whole new programs from scratch would be really challenging, because the development time is not funded anywhere." One participant noted how a lack of funded administration time could potentially cut efforts decrease risks to the health and welfare of service users and employees: "We'll always have a look at risk, but there might be some NDIS providers that say, 'You [the service users] can go and do that,' without considering what the ramifications are."

Changing services

The NDIS provided opportunities for organisations to receive additional funding for service provision. However, participants noted that the funding needed to lead to good quality services for people with disability: "It's great to have the funds there, [to] give families an opportunity; be accessing more things. But service provision needs to be good, too." Many described how their organisations were adapting to the new funding model. However, for many organisations, these adaptions meant changes to services. Participants described how organisations tried to anticipate the impact of the funding change on service activities and financial viability of these services. Participants highlighted that in rural areas, services needed to generate immediate interest from people with NDIS funding to remain viable: "If we've only got three [people] wanting to pay for that service, do we run the program? …The viability of some programs is going to come down to who's prepared to pay, use their money for that service."

Organisations responded to this financial pressure in different ways. Some participants described how it had "prompted us, or forced us, to be more creative in how we do some things." Several participants described expanding into new service markets. One explained how their organisation had recently opened allied health services for adults: "We've just started up a lifestyle program for young adults and teenagers." Others described exploring opportunities to receive funding in other allied health services being funded by the NDIS, such in occupational therapy services. One participant described their concern that the new funding model may tempt service providers to "over-service" people with NDIS funding who could easily demonstrate goals being achieved, and disregard people who might require more support to demonstrate goal achievement. They explained how this could result with groups of people with disability not being serviced: "If you put in an outcomes model, so you pay people on outcomes, they cherry pick; they only take the easy ones. …I've seen it happen in those markets and the most disadvantaged people miss out."

While some participants described the opportunity for service growth, others described how organisations were having to make bold decisions about the future of existing services: "It does mean offering programs that are financially viable and not being able to offer those that aren't." These participants highlighted how the price caps associated with the change in funding model prevented organisations from covering basic organisational expenses: "You can't not pay Work Cover. You can't not pay your insurances. You can't not run your fleet. So the rest of the organisation would have had to have supported a nonviable program." As a result, organisations cut services because they were no longer cost effective: "Some programs are not financially viable to operate under the NDIS, so we won't be able to continue with those." Participants described narrowing the types of services and activities within them. For example, several described how group services relating to school-aged children, such as school holiday and after-school programs, had closed or were at risk of closing in the future. An occupational therapist suggested the new funding process limited the capacity of allied health professionals to provide "future planning" therapy, and provide equipment for people with degenerative disabilities. Another allied health professional described how they were no longer able to offer services requiring time to set up or pack away equipment:

> In the past we've run [services] where children are working on specific gross motor skills. That often requires a lot of equipment to be set up in preparation for that. Now there's no space to actually spend half an hour setting up and packing up equipment.

Allied health professionals working within disability services and community health service organisations noted that the "cap on the amount of travel that can be charged to someone's plan" prevented staff from providing services in the service users' own environments, and instead, encouraged allied health professionals to work in clinical spaces. Participants working in disability services were unclear about whether they would be able to continue providing transport for people with NDIS funding. One queried: "We bus the students to places—are we going to have the funding to do that?"

The NDIS required organisations to work in service user-led ways. This challenged allied health professionals who were unfamiliar with "families … dictating that to us that 'that's what we would like.'" The changes also challenged

traditional models of allied health service provision, where professionals typically used a multidisciplinary approach to address the family unit of a person with a disability. One participant explained:

> I think the NDIS funding … is somewhat missing that mark… New families coming into the system… they see it very much directed at the child because that's how the plan's written, the goals are written very specifically around the child. Even the family's understanding isn't about, 'Let's operate with you as a family. Let's talk about the siblings in the family.'

Changes for people with disability and their families

The NDIS provided funding to people with disability who had previously not received funding or services. This was seen as a positive change for people with disability, and for organisations that had previously provided services at no cost to people who could not afford to pay for them. However, a few participants noted that people with disability were receiving inequitable amounts of NDIS funding, with some people receiving excessive amounts of funding for services, and others receiving little or no NDIS funding for required services. While some organisations chose to continue to provide free services, a number of participants described how their organisation had no choice but to cease the provision of free services to people with disability: "We used to carry individuals. If they couldn't pay… we'd write off debts. We can't write off debts now. So, if they're not paying their bills, then we can't continue to service them."

Allied health professionals, such as occupational therapists and speech therapists, recalled having frank conversations with people with NDIS funding and their families to develop service agreements that maximised the impact of NDIS funding. These participants described how they now encouraged families to take responsibility for tasks that they would have previously completed as part of the service, such as researching pieces of equipment or coordinating other tasks relating to services. If allied health professionals needed to complete work beyond existing service agreements, they had to establish new service agreements with the person and their families: "'You've asked me to write a letter to your paediatrician. I am able to do that. I expect that will take me a half-an-hour to do. Are you happy with me doing that?'" They found it "fairly unpleasant" to talk with people with NDIS funding and their families about money; to explain to them that "they're not getting the same services that they had." They explained how changes to the NDIS had stressed relationships between service users, families and organisations. Several participants recalled recent events where families of young people with disability had not received adequate funding for services and threatened to relinquish responsibility of their child. One noted that the sudden access to funding through the NDIS meant many families were waiting for services and were confused about how to proceed through the service system:

> We know families that don't know where to go, what to do. …We used to have a referral pathway in Victoria that was working reasonably well and that's been interrupted. …Families are waiting significant periods of time to access service.

Changes to the service market

The NDIS had impacted on the service market in rural areas of Victoria. Organisations that had traditionally functioned as non-profit community-based organisations were now in competition with other organisations, including for-profit organisations: "We're no different moving forwards, to any other private provider. We're in the same market, after the same dollars as everybody else." Participants working in disability services or community health service organisations suggested that the "NDIS has seen an end" to community-based, non-profit allied health service provision. One participant working at a community health service felt uncomfortable about the change: "Clinicians have come into community health because they like that model of care, where you've perhaps got a bit more time; you can perhaps have more regard for quality. …But that model of care is going."

Participants described how the transition to a competitive service market coincided with a time of increased service demand. They noted that organisations in rural areas were "struggling to keep up" with the additional demand for services. Service markets in some rural areas were somewhat "thin" in the range of services available to people with NDIS funding: "The problem in our region is, and I'm sure in a lot of the regional areas… There's not the diversity of services here that was hoped for. …Not that range of choice." One participant who worked at a hospital noted they did not have the capacity to provide services to people with NDIS funding who required intensive support. The lack of local service providers meant people with NDIS funding had to find services outside of their local town:

> Our gym doesn't have capacity to see someone one-on-one four times a week who's in a wheelchair, unfortunately. So, I've had to say to them, 'Look, try [another town].' …I think [this] would be the same in a lot of smaller towns.

