
OVERVIEW

Key points

- Most families and individuals cannot adequately prepare for the risk and financial impact of significant disability. The costs of lifetime care can be so substantial that the risks and costs need to be pooled.
- The current disability support system is underfunded, unfair, fragmented, and inefficient, and gives people with a disability little choice and no certainty of access to appropriate supports. The stresses on the system are growing, with rising costs for all governments.
- There should be a new national scheme — the National Disability Insurance Scheme (NDIS) — that provides insurance cover for all Australians in the event of significant disability. Funding of the scheme should be a core function of government (just like Medicare).
- The main function (and source of cost) of the NDIS would be to fund long-term high quality care and support (but not income replacement) for people with significant disabilities. Everyone would be insured and around 410 000 people would receive scheme funding support.
- The NDIS would have other roles. It would aim to better link the community and people with disabilities, including by using not-for-profit organisations. It would also provide information to people, help break down stereotypes, and ensure quality assurance and diffusion of best practice among providers.
- The benefits of the scheme would significantly outweigh the costs. People would know that, if they or a member of their family acquired a significant disability, there would be a properly financed, comprehensive, cohesive system to support them. The NDIS would only have to produce an annual gain of \$3800 per participant to meet a cost-benefit test. Given the scope of the benefits, that test would be passed easily.
- The scheme should involve a common set of eligibility criteria, entitlements to individually tailored supports based on the same assessment process, certainty of funding based on need, genuine choice over how their needs were met (including choice of provider) and portability of entitlements across borders. There would be local area coordinators and disability support organisations to provide grass roots support. The insurance scheme would take a long-term view and have a strong incentive to fund cost effective early interventions, and collect data to monitor outcomes and ensure efficiency.
- The above features would be best met by a having a single agency overseeing the NDIS — the National Disability Insurance Agency. It would be created by, and report to, all Australian governments. It would have strong governance arrangements, with an independent commercial board, an advisory council of key stakeholders, clear guidelines to ensure a sustainable and efficient scheme, and legislation that protected the scheme from political influences.
- It would be the assessor and funder, but not the provider of care and support. Services would be provided by non-government organisations, disability service organisations, state and territory disability service providers, individuals and mainstream businesses. Increased funding, choice and certainty are the key features of the recommended scheme. Advocacy would be funded outside the scheme.
- An alternative but inferior option would be a ‘federated’ NDIS. This would give state and territory governments control over their own systems, but with some common core features. Such an arrangement could easily revert to the current flawed and unfair system, with ‘agreements’ breaking down into disputes about who is to pay, how much and for what.

Key points (continued)

- People would have much more choice in the proposed NDIS. Their support packages would be tailored to their individual needs. People could choose their own provider(s), ask an intermediary to assemble the best package on their behalf, cash out their funding allocation and direct the funding to areas of need (with appropriate probity controls and support), or choose a combination of these options.
- The NDIS would cover the same types of supports currently provided by specialist providers (but with sufficient funding), give people more opportunity to choose mainstream services, and encourage innovative approaches to support.
- The Australian Government currently provides funding to the disability sector of around \$2.3 billion, while state and territory governments provide funding of around \$4.7 billion — a total of over \$7 billion.
- Current funding for disability is subject to the vagaries of governments' budget cycles. People with disabilities have no certainty that they will get reasonable care and support over the long run. Resourcing might be good one year, but insufficient the next, with many people missing out. The Commission estimates that the amount needed to provide people with the necessary supports would be about double current spending (an *additional* \$6.5 billion per annum).
- The Commission proposes several options for providing certainty of future funding. Its preferred option is that the Australian Government should finance the entire costs of the NDIS by directing payments from consolidated revenue into a 'National Disability Insurance Premium Fund', using an agreed formula entrenched in legislation. The amount needed could be funded through a combination of cuts in existing lower-priority expenditure, fiscal drag, and if necessary, tax increases.
- A less preferred option is that all governments could pool funding, subject to a long-run arrangement based on the above formula, and with pre-specified funding shares. This would need to be closely monitored by transparent accounting and penalties for failure to meet commitments.
- The scheme would gradually be rolled out from mid-2014. It would start in a few regions. That would allow fine-tuning of the scheme, while providing high quality services to many thousands of people. In 2015-16, the scheme should cover all regions of Australia for the highest priority groups, and should progressively expand until the scheme covered all people by the end of 2018-19.
- A separate scheme is needed for people requiring lifetime care and support for catastrophic injuries — such as major brain or spinal cord injuries. Currently, many Australians get poor care and support when they acquire such injuries because they cannot find an at-fault party to sue.
- A no-fault National Injury Insurance Scheme, comprising a federation of individual state and territory schemes, would provide fully-funded care and support for all cases of catastrophic injury. It would draw on the best schemes currently operating around Australia. State and territory governments would be the major driver, developing a comprehensive scheme by 2015.

Overview

Current disability support arrangements are inequitable, underfunded, fragmented, and inefficient and give people with a disability little choice. They provide no certainty that people will be able to access appropriate supports when needed. While some governments have performed much better than others, and there are pockets of success, overall, no disability support arrangements in any jurisdiction are working well in all of the areas where change is required. The current arrangements cannot be called a genuine ‘system’ in which different elements work together to achieve desired outcomes.

The central message of this report is that a coherent and certain system for people with a disability is required — with much more and better-directed resourcing, a national approach, and a shift in decision-making to people with a disability and their carers. This overview explains what is wrong with the current arrangements and how to improve them. It shows how a new system would work for people with a disability and their families, and how it would provide benefits for the community as a whole.

Why is change needed?

The existing disability support ‘system’ is unsustainable on multiple grounds.

It is becoming increasingly unstable. The high costs of addressing people with crisis needs impede funding for other support services. This is because when faced with budget constraints, systems have little choice but to give priority to families in crisis. This displaces funds for early intervention and respite programs, increasing further the number of families falling into crisis, and leading to an ongoing causal relationship between shortages and crises.