Participants also explained that services that were available had growing waiting lists: "The biggest barrier for me is that staff simply don't have any capacity. If we get a new case coming in today, who do I give that case to? …My staff are sitting there with a waiting list." The competitive nature of the service market placed significant pressure on rural organisations to keep up with service demand, or risk service users "going somewhere else." One psychologist recalled a conversation with a support coordinator, where she was told, "If you don't do it [provide the services], I will find another psychologist to do it." Because existing rural organisations struggled to meet service demand, new organisations were opening in rural areas. A number of participants explained the sense of distrust for new organisations as being "a very rural thing": "It's probably a little bit indicative of rural mentality that people don't trust newcomers. … If they look like they've only sprung up because there's a business opportunity created by the NDIS, they're [local service users are] even more hesitant to recommend them." The extreme end of the changes to the service market saw rural health and human service organisations questioning their capacity to provide NDIS funded services, and de-registering as NDIS service providers. One participant explained:

> We thought long and hard about whether we as an organisation were going to participate in the NDIS. We anecdotally thought that it might be very difficult for us because of the [cost] prices. ...Our [disability] service was dabbling in fee-for-service at the time and we thought we'd build that up and have some NDIS stuff and somehow it might be viable. …We were quite shocked to find that in fact it was absolutely not viable for us in any shape or form.

Changes to the rural workforce

Participants described how the NDIS had changed the rural health and human services workforce. They described how experienced professionals were "moving around," partly because they were "making decisions about whether they want to be part of the NDIS," although more because the new funding model had forced changes to the workforce. Some explained how senior level allied health professionals were occupied with managing services during the NDIS transition rather than doing other tasks, such as providing services or supervising less senior allied health professionals. One described explained how the funding changes had created "shorter-term contracts" and more precarious employment conditions for allied health professionals: "The insecurity for the worker at the moment is incredible." Another described how, at the time of interview, their entire team of allied health professionals were at risk of losing employment: "I have contracts that are up for renewal at the end of June and I still don't know whether they're going to roll them over…That makes it very difficult to manage a workforce with that level of uncertainty." Participants suggested the capped service prices could lead to increased casualisation of the allied health workforce, which would make it difficult for organisations to incentivise staff to work well: "[It] was barely enough to pay a person for their exact time. It didn't cover their transport. It didn't cover any form of supervision [or] training. …We wouldn't have any ability to wrap anything round them to support them." Some described rural organisations were finding it difficult to recruit allied health professionals under the NDIS: "[We] can't get them."

The NDIS funding changes had shaped the types of professionals that health and human service organisations recruited for NDIS service provision. Participants described how organisations were reducing managerial and administration roles and "recruiting to the waiting lists," which meant recruiting speech therapists and occupational therapists because their services were in demand: "When someone leaves, we wouldn't necessarily be replacing like-for-like. We would be looking at where is the demand for service and replacing based on that demand." Recruiting to the waiting lists also meant not employing allied health professionals who were rarely requested through NDIS funding, such as social workers. Participants explained that service demand was now driven by people with NDIS funding and their families. Many highlighted that families lacked awareness of the work undertaken by allied health professionals: "That's a disadvantage for lesser known service [providers] like social work[ers] and educational advisers. We clearly understand … what they have to offer, [but] families don't necessarily understand those roles." The loss of managers, administrators, and particular allied health professions from rural organisations equated to a significant overall loss to the rural allied health workforce, at a time of high service demand. A few participants highlighted their concerns about the loss of workforce: "It would be such a shame to lose the experience out of the industry, it really would. And that's what it looks like is going to happen across the board."

Participants were concerned about the potential impacts of low competition for some allied health roles and high demand for allied health service provision. They suggested that "small, individual and private providers… flooding into the markets" would fill allied health service gaps. One participant noted these smaller organisations were "very efficient… because they [ran] on very low set up and running costs," although warned these service providers did not "necessarily attract the best people." Some participants suggested these service providers would hire graduate allied health professionals who have little professional experience. One participant explained that this would reduce service quality in rural areas:

> I think that will then reduce the quality of service. Not to discredit a new graduate, but it's hard work. Those clients can be really hard work. …And to know where you fit in with it … comes back to years of experience. …You go, 'Oh I made lots of mistakes along the way.' And you have to make lots of mistakes along the way, to work out how to become a great therapist.

However, some conceded that it was better to have well supported graduate allied health professionals, than no allied health professionals in rural regions. One participant described using traditional workplace conditions to recruit prospective allied health professionals:

> We have good facilities here. And supervision and good corporate support… We're a very expensive organisation but hopefully clinicians will then translate that into a positive experience from working here. We've got a fleet of cars out there. You know, we've got a good office environment. Get paid on time. We've got a payroll, we've got human resources, we've got clinical supervision. All those things … hopefully mean that somebody would rather come here than perhaps just be working out on there, on their own.

Many emphasised that a strong allied health workforce, which included graduates and allied health students, was necessary to provide good quality services to people with disability living in rural areas of Victoria:

> We all know why we're here, and we know it's for the families and the participants and we're not going to deny that at all. But now it's important to look at the workforce; the people that are here to support the families—and the workforce includes students.

Impacts of the NDIS on student placements

Of the 20 participants, eight perceived the NDIS as having had a significant impact on student placements in their organisation. Four others perceived the NDIS to have had no impact on student placements, and the remaining eight participants perceived it to have insignificant impact or were unsure about its impact on student placements. Of the eight participants who perceived the NDIS to have had a significant impact on student placements, five worked at disability service organisations and the remaining three worked at community health services. Of the four participants who perceived the NDIS to have had no impact on student placements, two worked at private allied health practices, one at a community health service, and one at a hospital. Of the eight who perceived it to have insignificant impact or were unsure about its impact on student placements, four worked at community health services, three worked at hospitals, one at a private allied health practice. Participants described how the NDIS had varying impacts on the number of student placements, and their nature and quality. They also explained how changes in service provision and workforce resulting from the NDIS impacted on the capacity of organisations to offer student placements in the future.

Changes to some but not all student placements

The NDIS had impacted some but not all of the student placements offered by organisations involved in the study. Allied health professionals working at private practices, who were accustomed to fee-for-service funding, described the NDIS as having very little impact on their capacity to offer student placements. One allied health professional explained: "The NDIS is having an impact in funny little areas, but definitely really nothing to do with the students." Similarly, participants working at complexly-funded organisations, such as hospitals or larger community health services, were unaware of any immediate impacts of the NDIS on student placements. One participant working at a hospital suggested the NDIS could increase the number of placements offered to students: "It might up the number of staff in the department, which would therefore allow us to take on more students." Participants working in complexly-funded organisations explained that NDIS funded services were not the "sole practice" of those organisations. This meant staff could carry on as usual with organisational activities such as student placements: "We will still accept

students to come in and get their hours… Where our client[s] might be an NDIS [participant]—they're still a client. They'll get their service. …And the student will get to be a witness too." These complexly-funded organisations had financial resources to employ student placement coordinators and NDIS transition project workers to support allied health professionals with their day-to-day tasks, including supervising students.

Many participants who worked at disability service organisations or smaller community health service organisations with less complex funding or with a heavy reliance on NDIS funding, explained how the NDIS funding model directly impacted on all organisational activities, including student placements: "Our [funding] bucket is tipping and emptying over to the NDIS as people get their packages and move away. …That's impacted on what we can do and how we can do it. But yeah… student placements now are intermittent."

Changes to the number of student placements

Some participants described how their organisation found it difficult to host students during the period of transition to the NDIS. They recalled how they and their colleagues had been highly focused on learning new organisational processes and NDIS-related practices, and as a result, the students on placement had experienced the stress of the transition. Others described how their organisation had "made a blanket rule" to halt student placements due to the NDIS: "We've stopped all placements altogether because of the NDIS. NDIS is the majority of our work now." Some decided to halt student placements for the entire duration of the transition period: "We made a conscious decision to not offer student placements in 2017 because we were transitioning to the NDIS and needed all our time and energy focused on that transition, rather than on student placements." They described this decision as regrettable, and "a little bit sad" because the transition itself presented a good learning opportunity for students. One participant, whose organisation was in the process of transitioning at the time of interview, suggested that "it really would be the straw that broke the camel's back if I asked one of my clinicians… to take on a student." Participants described how capped NDIS service prices meant allied health professionals were expected to achieve direct therapy billable targets of between 70-80 per cent of their overall time. This made it difficult for organisations ask staff to supervise students, as one participant explained:

> Our therapists have targets that they need to meet, so they have a number of clients that they need to see a day, or a number of hours that they bill out a day. So, I have to be conscious of therapists being able to meet that without detracting from their job to then supervise a student.

Changes to the nature and quality of student placements

Many participants from organisations impacted by the NDIS described changes to the nature and quality of student placements. A number were quick to point out that the changes were not "just a result of the NDIS," but reflected the growing pressure from universities and other tertiary education institutions on organisations to host students: "The overall demand for student placements has increased, which is putting pressure on all organisations." Many described narrowing their placement offers to students who lived in the local area, to increase the chance of securing qualified allied health professionals in a changing rural workforce: "We now, 99 per cent of the time, only take local students." One participant described how the merging of service management in organisations meant students now undertook in a broader range of activities on placement. Others described the NDIS having the opposite effect; suggesting that allied health teams had narrowed the range of student placements offered to reflect their immediate focus in service delivery: "When I ask these [mental health service] teams 'Are you happy to have an OT student?' They'll say 'No.'" Others explained how the expanding NDIS-related administrative tasks expected of allied health professionals meant students were unlikely to experience tasks undertaken prior to the NDIS:

> In the past I've had a social work student in [that team] … I've had nursing students there... And none of those [students] are going in there at the moment. … Because they're [allied health professionals] just head down, bum up getting [NDIS participant] plans done. That's all they've got time for. Their work used to be more around making sure that a client assessment had been completed, and then going on to care planning and monitoring the clients, and regular welfare checks... They just don't have time for all of that anymore.

The NDIS funding changes resulted in organisations having less capacity to supervise students: "People will be so focused on having to meet such and such a code to be able to bill it… The placement will be different to what it used to be." Many participants noted that the funding provided by universities did not cover the actual cost of providing supervision. They described how organisations were likely to offer placements requiring low or minimal student

supervision. This meant hosting students on their final year placement because these students could undertake complex work independently, or hosting students on their first-year placement, which largely comprised observational activities:

> We've changed the placements that we offer. The really easy ones are the first-year placements, which are observational. You just come in, spend a day with someone and observe what's going on. …Then the other ones are probably fourth-year placements where we would expect them to be more independent and be up and running and having a clinical case load that they're working through.

A few participants noted that they had considered offering students "placements where there is no specific supervisor." However, they were concerned that this would place students in a "challenging" situation, where they may be in attendance during placement but not have the opportunity to gain the knowledge, skills or confidence to work as allied health professionals. They were also concerned that unsupervised students would adopt poor practices observed during placement without the opportunity to discuss their observations with qualified allied health professionals.

Many participants were concerned that these changes to student placements, and specifically to the capacity of organisations to provide adequate supervision, could reduce the overall quality of student placements: "I knew it wasn't possible to give them quality placement when I couldn't supervise them two days of the week." Participants explained that rural organisations impacted by the NDIS faced a decision about whether to continue offering student placements. Some explained that organisations could either accept the changed nature of student placements and continue to offer student placements, or decide not to offer student placements. This choice was made more complicated by unclear NDIS policies surrounding allied health student placements in NDIS service providers. A number of participants were confused about whether they could charge people with NDIS funding for student-led services, or for services where students were in attendance. One participant, who worked at a community health service organisation, decided they would not host student until NDIA provided further clarification:

> The barrier now is the NDIS. …We would still be quite happy to have students once we feel we're comfortable in the new [NDIS] world and program. But… our understanding is that we can't charge for NDIS services if a student delivers them and until we're told otherwise—or if we've got that wrong, tell us now.

Changes to service provision impacted opportunities for student placements

Many participants explained how the changes to service provision in rural organisations impacted on student placements. In organisations where services had closed, student placements "had just gone." Organisations overloaded with NDIS-related administration had little capacity to complete further paperwork to gain service user permission for students to observe or participate in service provision. One participant was unsure whether their current paperwork adequately captured the required permission:

> This [permission] should be written up in a client service agreement, [noting] that a student might be involved [in service]. I don't think our service agreements have [space for that information] at the moment. …It would nearly have to be if we were going to be taking students reasonably regularly.

Participants explained that the changes to service provision made it difficult for organisations to offer student placements that have "fairly specific requirements." A number of participants representing different allied health professions explained how the NDIS service provision policies did not allow students to experience therapy planning and service provision during placements: "I don't know that they'd be able to tick off the things that they are required to do for a clinical placement at this stage."

The competitive nature of NDIS service provision made it more difficult for organisations to offer student placements. Participants explained how poor interactions between students and service users with NDIS funding could risk organisational reputation and create "funding issues." They explained that it was critical for rural health and human service organisations to maintain a good reputation by demonstrating best practice services and offering highly qualified professionals for service provision. Some suggested student-led services were "just not going to work" because families preferred to purchase services provided by qualified professionals:

> The person who's running the session has to be registered [with an allied health profession]. We can't say to a family, 'Well, here's the registered OT and she'll be here but she's not running your session. A student is.' That's completely not acceptable. The person who's registered has to run that session.