Another contributor to the pressure on existing arrangements is that people with disabilities are living longer, and at some point can no longer be supported by their ageing parents or partners. Eventually this cycle must either absorb more and more funds, or leave people in increasingly abhorrent conditions.

Moreover, there is general agreement by people with a disability, their families, service providers and governments that existing support services for those with significant disabilities are not functioning well in many other areas, even for those who do receive funding.

- There is not sufficient resourcing, with many gaps in services in all jurisdictions and most locations. Rationing is likely to get worse unless there is reform.
- Rationing places an unreasonable burden on people with a disability and their families. It means lower levels of wellbeing and large forgone life chances. There are particularly big gaps in the availability of support at key transition points in people's lives. People wait years for specialist wheelchairs, need to stay with their parents instead of moving into independent supported accommodation, and do not get timely or sufficient access to support. Carers have among the lowest levels of wellbeing of any group of Australians.
- People with similar levels of functionality get access to quite different levels of support, depending on their location, timing or the origin of their disability — what some call the 'lottery' of access to services. For instance, some jurisdictions have fault-based motor vehicle compensation arrangements (Queensland, ACT, Western Australia, and South Australia). In these jurisdictions, someone acquiring a catastrophic injury in a motor vehicle accident would have to successfully sue an at-fault party to get adequate lifetime care and support. Other jurisdictions provide comprehensive coverage on a no-fault basis for such accidents.
- People with disabilities and their carers do not get the certainty of lifelong support needed for proper life planning and cannot avoid the extreme anxiety about the adequacy of future funded support when informal care is no longer reasonable or feasible. Current funding for disability comes from two levels of government, which are subject to annual budget cycles — making it hard to give people with disabilities any certainty that they will get reasonable care and support over the long run.
- Inadequate services can hit certain communities particularly hard — such as people in regional and remote areas, people from a non-English speaking background and Indigenous people.
- Under-servicing in one area — such as not enough access to respite and home modifications — results in costly additional servicing in another less appropriate area or at a later time (such as someone staying in hospital because their home has not been modified).
- People with a disability have too little control over what happens to them and limited choice of service providers. The usual justification for such paternalism — the complexity of services — has little application in a sector where one of

the most important services is relatively straightforward personal support in which the empathy and responsiveness of the carer is the most important feature.

- The ‘system’ is hard to navigate (a ‘confusopoly’ in the words of one participant — box 1) and is not well integrated nationally. Even within a jurisdiction, people deal with a multitude of programs and agencies, few of which coordinate or share information. If people move across state boundaries, their entitlements can stop at the border.
- People are told they must fit the programs — rather than have programs meet their needs — with wasteful effort going into manoeuvring around the rules. Some people fall inevitably through the cracks, notwithstanding administrators accepting that their reasonable needs are not being met.
- Apart from its inadequacy, funding for service providers uses outdated models and comes with unnecessary compliance burdens, stifling innovation and flexibility.
- Approaches to delivery of supports and administrative processes are only weakly evidence-based, despite the billions of dollars given to such services each year.

People often experience these deficiencies over their whole lives. Disability exacerbates disadvantage. People with a disability and their carers often also experience low levels of income, educational attainment, employment, superannuation, health and wellbeing.

The costs of doing nothing

The cost of doing nothing would be the persistence and increasing intensity of the above deficiencies. Moreover, governments could not feasibly do absolutely nothing. They would need to patch up their systems to arrest the vicious cycle produced by systems in crisis. In effect, all governments face future liabilities with their current unstable systems. The implication of this is that the upfront *fiscal* costs, while significant, are partly offset by eliminating the hidden future liabilities of the current system. Moreover, from an *economic* perspective, the benefits of the NDIS will exceed the costs.

A new approach is needed

The flaws of the current system have driven strong demand for an entirely new approach. The key test of a new scheme will be the extent to which it can address existing deficiencies in an equitable, efficient, cost-effective and accountable way (while avoiding new pitfalls).

Box 1 **Some comments from participants in this inquiry**

The regularity with which I meet parents with murder suicide ideation as they have been unable to find adequate help for their child is both alarming, but also a marker of the failure of coordination of any service ... I also note that murder suicide in these families is becoming a more recognised event, as recently occurred in Victoria. (personal submission, senior psychiatrist)

Those still having to fight for reasonable care and respect, have little hope of departing this world in peace their adult family member will receive consistent quality of life care. (LISA, sub. 1023)

We have from our personal point of view been spending over a year to just try and get a high-low bed because my son is 113 centimetres tall at four, he weighs 25 kilos and he does not walk. He also has hypotonia, so has low tone, so he is very floppy. (Timothy Smith — Fortitude Parents Group, Sydney Hearings, Transcript, p. 716)

We saw our adult children reach their late twenties and thirties with no hope of achieving the independence that moving out of home brings. We saw ourselves caring until we die, with no hope of humanely and gradually transitioning our people into a new residential setting. (Ryde Area Supported Accommodation for Intellectually Disabled, sub. 204, p. 1)

I am a mum of a young child ... with multiple impairments – physical, sensory, intellectual – she is expected to be non-verbal for life ... There is a myriad of paperwork to be completed, you must re-prove your child's disability to every agency that you encounter ... there are wait lists for services, lack of physiotherapists, lack of funding. (name withheld, sub. 9, p. 1)

Unnecessary paperwork and revision [is] required when care requirements are ongoing. (Debra Australia, sub. 554, p. 3)

... it took over 2 years from when it became pretty clear I needed a motorized wheelchair to when I finally got one, and then yet longer to get transport training. This held me back unnecessarily from gaining independence and impacted on my self-confidence. I missed out on many opportunities to take part in the community, including doing some valuable volunteering. (Samantha Peterson, sub. 581, p. 1)