Participants from smaller organisations, such as private practices, were concerned they would lose service users with NDIS funding by involving students: "People are saying, 'We're paying for qualified staff to… look after our child.' What would they think about having a student?"

Changes to workforce impacted opportunities for student placements

The changes to the rural allied health workforce resulting from the NDIS appeared to impact on some student placements in rural organisations. Some participants spoke about the general impact of the workforce on student placements. They highlighted how organisations might struggle to develop consistent service processes for students to learn about their profession and about rural health and human service provision more generally, considering the increasingly casualised nature of the workforce: "A casualised workforce is—you can't instil that culture and you can't monitor it and you can't reward people with it. And casualisation of the workforce means you've got buckleys of having students." Other participants highlighted particular changes to the workforce and its impact on student placements. They explained how allied health professionals were less likely to receive training for student supervision because organisations could not support them to undertake tasks that were not central to generating income:

> We've also sent people on student supervision training [in the past]. … But again, that's not billable. So, the likelihood of us doing that will decrease, because it's a day [of training to] … learn how to be a student supervisor. That's not being funded anywhere. So we are more likely to send someone off to do training that is clinically related to them being able to generate income, than we are to them learning how to be a student supervisor.

Participants noted that students were aware of the changes to the workforce, and were hesitant to take on NDIS-related placements and projects during placements. One recalled her surprise when they could not find a student to take on, what she considered, an interesting placement project:

> I was really surprised that the feedback from this coordinator was that students are a bit hesitant about NDIS associated projects. I would have said it's a perfect project to do as a student, you know 'Wow let's get in and get to know it [the NDIS]', but there's a lack of confidence in knowing what its impact is and how it's going to play out, and a lack of confidence in their knowledge about NDIS. So… that's putting doubt whether we can actually get someone [a student].

Many participants were concerned that the changes in the allied health workforce might turn off more than just the occasional student, but the next generation of allied health professionals:

> If that's [the NDIS] creating insecurity for [allied health professionals], what's that doing for others who are only new to the field? What is that doing for students in student placement? …When they start seeing all this … How does that… generate a secure future for them?

Allied health student placements are in doubt for organisations experiencing funding changes

Participants explained how their organisation wanted to offer student placements, as they had done prior to the NDIS. However, those working for an organisation significantly impacted by the NDIS, explained that their organisation had limited capacity to offer student placements going forward: "For us, there is a desire and a commitment to student placements, but it's actually whether that becomes financially viable for us to offer them." One participant described how their organisation had explored different ways to continue to offer student placements, although concluded that they were a costly activity:

> We've looked at… we've had two students. We've shared supervision. We've done all different kinds of things. But the reality is, you still need someone who is scheduling their time, initially even- who's checking in with them, making sure that things are running smoothly each day, providing direct teaching opportunities for them, providing direct feedback, filling in the assessment forms? All of that is non-billable and it takes time.

Many participants highlighted that other stakeholders had failed to support rural organisations to offer student placements during the transition to the NDIS. A number spoke critically about NDIA. They rejected the Agency's

guidelines for supporting allied health student placements; particularly the notion that organisations should provide student-led services to people with NDIS funding, as a free and supplementary service to those listed in service agreements. From the service provider perspective, student-led free services detracted from potential billable hours and income, and cost the organisation because supervisors needed to supervise students during the provision of student-led services: "The NDIA… expect[s] if you had a student working with a participant that you might offer that participant some additional sessions. …That, financially, isn't going to sit well with my organisation … That's again, not covering the therapist's time." Participants also acknowledged how universities had failed to support rural health and human service organisations to offer student placements, despite being "aware of the challenges" that they faced. A few described having to manage fairly aggressive requests from university placement coordinators to place students. One described delaying their response to the coordinators: "I was very slow to get back to [the university]. And I said, "Look, I don't even know if we're going to have staff working in [service programs], so I can't take on a placement."

Participants described the NDIS as the "nail in the coffin" for student placements because it exacerbated issues for rural organisations already struggling to host students. Participants were concerned if and how students were going to find placements given that for organisations, "having a student takes a lot of time" and that "time is money in the world we're moving into." Many considered it a "simple equation"; that "increasing financial barriers" directly translated into a lack of time to supervise students: "They don't have time to say, 'Right, I'll stop that now and I'll go and spend an hour talking to a student.' …You have to take time away from your billing activities in order to support a student." One recalled their surprise about the cost of supervising students:

> We [calculated the cost of placements] before we transitioned to the NDIS, working out how much of our time is direct time and all that stuff. At the time we had two speech students with us and when the data came back it was a bit staggering how much time was spent just on doing supervising of students and writing reports up for students. …that you don't get paid for. … That's when we sort of went, 'Whoa. We're probably not going to be able to do that.'

Another provided an in-depth account of their calculations for deciding whether to offer student placements in the future. They too, considered costs associated with supervision as a significant barrier, and concluded that without having additional resources, the organisation could not continue to host students:

> If I've got a clinician working seven and a half hours a day, I need them to bill five of those hours. They've already got a certain amount of down time, because they come to meetings for instance or … spend time with me in supervision. It's two and a half hours of down time, five hours of billing time. Where am I going to put that student in that day? If they're in the billing time and they're [allied health professionals are] now only doing four hours of billing, they're not covering their wages. That's the reality.

Overall, participants were concerned about the lack of capacity for rural health and human service organisations to continue to offer allied health student placements, and were worried that it could lead to further depletion of a workforce struggling to keep up with service demand: "There won't be enough people around to actually provide services… People are on waiting lists because there's not enough people around to provide the services." They argued that more, not fewer student placements were required to meet the additional demand for qualified allied health professionals in rural Victoria:

> There'll be more service providers but … where is this workforce? Now there's a whole other business, the NDIS and their ECEI [Early Childhood Early Intervention] Partners [contracted by the NDIA to provide NDIS planning and capacity building services], who are needing to recruit early intervention practitioners. That wasn't there before, but we've only got a limited pool of people with that expertise. Where's the thinking about extending that expertise? In fact, what we've got is pressures on us [health and human service organisations] being able to support that learning of young graduates or young undergrads.

Ways to support organisations to offer [more] student placements

Rural health and human service organisations faced many barriers to offering student placements, including those new barriers presented by the NDIS. Many participants suggested that it was not feasible to expect organisations to host students while they transitioned to the NDIS: "When a roll-out's happening, you could give us a lot of financial

incentives and we would still be saying, 'No,' because it's a balance between staff well-being and our focus on [service users] at that time." However, many suggested that rural organisations would consider offering student placements once they had transitioned to the NDIS. Participants looked forward to hosting students in the future: "I'd really like us to get back to the point where we really could [have students]. …I really like having students."

Participants explained that their organisation was prepared to explore ideas that would enable them to host students in the future. They drew on their knowledge of the enablers and barriers to student placements and on their current experiences with the NDIS, and offered a number of suggestions for supporting organisations to offer student placements. These suggestions included ensuring there was sufficient student accommodation in rural areas, increasing support for students to socially engage while on placement, ensuring organisations had adequate physical space and resources for students, including desk space and computer access. A number of participants suggested coupling students on placement so they could "support each other" with learning and skill development, and provide a sense of familiarity while away from home. Other participants suggested increasing professional development opportunities for allied health professionals, particularly around supervision skills and NDIS knowledge: "It's that support in terms of your time management, efficiency… How to plan for students and for us, I guess. At the moment, we really need to know specifically what are the do's and don'ts around NDIS and students." Some suggested organisations could work together to share ideas about hosting students as NDIS service providers: "It would be really good to know what other organisations are doing … how they're managing."

Participants explained that "there's got to be some more incentives to take students." They suggested organisations required financial incentives to offer student placements, but also pointed out that non-financial incentives were also required: "It's so easy to say that money will fix everything, but I don't think money's what will fix that problem." They argued that rural health and human service organisations could no longer shoulder the bulk of the responsibilities associated with student placements, as they had done in the past. They reimagined their placement responsibilities in line with what they considered to be realistic in the NDIS funding context. Many suggested organisations take responsibility for particular elements of student placements, particularly those relating to experiences of service provision and "experiential learning." Some suggested organisations take responsibility for keeping record of student attendance: "We just need to say they came [to the service] and they're doing their own work. … [To] say, 'Yep, they showed up'. [We] can sign them off for the days they needed to be here." Many argued organisations should not be responsible for other elements of student placements, including ensuring that students are "doing their full placement hours and meeting all of their study type requirements." Participants proposed that universities, government departments and agencies such as the NDIA, and allied health professional bodies accept more responsibility for the work of enabling student placements, so that the rural allied health workforce can build to meet the growing demand for allied health services in rural Victoria:

> This is an issue that the sector needs to take responsibility for, and not just leave it up to organisations, because organisations won't be able to fill in the gaps. … It is an issue that universities need to be involved with. It is also an issue that NDIS need to be involved with to find some way of organisations being able to offer student placements. Otherwise, we're going to end up … with gaps in services because we don't have clinicians trained to meet some of the most complex needs of people that we have in the community.

Universities need to accept more responsibility

Participants explained that universities need to accept more responsibility to enable student placements. They argued that universities were ultimately responsible for achieving the task of producing skilled allied health graduates: "It is up to unis now … to step up and take responsibility for their own students because they belong to them." They also suggested the future success of rural allied health student placements hinged on universities providing organisations with more support to offer student placements: "Better support from the universities, I think, is really the key." Participants offered a few suggestions for how universities could enable student placements. They suggested organisational staff could support university staff to reconcile placement expectations with the realities of day-to-day service provision in organisations: "The universities need to link back in with the supervisors about what the real expectations of placement are. Sometimes I think there can be a bit of a gap between real life and university life." Some explained universities may need to drop their expectations: "It's perhaps about unis looking at what their requirements are in a placement. What is it that they absolutely, as a benchmark, must have as a requirement? And maybe they need to revisit that now in NDIS-land."

Many participants advised universities make changes to the nature of placements, to comprise less organisationally-provided supervision and clinical service provision experiences, and more observational activities for students:

> Maybe it's about their students doing more observational work and more self-reflective work and taking that back to their uni supervisors rather than to expecting our therapists to be that person for them and us to be marking them, because we just don't have time to do those big documents.

Others suggested universities could design placements in a way that maintained hands-on clinical experiences without placing too much responsibility on organisations. They advised universities run student clinics through clinical facilities made available by rural health and human service organisations, and supervise their own students: "The uni [could] do it themselves … [the] actual clinical stuff… They actually open it up for families to go and have free sessions and …The students have hour slots… and they [university staff] supervise it."

Many participants suggested that universities need to prepare students "before they come on placement." This included ensuring that students had a good understanding of the NDIS, of working with people with profound disability and their families, and of working in rural communities. Participants suggested that university staff may also need to become more familiar with the changing nature in service provision so that students are well-prepared:

> The universities need to understand how the NDIS has changed that environment and how that will impact on students. … It gets left to us to try and help the students understand why the work is the way it is. I think the reason the universities don't understand it is they haven't got lecturers and course co-ordinators who are working in the changed environment. It's all so new, that unless they've got people who for instance in the LAC [local area coordinator partner in the community organisation] or something like that, or as a service provider, they have no understanding of it, therefore they've got nothing to pass on to the students. So students arrive here and they're like, 'What?'

Participants suggested universities take more responsibility for administrative tasks associated with student placements. Some advised universities reduce unnecessary placement-related paperwork to ease the workload for rural health and human service organisations: "It comes down to us really having a less-involved process, more like a checklist, not all this other [administrative] stuff that we've been doing over the years. Mountains and mountains of stuff." Participants also suggested universities take the lead in contacting organisations and organising placements: "[Educational] institutions should be the ones negotiating the placement." They suggested universities build the supervisory capacity of health professionals within rural health and human service organisations, by offering training on relevant topics such as managing underperforming students, and student supervision under the NDIS: "It'd be good to get some good quality external supervision training for the staff." Finally, participants suggested universities properly fund rural health and human service organisations to host students on placement. Many participants suggested financial incentives would significantly increase the capacity for organisations to host students:

> If you say to me, 'I'll give you … an hour a day of funding', then all of a sudden I can afford for them [allied health professionals] to do four hours a day and spend an hour with a student because they're getting funded for it.

A few emphasised universities would need to fully fund the cost of student placements, rather than provide ad-hoc funding or supports, such as funding for external supervision, if placements were to continue in their current form:

> They're [universities are] the ones asking us to do the placements. So are they going to pay us to do the placements? Are they going to pay the real cost to do the placements? … It's not enough just to say, 'Oh, we'll have an external supervisor come in and support the students.'

NDIA and other government departments need to accept more responsibility

Participants suggested the NDIA and other government departments and agencies need to accept more responsibility to enable student placements. They suggested the NDIA provide clear policies surrounding student placements in rural health and human service organisations, particularly regarding the conditions under which students can provide services to people with NDIS funding. Participants also suggested the NDIA clarify how organisations would be incentivised to provide free student-led services that would otherwise generate income for the organisation. Participants explained that state and federal governments have a responsibility to secure the future rural allied health workforce, by financially supporting rural health and human service organisations to offer student placements. Many advised organisations required approximately four-to-five hours per week of funding, per student, to host students on

placement. A few suggested that this funding would go some way to incentivise organisations to host students: "I think if we had some hosting money, you know, that would certainly help."