When I was vertical I had a lot more respect. As soon as I parked my backside into a wheelchair, the way society treated me and the way that I was shunned and excluded just blew my mind. I had no idea what people in chairs had been facing all their lives ... We only get four hours of help a week, and with those four hours there are very strict, rigid guidelines that we can use them for, so therefore they will say, "No, we can't do that to help you," "No, if it's classed as respite, we can only do this, this and this" ... I got extremely depressed, and that was the only time that I thought to myself, "I'm living in Australia and yet I'm reduced to this." (Ms Shaunagh Stevens, Melbourne Hearings, Transcript, p. 180)

... not only do you have to deal with disability, but the uncertainties of disjointed, complex and inadequate array of disability supports. (Ben Lawson, sub. 103, p. 2)

I find myself dealing with anxiety and loneliness and the possibility of when my parents grow older, that I will have no support and services available. (Garry Burge, sub. 2, p. 1)

We currently have over 100 women with disabilities throughout WA as members. There is widespread agreement from our membership that the current disability support system has many flaws and often fails to provide women with disabilities in particular with the supports they need to live a safe, happy and productive life. (Women with Disabilities WA, sub. 1009, p. 1)

(Continued next page)

Box 1 Participants' comments (continued)

Following our paediatricians pronouncement that she was indeed permanently intellectually disabled, we were very much left to navigate the maze of disability life by ourselves, unsupported, save for some family members and close friends, and the kindness and understanding of some of our daughter's initial therapists ... The confusopoly added anxiety and pressure to an already extremely stressful situation. (Name withheld, sub. 482, pp. 1–2)

The scheme needs to be national so that people with disability can take their funding with them when they move across state and territory boundaries. The money needs to be attached to the person (direct funding) and not to an organisation or program. Families at present are bound to stay in the same place as the funding they have received. If that place is the ACT then you can't move anywhere. (Sally Richards, sub. 26, p. 5)

Then "sliding doors and groundhog day" revisited with government changes to policy and funding arrangements which stopped funding to individuals on the basis of individual need and went back to block funding of organizations — leading again to disempowerment, no choice, a take or leave it attitude of service providers and retribution for leaving, or complaining, about a service that is unacceptable, inadequate or unsatisfactory. ... All the power is vested in the service provider. (Felicity Maddison sub. 380, p. 1)

This group [acquired brain injury] rarely receives adequate funding to fully support their needs because of the high cost of those needs and as a result experience pain and discomfort, isolation, loneliness and despair. This limited funding also impacts on their capacity to receive appropriate allied health supports and the ability to access their local and broader community. (Inability Possability, sub. 514, p. 4)

I have seen grandparents weeping in despair at a public meeting about disability support, as they describe how badly they need help, and appropriate supported accommodation for their violently autistic grandson. (Name withheld, sub. 253, p. 3)

No one likes to see innocent kids suffer in any way and the pain we feel as parents having to watch this every day and to be helpless to change things, all we can do is scream out for assistance, and now is the time for some screaming (Name withheld, sub. 13, p. 4)

The way funding is allocated is a joke. Submissions are sent in and if you are about to die or divorce or have a breakdown, you might get considered. (Leonie Walker, sub. 12, p. 1)

Looking overall as a money matter, what strikes me is that money is being wasted here. By not spending the money on aids, you're probably creating disability for the future and also by not meeting properly the costs of disability, you're putting more stress on those carers and you're probably causing more suicide, divorce, separation, abandonment. As economists, this is an area crying out for an economic improvement. (Richard Cumpston, Canberra Hearings, Transcript, p. 370)

For many people with acquired brain injuries and their families in Western Australia it has to be said that the system is not just broken, it barely exists at all. (Helen Lynes, Headwest Brain Injury Association of Western Australia, Perth Hearings, Transcript, p. 941)

There are many possible models for a national disability scheme, varying in scope (relevant users, types and levels of support, generosity and duration), funding sources, decision-making arrangements and governance.

One option would be to substantially increase disability funding, but otherwise largely preserve the current arrangements. That would have beneficial effects, but it would fail to provide the certainty of support, early intervention and power over their lives that people are seeking. It would also not overcome the fragmentation and other inefficiencies identified above.

As such, the inquiry has focused on designing a coherent national system for disability support that is centred on removing the deficiencies of the current arrangements (table 1).

First, the Commission is proposing a National Disability Insurance Scheme (NDIS) overseen by a new organisation, the National Disability Insurance Agency. This would provide assessments, and funding to individuals and to organisations.

Second, the Commission is proposing a National Injury Insurance Scheme (NIIS) to address catastrophic injuries from accidents, such as quadriplegia, acquired brain injuries, severe burns and multiple amputations. The scheme would comprise a coherent set of state-based, no-fault arrangements for providing lifetime care and support, building on existing schemes. It would have the same basic goals as the NDIS, but would be funded differently. Its role and links with the National Disability Insurance Agency and NDIS are discussed later.

Who is the National Disability Insurance Scheme for?

The NDIS aims to achieve better outcomes for three different groups of people.

Tier 1: Everyone

In one sense, the NDIS is for all Australians, since it would provide insurance against the costs of support in the event that they, or a family member, acquire a significant disability. Insurance is valuable even if someone makes no claim. (Many people, for example, insure their houses against loss. Most never make a claim, nor do they expect to, but they willingly pay premiums each year to cover the risk.) The likelihood of someone acquiring a significant disability in any given year is low, but much higher than in many other areas where people want insurance.