Allied health professional bodies need to accept more responsibility

Participants recognised the efforts of allied health professional bodies to incentivise individual allied health professionals to supervise students by providing professional development points: "Taking on two fourth year students a year would just about get me my whole [professional] points for the year." However, participants advised that allied health professional bodies could take on more responsibility, by working with universities to develop student placements which comprise only necessary activities, and reduced expectations previously placed on rural health and human service organisations.

Student placement stakeholders need to work collaboratively

Participants suggested all stakeholders involved in allied health student placements need to work collaboratively to identify barriers and implement strategies, to ensure rural organisations impacted by the NDIS have the capacity to offer student placements into the future:

> I think it all has to link together. We can't work in silos, you know? …We can't have the universities in a silo, the organisations in a silo, the research in a silo, the government bodies in a silo. There has to be more linkages and I know often when something's new like the NDIS that, yes—there is going to be a bit of that silo [approach] because they've got to get off the ground and get it up and running. And yes, we know it [the NDIS] will take time to mature and get right. It could be 20 years from now, but it doesn't mean we can't try and connect the dots a little bit more now.

Discussion

The NDIS represents significant change in Australia's disability policy landscape. It represents major change in the way many health and human service organisations are funded, the way they provide services, and the way they carry out other organisational activities. The aim of this study was to explore the perceived impacts of the NDIS on nursing and allied health student placements among staff in organisations funded at least partly by the NDIS, located in rural areas of Victoria. This study found that health professionals perceived the NDIS to have impacted on student placements in some rural health and human service organisations more than others. The organisations impacted were in the process of transitioning to the NDIS, and had previously relied on block funding although now heavily relied on NDIS fee-for-service funding. Community health services and disability service organisations appeared more impacted by the NDIS than private practices or hospitals. This study revealed that in the former organisations, the NDIS had changed the nature of student placements, and in some cases, saw the end of student placements. Changes to student placements in these organisations were part of a broader set of organisational changes in response to the NDIS.

Rural organisations impacted by the NDIS underwent significant changes to existing organisational structure and processes. These organisations experienced changes to the type of services provided and the nature of activities offered within services. Participants described how organisations had closed or were considering closing services. These changes to service types and activities impacted people with disability and their families living rurally. Echoing Warr et al. (2017) the findings of this study suggest that people with disability living rurally may not have much choice or control over their services because, in rural areas, there may not be range of services to choose from. Without a steady flow of business from people with NDIS funding, rural organisations providing NDIS services are unlikely to have the capacity to respond flexibly to service demand. Rural organisations and people with NDIS funding face a great deal of uncertainty in the quasi-market environment introduced by the NDIS (NDS, 2018b).

The findings indicate that the NDIS may have impacted on the rural allied health workforce. Participants described how the NDIS generated employee movement in rural health and human services organisations, created redundancies in management and administration, and encouraged organisations to adopt precarious employment arrangements with less wrap-around employee supports. Participants also described how rural organisations impacted by the NDIS were unlikely to employ allied health professionals providing services that were less frequently requested by people with NDIS funding, such as social workers. This suggests that allied health professional bodies experiencing reductions in service demand since the implementation of the NDIS may need to look closely at how their services align with the NDIS, and act to ensure they remain available to people with disability living rurally.

Participants' perceptions suggested that the NDIS has impacted on the number and nature of student placements in some health and human service organisations in rural Victoria. The findings suggested organisational resources for hosting students had dwindled, although organisations remained interested in hosting local students in the future. Rural organisations offered student placements for a range of reasons, including to recruit future allied health professionals, and to help build the rural allied health workforce more generally. However, the finding that many organisations now looked to offer placements to local students as a targeted strategy to recruit allied health professionals, rather than boost the allied health workforce more generally, reflects the broader shift toward a competitive health and human services market. Organisations are competing with each other for funding (Green et al., 2018), and for qualified employees in rural areas (Lincoln et al., 2014). This may result in these organisations becoming less interested in hosting students to help build the rural allied health workforce more generally. Their preference to host local students could potentially result in fewer metropolitan-based students experiencing rural health during their studies. Considering rural placements go some way to encourage metropolitan students to practice in regional areas (Taylor et al., 2009), a lack of exposure to rural health via student placements could possibly dampen efforts to encourage metropolitan-based allied health professionals to work rurally. This finding suggests that rural organisations may require further incentives to host metropolitan-based students.

University Departments of Rural Health student support scheme teams may recognise that the reasons driving rural organisations to offer student placements are changing. Student support scheme staff may want to consider adapting their approach to encourage organisations to offer student placements. For example, rather than appealing to their commitment to building the allied health workforce, these teams could support organisations to use student placements to meet their own recruiting requirements. Student support scheme teams could encourage organisations to work collaboratively and form alliances to offer student placements, although they will need to remain aware that competition between these organisations may increase over time (Green et al., 2018). Further research is required to

explore if and how student support scheme teams have adapted their work of facilitating student placements to the developing competitive service market, and to explore suitable approaches for working with rural organisations in the future.

Participants described other changes to student placements. The narrowing of placements to particular professions could result in fewer opportunities for students to experience interdisciplinary work practices. The narrowing of activities within placements could lead to students feeling less prepared to enter the workforce on graduation. The finding that low NDIS service prices could result in students being unsupervised, is particularly concerning. The supervision of students on placement allows students to reflect on observations, apply knowledge to practice, and feel supported in their time away from home (National Rural Health Alliance, 2004; Severinsson & Sand, 2010). The limited capacity for organisations to provide supervision within NDIS funding suggests that universities may need to explore the idea of using alternate modes of supervision (Thomasz & Young, 2016). Increasing the use of external supervision could relieve organisations of a significant responsibility involved with placing students and encourage them to consider offering student placements. Further research is required to explore the benefits and limitations of using external supervision with allied health students on placement in rural organisations providing NDIS services.

Many participants from rural health and human service organisations impacted by the NDIS felt their organisation had little capacity to offer student placements going forward. These organisations were no longer able to absorb the costs associated with hosting students. The loss of student placements in rural organisations providing NDIS funded services could decimate the number of experienced allied health professionals available to provide services to people with disability in the future. The impact of the NDIS on student placements in rural Victoria needs to be addressed with targeted strategies to ensure there are qualified and experienced allied health professionals wanting to work with people with disability in rural communities. These strategies could be underpinned with the understanding that rural health and human service organisations can no longer shoulder the responsibility of ensuring allied health students gain hands-on, practical and rural experience before joining the workforce. All stakeholders involved with student placements, including universities, government departments and agencies, and allied health professional bodies, must accept their responsibilities in enabling student placements. These stakeholders may need to take on the responsibilities that rural health and human service organisations have previously carried, including organising placements, completing student-related paperwork, and ensuring students gain appropriate experiences, knowledge and skills while on placement. These stakeholders must also work together to identify and implement strategies that support rural health and human service organisations, particularly community health service and disability service organisations, to continue to offer student placements. These strategies could include the use of further financial incentives to cover costs of student supervision, supervisor training or administrative work related to hosting students. These strategies may also include the provision of non-financial incentives that meet the particular requirements of individual organisations.

It is important to highlight the strengths and limitations of any study. This study explored the perceptions of 20 health professionals in rural Victoria regarding the impact of the NDIS on student placements in rural health and human service organisations funded by the NDIS. The perceptions provided by the 20 participants were particular to their own experiences, and to their organisations situated within one state jurisdiction in Australia. Exploring the perceptions of health professionals in other jurisdictions could provide insight into perceived impact of the NDIS on allied health student placements in Australia more broadly. Further, many participants had only had short-term experience with the NDIS as it was only recently implemented in their region. Nevertheless, this study provides important insight into the perceived impacts of the NDIS on rural Victorian health and human service organisations, and on their capacity to provide services to people with disability, and to conduct other organisational activities, such as hosting students on placement. This study suggests the importance of paying attention to the wider impacts of policy reforms on student placements and on the rural allied health workforce. Further research is required to capture the long-term impacts of the NDIS on rural allied health student placements. This research could help to explore potential strategies to support rural health and human service organisations to continue their positive impact on rural communities, and to support people with disability living rurally, to lead meaningful lives.

Recommendations

Based on the findings from the study, the following recommendations are provided:

1. That the NDIA and other federal government departments commit to taking up additional responsibility to support rural allied health and human service organisations, so they can continue to offer student placements and build skills in the rural allied health workforce in disability practice. These responsibilities include: providing further financial or other incentives to meet rural health and human service organisations requirements to offer student placements and providing clarity on billing for student-led services and payment for student supervision.
2. That all stakeholders involved with rural allied health student placements including universities, state and federal governments and in particular NDIA, allied health professional bodies, student support scheme teams, and rural allied health and human services develop mechanisms to work collaboratively to identify ongoing issues of concern, and implement strategies to encourage rural allied health and human service organisations offer student placements.
3. That the Federal Government or agencies, such as NDIA, provide further resources to continue research on the impact of the NDIS on rural health and human service organisational activities beyond service provision. This could include research exploring the impact of the NDIS on work toward building communities that are inclusive of people with disability, and work toward building the workforce to meet the growing demand for services in Victoria or in other jurisdictions in Australia.

"We do need to pay attention,
if we want to have a vibrant and viable workforce…
And that is not just the responsibility of the organisation to provide placements."

References

Australian Bureau of Statistics. (2017). *Regional Population by Age and Sex, Australia, 2017*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/0/151AA7593B394934CA2573210018DA4A?Opendocument

Australian Rural Health Education Network. (2017). *ARHEN Annual Report.* Retrieved from http://arhen.org.au/wp-content/uploads/2018/01/ARHEN_AR_2017_v8-lr-low-res-for-website.pdf

Barnett, T., Cross, M., Jacob, E., Shahwan-Akl, L., Welch, A., Caldwell, A., & Berry, R. (2008). Building capacity for the clinical placement of nursing students. *Collegian, 15*(2), 55-61. doi:10.1016/j.colegn.2008.02.002

Brotherhood of St. Laurence. (2018). Evaluation of local area coordination under the NDIS. Retrieved from https://www.bsl.org.au/research/projects/evaluation-of-local-area-coordination-under-the-ndis/

Carey, G., Malbon, E., Olney, S., & Reeders, D. (2018). The personalisation agenda: The case of the Australian National Disability Insurance Scheme. *International Review of Sociology, 28*(1), 20-34. doi:10.1080/03906701.2018.1425084

Carey, G., Malbon, E., Reeders, D., Kavanagh, A., & Llewellyn, G. (2017). Redressing or entrenching social and health inequities through policy implementation? Examining personalised budgets through the Australian National Disability Insurance Scheme. *International Journal for Equity in Health, 16*(1), 192-204. doi:10.1186/s12939-017-0682-z

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London, UK: Sage.

Department of Health. (2013). *Review of Australian Government health workforce programs*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/$File/Review%20of%20Health%20Workforce%20programs.pdf

Department of Social Services. (2015). *Sector Development Fund: Strategy and operational guidelines*. Retrieved from https://www.ndis.gov.au/html/sites/default/files/documents/SDF-Strategy-Operational-Guidelines-Dec-2015.pdf

Dew, A., Barton, R., Ragen, J., Bulkeley, K., Iljadica, A., Chedid, R., . . . Veitch, C. (2016). The development of a framework for high-quality, sustainable and accessible rural private therapy under the Australian National Disability Insurance Scheme. *Disability & Rehabilitation, 38*(25), 2491-2503. doi:10.3109/09638288.2015.1129452

Disability Reform Council. (2015). *Integrated market, sector and workforce strategy*. Retrieved from https://www.dss.gov.au/sites/default/files/documents/07_2015/ndis_integrated_market_sector_and_workforce_strategy_june_2015.pdf

Flinders University. (2018). Building the allied health workforce for an NDIS future. Retrieved from http://www.flinders.edu.au/sohs/building-the-allied-health-workforce-for-a-ndis-future/project-home.cfm

Gallego, G., Dew, A., Lincoln, M., Bundy, A., Bulkeley, K., Brentnall, J., & Veitch, C. (2018). Carers' preferences for the delivery of therapy services for people with disability in rural Australia: Evidence from a discrete choice experiment. *Journal of Intellectual Disability Research, 62*(5), 371-381. doi:10.1111/jir.12469

Gilroy, J., Dew, A., Lincoln, M., & Hines, M. (2017). Need for an Australian Indigenous disability workforce strategy: Review of the literature. *Disability & Rehabilitation, 39*(16), 1664-1673. doi:10.1080/09638288.2016.1201151

Grbich, C. (2013). *Qualitative data analysis: An introduction* (2nd ed.). London, UK: Sage.

Green, C., Malbon, E., Carey, G., Dickinson, H., & Reeders, D. (2018). *Competition and collaboration between service providers in the NDIS*. Sydney: Centre for Social Impact, UNSW. Retrieved from http://www.csi.edu.au/research/project/competition-and-collaboration-between-serviceproviders-ndis/

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi:10.1177/1049732305276687

Humphreys, J., Lyle, D., & Barlow, V. (2018). University Departments of Rural Health: Is a national network of multidisciplinary academic departments in Australia making a difference? *Rural & Remote Health, 18*(1), 1-11.