Table 1 Overcoming the problems of the present system

<i>Current problem</i>	<i>How the proposed arrangements would address the current problems</i>
Poor national insurance (people without a disability have no clear coverage if they acquire a disability)	Full coverage of all Australians for the costs of long-term disability care and support, so people without a disability could feel confident that they or their families would be supported in the event of a significant disability. Insurance has value for people even if they make no claims
Inequitable (eg what you receive in assistance depends on where you live)	A national scheme with national standards and entitlements that would cover people with significant disabilities arising from non-accidents State-based arrangements for no-fault insurance coverage of all catastrophic accidents — with minimum national standards
Underfunded with long waiting lists	Funding would be doubled and tied to the Australian Government’s revenue-raising capacity (characterised by more efficient and sustainable taxes)
Failures to intervene early (eg people stuck in hospital because of insufficient funds for minor home modifications)	The schemes, like all insurers, would aim to minimise long-term costs, so they would have a strong incentive to undertake early intervention where it is cost effective. The scheme would spend dollars to save more dollars and people would not have to wait for basic supports like wheelchairs and personal care
Fragmented	Universal schemes; locally responsive within nationally coherent framework; funds and assessments portable across borders and support providers
Lack of clear responsibilities	Assessments under the NDIS would identify and facilitate referrals to the right supports outside the NDIS
People with disabilities and their families are disempowered and have little choice	People would be able to choose their provider or providers. They could choose to have a disability support organisation manage their packages or to act in other ways on their behalf They would be able to manage their own funds if they wish (within rules)
Little future planning	The NDIS would encourage and support people into work and/or being more involved in the community. People’s short and long-term plans would be reflected in their individual support packages
Family and carers are devalued	The support provided by families would be considered in assessments, and where appropriate, carers also assessed and given additional supports
Insufficient engagement with the community	The NDIS would leverage a bigger role for community groups and not-for-profit organisations to connect people with disabilities with the community
Economically unsustainable	Appropriate funding would stabilise the withdrawal of informal care under the present crisis-based system (which is leading to the costly withdrawal of informal supports by non-coping carers)
Inefficient with weak governance	The new scheme would be run to insurance principles by a commercial board with strong and constant monitoring by Treasury. Advice from a council of stakeholders (people with disabilities, carers and providers). People with disabilities and their families would have more control over the services they receive. They would have a strong incentive to maximise outcomes, and a direct stake in cutting waste and unnecessary services. Many safeguards to ensure costs did not get out of control. Benchmarking against schemes overseas and between the NIIS and NDIS
People have no confidence about the future: what services will and will not be available	The scheme would focus on long-term care and support needs. People would have clear entitlements to their assessed needs. There would be arrangements to guide people through the system, with strong complaints and appeals mechanisms Strong reserves to buffer the insurance fund. The scheme funds would not be tied to the annual budget cycle, but would have mandated funding hypothecated to a separate fund
Poor information, poor data collection for disability services to ensure efficient management	Information provision through web and other means by a single national agency, disability support organisations to act on behalf of people, availability of objective information about supplier performance; coherent collection of data by the scheme to manage costs and to assess outcomes
Poor evidence base	Research function and evidence-based practice

For instance, Down syndrome (trisomy 21) affects around one in every thousand live children born each year, and more than one in 50 for mothers aged in their early forties. This is just one of many conditions leading to lifelong support needs for the person with a disability. To give an overall indication of the risks, on average every 30 minutes someone is diagnosed with a significant disability requiring the kind of support that the NDIS would provide.

Some people are uncomfortable with the word ‘insurance’, but the Commission’s use of the word simply reflects the need to ensure that the community pools resources to provide reasonable long-term supports for people acquiring a significant disability.

An important role of the NDIS would also be to minimise the impacts of disability. This includes:

- promoting opportunities for people with a disability
- creating awareness by the general community of the issues that affect people with a disability, and the advantages of inclusion
- drawing on its data and research capabilities to engage with other agencies to improve public health and safety.

In the awareness area, for example, the NDIS could recognise and encourage employment of people with a disability and try more generally to combat stereotypes that reduce opportunity. The potential benefits of a more inclusive society also extend to the wider community, including to employers. The costs associated with undertaking the three functions above would be very small and in some cases would come from existing resources. The agency heading the NDIS, the National Disability Insurance Agency, would collaborate with not-for-profit organisations and other stakeholders in undertaking these functions.

Tier 2: People with, or affected by, a disability

Anyone with, or affected by, a disability could approach the scheme for information and referral services (as distinct from funded support). The scheme would also provide general information about the most effective care and support options. This would include providing linkages and referrals to relevant services for which the NDIS was not directly responsible, such as mainstream services and community support groups and services. However, it would be critical to provide any referral and information services cost-effectively, with strict cost limits. As in tier 1, the population of potential ‘customers’ would be very high, but the overall costs would be small.

An important role for the NDIS in both tiers 1 and 2 would be to strengthen voluntary links between the community and people with disabilities — to stimulate ‘social capital’. The goal would be to increase, rather than crowd out existing formal and informal arrangements. For example, local area coordinators (the scheme’s case managers) could help link people with disabilities to local community groups (for example, a sailing club) and the NDIS would sometimes provide small grants to help such groups involve people with disabilities. Not-for-profit organisations would take the lead in community capacity building, marshalling the voluntarily provided resources that they previously used to prop up under-funded direct services. Local government may also be providers of such activities when they wish to take on that role or already do.

Consistent with these aims, all governments would continue to support a range of community and carer support services, including some existing or modified Home and Community Care services, for people with lower level or shorter-term disabilities. These would be similar to those proposed within a reformed aged care system, and would be directly accessible by people with disabilities and their carers. They would be largely block-funded, with some limited user charges.

Tier 3: Access to funded individualised supports

Tier 3 would be targeted at the much smaller group of people with significant care and support needs. A focus on pooled funding to meet such needs is consistent with the fact that risk-pooling through insurance tends to focus on higher-cost, less frequent events, like early death, serious injury and property loss. Many families and individuals have an ability to bear and finance some risks themselves, and this is often a more efficient and flexible way of addressing smaller and more common risks than formal risk pooling through insurance. The focus on those most in need of funded supports would also recognise that it is important not to displace the role of the family and the community in engaging and supporting people with disabilities where people’s needs are smaller or best met in ways other than taxpayer funding. As one participant said: ‘you cannot buy a friend’.

The NDIS would also not cover people whose requirements for support would most appropriately be met by other systems. Accordingly, the NDIS would not cover people:

- acquiring new catastrophic injuries, which would be covered by the NIIS as it developed (though people with injuries acquired before the establishment of the NIIS would be covered by the NDIS)

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- with certain health conditions for which the publicly-funded healthcare system was best suited. For example, the care needs of people with terminal cancer would be best addressed in a palliative care setting. People with less severe musculoskeletal and psychological conditions would also typically receive assistance from the health system
 - people acquiring a disability after the age pension age
 - people *defined* as having disabilities, but for whom the NDIS is not needed. For example, a person whose periodic back pain sometimes prevents them from picking up an object from the floor without assistance, and a person with asthma who could not communicate while having an attack are both defined as having a disability using current disability classification systems. (The latter would be defined as having a severe disability.) These people would not typically need (or want) funded support.

A person getting funded support from the NDIS would have a disability that is, or is likely to be, permanent. ‘Permanent’ refers to the irreversible nature of the disability, even though it may be of a chronic episodic nature. For example, this would include people with significant and enduring psychiatric disabilities, who periodically rely exclusively on support from the clinical services of the mental health system, but at other times are able to live in the community provided they have appropriate supports.

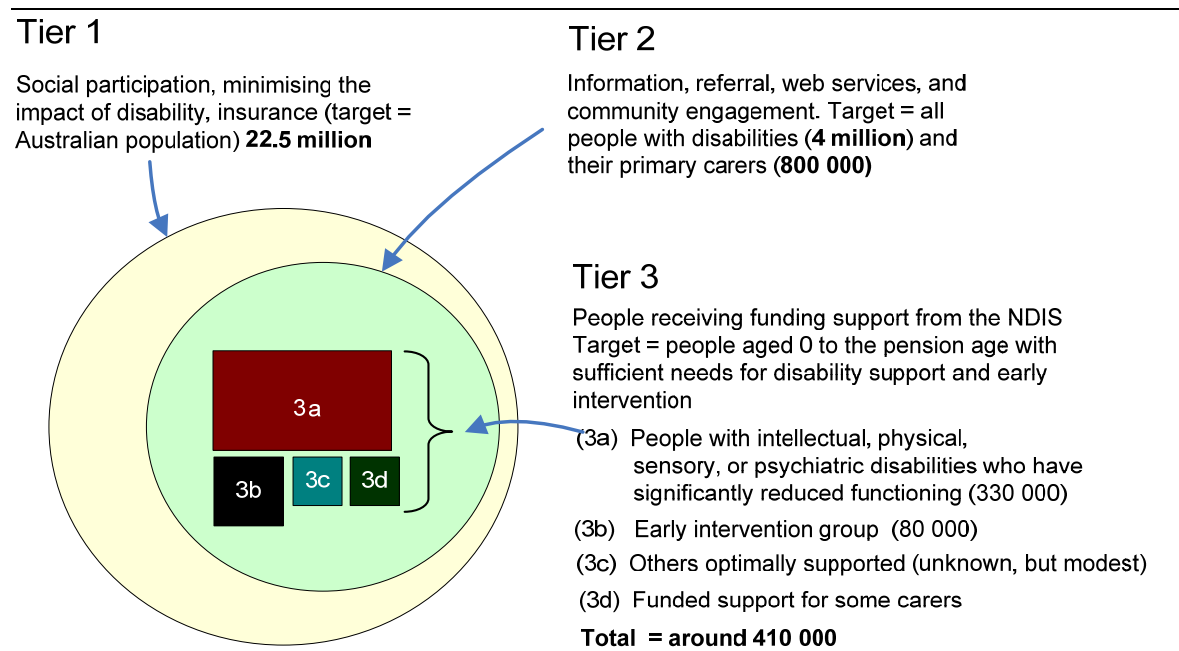
In addition to the above requirements, people would have to meet at least one of the following conditions. They would:

- have significantly reduced functioning in self-care, communication, mobility or self-management and require significant ongoing support. For example, this would include people who need support in toileting, who require significant support for mobility and/or communication or who require supports in self-management and planning to live successfully in the community (such as those with intellectual disabilities or those with significant and enduring psychiatric disabilities). This group comprises around 330 000 people (3a in figure 1), and/or
- be in an early intervention group (3b) (around 80 000 people). This would encompass people for whom there was good evidence that the intervention would be safe, significantly improve outcomes and would be cost-effective. It would include those for whom interventions would improve functioning (as in autism, acquired brain injury, cerebral palsy and sensory impairments) or delay or lessen a decline in functioning. This might include people with newly diagnosed degenerative diseases, such as multiple sclerosis and Parkinson’s disease, for whom early intervention would enhance their lives. For instance,

assisting in retaining bladder control can benefit people with worsening multiple sclerosis.

There would also be scope to include people who have large identifiable benefits from support that would otherwise not be realised (3c). This category takes account of the difficulties of slotting everyone into the specific groups above. The National Disability Insurance Agency would apply this third criterion judiciously rather than routinely. It would be constrained by guidelines, and monitored rigorously for its effects on scheme costs. If the Agency were to use this criterion loosely, it could pose a risk to the overall financial sustainability of the scheme. Finally, some funding would be available for carers who were under great strain and needed some support (3d).