Jenkin, E., & Wilson, E. (2009). *Inclusion- Making it happen: Key elements for disability organisations to facilitate inclusion.* Melbourne: Scope (Vic).

Keane, S., Lincoln, M., & Smith, T. (2012). Retention of allied health professionals in rural New South Wales: A thematic analysis of focus group discussions. *BMC Health Services Research, 12*(1), 175-186. doi:10.1186/1472-6963-12-175

Lincoln, M., Gallego, G., Dew, A., Bulkeley, K., Veitch, C., Bundy, A., . . . Griffiths, S. (2014). Recruitment and retention of allied health professionals in the disability sector in rural and remote New South Wales, Australia. *Journal of Intellectual & Developmental Disability, 39*(1), 86-97. doi:10.3109/13668250.2013.861393

Lyle, D., & Greenhill, J. (2018). Two decades of building capacity in rural health education, training and research in Australia: University Departments of Rural Health and Rural Clinical Schools. *Australian Journal of Rural Health, 26*, 314-322. doi:10.1111/ajr.12470

Malbon, E., Carey, G., & Dickinson, H. (2018). Accountability in public service quasi-markets: The case of the Australian National Disability Insurance Scheme. *Australian Journal of Public Administration, 77*(3), 468-481. doi:10.1111/1467-8500.12246

Mavromaras, K., Moskos, M., Mahuteau, S., Isherwood, L., Goode, A., Walton, H., . . . Flavel, J. (2018). *Evaluation of the NDIS: Final report*. South Australia: National Institute of Labour Studies, Flinders University. Retrieved from https://www.dss.gov.au/sites/default/files/documents/04_2018/ndis_evaluation_consolidated_report_april_2018.pdf

McKinsey & Company. (2018). *Independent pricing review National Disability Insurance Agency: Final report*. Retrieved from https://www.ndis.gov.au/medias/documents/ipr-final-report-mckinsey/20180213-IPR-FinalReport.pdf

National Disability Insurance Agency. (2016a). *Rural and remote strategy 2016-2019*. Retrieved from https://www.ndis.gov.au/medias/documents/h2c/hb0/8800389824542/Rural-and-Remote-Strategy-991-KB-PDF-.pdf

National Disability Insurance Agency. (2016b). *Terms of business for registered providers*. Retrieved from https://www.ndis.gov.au/html/sites/default/files/documents/Provider/TOB.pdf

National Disability Insurance Agency. (2017). *Frequently asked questions (faqs): Allied health practitioner students & provisional psychologists*. Retrieved from www.ndis.gov.au

National Disability Insurance Agency. (2018a). *Building the workforce and developing the market*. Retrieved from https://www.ndis.gov.au/building_workforce.html

National Disability Insurance Agency. (2018b). *Provider lists*. Retrieved from https://www.ndis.gov.au/participants/working-providers/find-registered-provider#provider-lists

National Disability Insurance Agency. (2018c). *Report to the COAG Disability Reform Council for Q2 of Y6 Full report*. Retrieved from https://www.ndis.gov.au/about-us/publications/quarterly-reports

National Disability Services. (2018a). *State of the disability sector report*. Retrieved from https://www.nds.org.au/news/state-of-the-disability-sector-report-2018-now-available

National Disability Services. (2018b). *State of the disability sector report 2018*. Retrieved from https://www.nds.org.au/news/state-of-the-disability-sector-report-2018-now-available

National Rural Health Alliance. (2004). *A quality rural placement system for health students*. Retrieved from http://ruralhealth.org.au/sites/default/files/position-papers/position-paper-04-04-01.pdf

Playford, D., Larson, A., & Wheatland, B. (2006). Going country: Rural student placement factors associated with future rural employment in nursing and allied health. *The Australian Journal of Rural Health, 14*(1), 14-19. doi:10.1111/j.1440-1584.2006.00745.x

Productivity Commission. (2017). *National Disability Insurance Scheme (NDIS) Costs*. Retrieved from https://www.pc.gov.au/inquiries/completed/ndis-costs#report

Severinsson, E., & Sand, Å. (2010). Evaluation of the clinical supervision and professional development of student nurses. *Journal of Nursing Management, 18*(6), 669-677. doi:10.1111/j.1365-2834.2010.01146.x

Taylor, S. J., Maharaj, P., Williams, K., & Sheldrake, C. (2009). Pharmacy students' intention to practise in a rural setting: Measuring the impact of a rural curriculum, rural campus and rural placement on a predominantly metropolitan student cohort. *Australian Journal of Rural Health, 17*(6), 305-309. doi:10.1111/j.1440-1584.2009.01102.x

Thomasz, T., & Young, D. (2016). Speech pathology and occupational therapy students participating in placements where their supervisor works in a dual role. *Australian Journal of Rural Health, 24*(1), 36-40. doi:10.1111/ajr.12238

Victorian Government. (2016). *Keeping our sector strong: Victoria's workforce plan for the NDIS*. Retrieved from https://www.vic.gov.au/system/user_files/Documents/ndis/NDIS%20Workforce%20Plan_Document_FullVersion_WACC.doc.

Warr, D., Dickinson, H., Olney, S., Hargrave, J., Karanikolas, A., Kasidis, V., . . . Wilcox, M. (2017). *Choice, Control and the NDIS*. Melbourne: University of Melbourne. Retrieved from https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0008/2598497/Choice-Control-and-the-NDIS.pdf

Webster, S., Lopez, V., Allnut, J., Clague, L., Jones, D., & Bennett, P. (2010). Undergraduate nursing students' experiences in a rural clinical placement. *Australian Journal of Rural Health, 18*(5), 194-198. doi:10.1111/j.1440-1584.2010.01153.x

Acknowledgements

We acknowledge and pay respect to the Traditional Owners of the lands upon which our campuses are situated. We would like to pay our respects to the past, present and future Elders across the Goulburn, Ovens Murray, Loddon, Central Highlands and Western District regions of Victoria, where this project was undertaken.

We would very much like to thank those who participated in this study for their important and thoughtful contributions.

We would also like to thank the University of Melbourne UDRH Going Rural Health student support team for identifying the need for research on the impact of the NDIS on allied health student placements in rural health and human service organisations.

This study was supported by the Australian Government Department of Health, Rural Health Multidisciplinary Training Programme.

For more information about this study or a copy of the summary report, please contact Claire Quilliam via email: claire.quilliam@unimelb.edu.au or telephone: 03 5823 4576.

POSTERA CRESCAM LAUDE
THE UNIVERSITY OF
MELBOURNE