Figure 1 The three tiers of the National Disability Insurance Scheme
2009 population estimates



The population estimates are indicative rather than precise because the survey and epidemiological data available are not designed for providing information on eligibility for supports, but for more general purposes. The ultimate numbers that would actually use funded NDIS services would depend on who approached the scheme and the results of their assessments. The Commission has not produced a long list of conditions covered by the NDIS because eligibility would be determined by functional limitations, not conditions.

The population of people accessing funded supports would be a fraction of those people who access (or are the targets of) tiers 1 and 2. But the overwhelming costs

of the NDIS will relate to tier 3, and it is here where good governance will be critical to ensure both high quality supports and scheme sustainability.

The NDIS would fund all people who met the criteria for tier 3 funding, and not just people who acquired a disability after the introduction of the scheme (as was the case with the NSW Lifetime Care and Support Scheme). Limiting the scheme to new cases of disability would create severe inequities, with the persistence of sub-standard support for hundreds of thousands of people for decades.

Many people currently eligible for specialist disability services may be concerned about whether they would still be able to get funded services under the NDIS. The NDIS would have broader criteria for providing funded services than existing state and territory arrangements and be based on guaranteed access to supports identified in an objective assessment process. Most people currently getting disability services would receive more support under the NDIS.

Aged care is a particularly important parallel support system

While there are many similarities between the conventional disability system and aged care, there are also many differences, such as in philosophy, employment goals, and the appropriateness of co-contributions, which mean that two systems are required.

However, many people who acquired their disability earlier in life are concerned that, as they age, they may ‘fall between the cracks’ of the two systems. They want to preserve the continuity of their support arrangements and ensure the adequacy of funding. For example, many people want the capacity to stay in their own homes (say a group home), to stay with the support workers they like and to use the service providers that best meet their needs, regardless of the system that accredits these providers.

The Australian Government has agreed to fund the disability support needs of such people under the National Health and Hospital Network Agreement with state and territory governments. It has agreed to fund specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians). This agreement is already factored into the Australian Government’s budget commitments, and therefore does not need to be incorporated into the estimated costs of the NDIS. (The only variation to the Agreement we are recommending would be that the NIIS would fund people over the age pension age who acquire catastrophic injuries, such as from a motor vehicle crash.)

That nevertheless leaves the practical issue of achieving the continuity of support as people with disabilities get older. The Commission proposes that, upon reaching the pension age¹ (and at any time thereafter), a person with a disability could elect either to stay with the NDIS or move to the aged care system.

- If a person elected to move to the aged care system, they would be governed by all of the support arrangements of that system, including its processes (such as assessment and case management approaches).
- If a person elected to stay with the NDIS care arrangements, their previous support arrangements would continue, including any arrangements with disability support organisations, their group accommodation, their local area coordinator, or their use of self-directed funding. The NDIS assessment tool would be used to determine their entitlements.
- If a person over the pension age required long-term residential aged care then they would move into the aged care system to receive that support, regardless of the age at which they acquired their disability.

The advantage of these flexible arrangements is that the NDIS would — from the perspective of any person — become a lifetime scheme if that was preferred.

Regardless of which system organised the supports, *after* the age pension age people with a disability would be required to make a capped co-contribution to their care on the same basis as the general population, if they had the financial means. This is consistent with the co-contribution arrangements recommended in the Commission’s parallel inquiry into aged care. The co-contribution reflects that the likelihood of disability in old age is high, can be anticipated, and that people can save to meet those costs. This proposal would not affect most people who acquired a disability earlier in life because they would not have earned enough income or acquired enough assets to trigger any requirement for co-contributions after the age pension age. However, some people who acquired a disability prior to the pension age may have built up sizeable assets and entitlements to retirement income. These would mostly be people who acquired a disability just a few years before the pension age, but it could include others. Like any other aged person, people in these circumstances would be expected to contribute to their care. Moreover, it would prevent people with assets or high incomes from attempting to enter the NDIS prior to the age pension age to escape the co-contribution arrangements in the aged care system. To provide an additional impetus for workforce participation, it may be appropriate for a lower co-contribution for people acquiring a disability early in their life. The Commission considers that the Australian Government should

¹ A younger age threshold would apply to Indigenous people given their lower life expectancy, as is recognised under existing aged care arrangements.

determine the appropriate aged co-contribution level as part of the implementation arrangements for the NDIS.

For people with disabilities who are eligible under the NDIS and who are below the age pension age but need to access aged care services, those costs would be met by the NDIS, without any co-contribution being required.

The assessment, funding and planning process

The NDIS would provide a number of supports and services, depending on a person's circumstances. The assessment and planning process would be a layered approach (figure 2). It would:

- determine the tier/s of the NDIS that would be appropriate to each person who contacts the system
- determine what supports outside the NDIS that people should be referred to, such as a not-for-profit organisation, Job Services Australia or a mental health service. This would be mainly targeted at people in tier 2, but would also be relevant for people in tier 3 who need supports both in and outside the NDIS
- for tier 3 contacts,
 - involve working with the person with a disability to develop a personal plan about what the person wants to achieve, including their employment and social participation goals
 - assess the nature, frequency and intensity of an individual's support needs, regardless of how these might be met. The assessment process would be person-centred and forward looking. It would consider the supports that would allow a person to fulfil a range of functions, rather than only respond to what an individual cannot do. However, the assessment would not be simply based on what people want, and it would be undertaken independently rather than through self-assessment alone
 - consider what reasonably and willingly could be provided by unpaid family carers and the community ('natural supports'). For example, it would not be reasonable to expect an 85 year old carer to provide the bulk of the support to her son with a disability. However, it would usually be appropriate to expect parents of a young child to provide low-intervention support overnight and for a reasonable period during the week, as this is what parents usually do for their children. Where informal carers meet a large share of a person's support needs, they would receive their own assessment to establish the sustainability of that care and ways in which they could be supported

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- translate the assessment process’s identified reasonable needs into a person’s individualised support package to be funded by the NDIS, after taking account of natural supports. Most people would get an entitlement to particular supports (hours of person-centred active support, aids and appliances, and so on). They could decide what service providers they wanted, or whether they wanted a disability support organisation to arrange their supports. Importantly, people could elect to get an individualised budget under self-directed funding if they wanted to manage their budget directly and were able to do so (see later). They might want to have a mix of options, such as choosing their own attendant carers, but having a disability support organisation manage all the administration.

The NDIS would periodically reassess people’s need for funded support as their circumstances changed, especially at key transition points, like leaving school, getting a job, moving out of home, or losing a natural support.

Assessments and information would be portable across the system — subject to protection of privacy — so that people would not have to repeat information for different providers or government agencies (such as repeated proofs that a child has a congenital intellectual disability). Support packages would also follow people across state and territory borders.

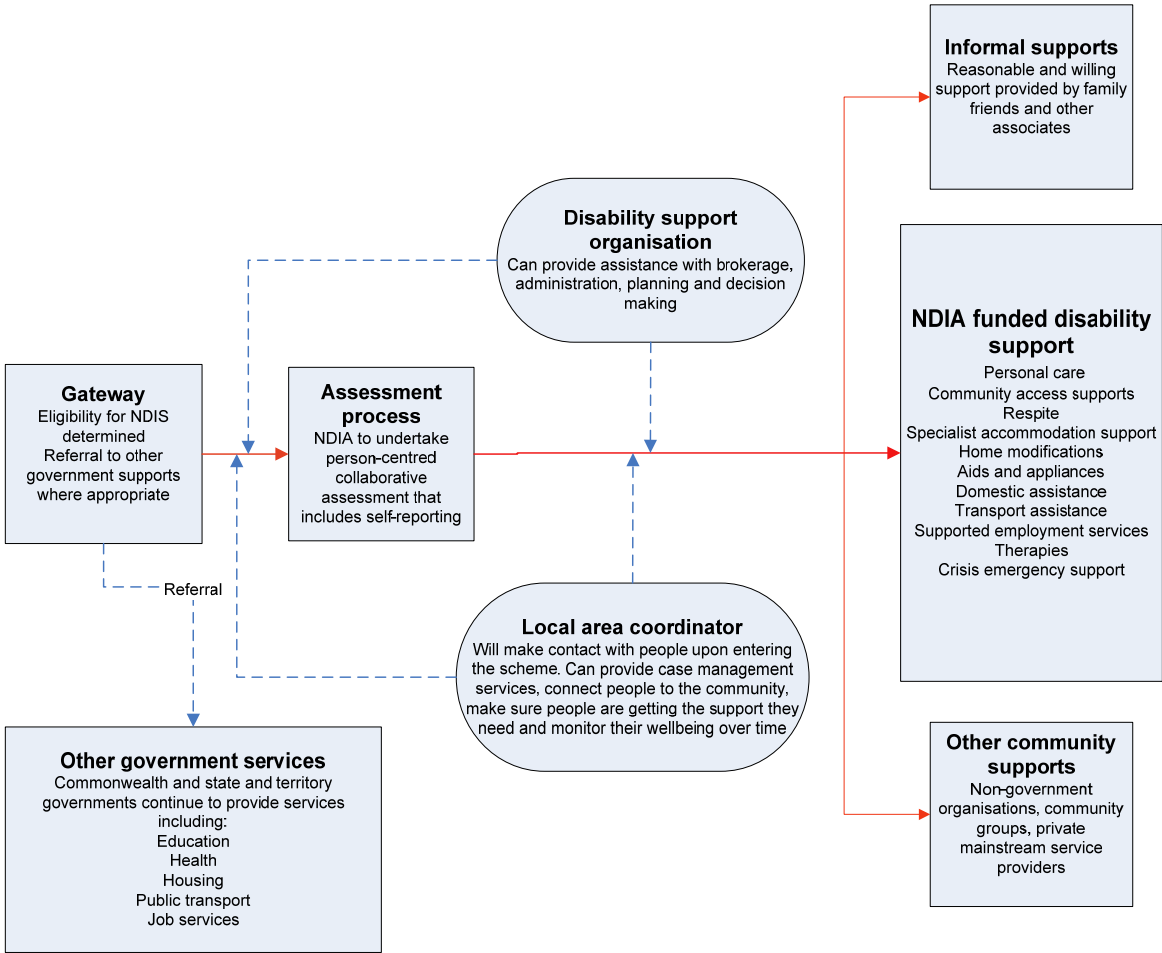
The assessment tools

Assessment tools are needed to determine the level of needs and funding for a person covered by the scheme. Good tools should be valid (testing what they purport to test), reliable (giving similar answers if people are re-tested, tested by another assessor, or if people with similar characteristics are assessed), rigorous and cost-effective. The Commission proposes a coherent package of tools (a ‘toolbox’), to be used across Australia, with different tools suited to particular needs for support (for example, aids and appliances compared with needs for job readiness training). The assessment tools would be developed within the framework of the widely accepted International Classification of Functioning, Disability and Health (ICF).

There is currently no ideal tool to use in the NDIS, but governments should not delay implementation of the scheme in the absence of ‘perfect’ tools. Accordingly, the NDIS would use the best available tools in its initial implementation phase, with the ongoing development of best practice approaches. Over the longer-term, the NDIS should oversee the development of its tools (and ideally hold copyright) since such tools effectively determine resource allocation and because the NDIS would

have the best evidence for their ongoing development. The tools should also be made available at no cost to researchers wanting to develop them further.

Figure 2 The assessment, funding and planning process



Careful use of assessment tools is critical

Wide or vague assessment criteria for funded support, exaggerated claims for supports, or the increasingly generous use of assessment tools by assessors would risk diluting resourcing, be unfair, undermine community acceptance of adequate public funding and threaten scheme sustainability. There are several safeguards to prevent this.

- Assessments would be designed to be as objective as possible. The people making assessments would need to be independent from the client (unlike treating general practitioners), be properly trained in the use of the tools and be approved or appointed by the National Disability Insurance Agency for the purpose of conducting NDIS assessments. The agency would monitor assessors

for their appropriate use of the assessment tools. ‘Hard’ assessments would be unfair on the client. Assessment ‘softness’ could jeopardise the scheme.

- Assessments would concentrate on the reasonable and necessary supports people require. People would be asked what they had received under the old system, what their goals are and what they need. Information about a person’s relevant medical conditions and specialist assessments would be made available to the assessor. Consideration would also be given to the informal care or natural supports available to the person, and any supports needed to assist carers in their role. The discussion would focus people on reasonable expectations about the packages they would receive (and in most cases, people would get greater, or more appropriate, support than at present). That information would also be useful in modelling the impacts of the new system. While there would always need to be stringent safeguards against soft assessments, an additional safeguard would be the reluctance by many people to receive more than the necessary personal care by non-family members.
- The assessments would not be ‘rubber stamped’. Prior to making budgetary decisions, the National Disability Insurance Agency would confirm that the particular assessment followed the appropriate protocol, and was consistent with the ‘benchmark’ range of assessed needs for other people with similar characteristics. Deviations outside the norm would need to be reviewed. That means that the agency would detect and adjust excessively hard or soft assessments before people got their individual packages. The NDIS would initially be rolled out in several regions in Australia — and this would help create sensible benchmarks and test assessment arrangements to ensure timely responses.
- The National Disability Insurance Agency would collect data to assess the reliability and validity of the assessment tools, and the tools would be developed over time. The assessment process would also be an important source of data for program planning, high level reporting, monitoring and judging the efficacy of interventions. It would also assist in forecasting the likely long-run liabilities for the scheme — a major focus for the management and sustainability of the NDIS.

Those safeguards aside, the goal of the NDIS would be to properly fund the reasonable assessed needs of people with a disability. This is an essential element of avoiding the uncertainty, chronic underfunding and unmet demand that has beset past allocation systems. Currently, the level of support is determined by annual government budgets that bear no consistent relationship to people’s actual needs.

What supports could people get and on what terms?

What's in?

The scheme would cover the current full range of disability supports (box 2). The development of more innovative supports would also be encouraged.

Supports would need to be reasonable and necessary. For instance, funded therapies would have to be in keeping with current clinical practice, evidence-based practice and/or clinical guidelines.

Should the NDIS cover all the costs of its supports?

Insurance products often require some form of co-funding from beneficiaries, and do so for a variety of reasons, such as reducing insurance costs, discouraging 'over-consumption' of services, reducing risk-taking behaviour, and targeting of taxpayer-funded measures at those without financial means. However, the grounds for such co-funding arrangements are weak, given the distinctive characteristics of the NDIS.

There should be no means testing. The Commission proposes that there should be no income or asset tests for getting funded NDIS services. This is because the social gains from insurance also apply to higher income groups, and asset and means tests would discourage work and savings incentives for a group of people already facing weak incentives in these areas. (This is quite different from aged care for the reasons given earlier, and where a co-contribution based on a means test is justified.)

Co-payments would not apply for clinically proven therapies funded by the NDIS. Co-payments are charges made each time a person uses a service. They can discourage people from using low-value therapies, which is both fair and efficient. However, co-payments can also have unintended effects because sometimes people might be discouraged from using essential therapies — and end up using more publicly-funded services elsewhere (for example, through hospitalisation or greater long-term use of personal care). Given this, the Commission proposes that the NDIS would fully fund the number of episodes of therapy appropriate to the person and that were supported by clinical evidence, with people meeting their full costs of further episodes if they want them.

Box 2 What supports would the NDIS provide?

Aids & appliances and home & vehicle modifications, including prosthetics and communications aids.

Personal care that supports an individual to take care of themselves in their home and community. This includes help with showering, bathing, dressing, grooming, personal hygiene including bowel and bladder care/toileting, assistance with eating and/or drinking, mobility and transfers; health maintenance, such as oral hygiene, medication use or regular and routine exercises and stretches. This would also include nursing care when this was an inextricable element of the care of the individual (for example, when meeting the care and support needs of a ventilated quadriplegic).

Community access supports to provide opportunities for people to enjoy their full potential for social independence. The intention is to allow people a lot of choice and innovation in this area. Supports would focus on learning and life skills development, including continuing education to develop skills and independence in a variety of life areas (for example, self-help, social skills and literacy and numeracy) and enjoyment, leisure and social interaction. The supports would:

- include facility and home-based activities, or those offered to the whole community
- include supervision and physical care
- range from long-term day support to time-limited supports.

Respite to provide a short-term and time-limited break for people with disabilities, families and other voluntary carers of people with a disability. Respite is designed to support and maintain the primary care giving relationship, while providing a positive experience for the person with a disability and includes:

- respite provided in the individual's own home
- respite provided in a community setting similar to a 'group home' structure
- host family respite that provides a network of 'host families' matched to the age, interests and background of the individual and their carer
- 'recreation/holiday programs' where the primary purpose is respite.

Specialist accommodation support, such as group homes and alternative family placement (but not places that provide primarily clinical supports).

Domestic assistance to enable individuals to live in the community and live on their own, such as meal preparation and other domestic tasks; banking and shopping; assistance with selecting and planning activities and attending appointments.

Transport assistance to provide or coordinate individual or group transport services, including taxi subsidies.

Supported employment services and specialist transition to work programs that prepare people for jobs.

Therapies such as occupational and physiotherapy, counselling, and specialist behavioural interventions.

Local area coordination and development, which are broad services, including individual or family-focused case management and brokerage (disability support organisations), as well as coordination and development activity within a specified geographical area. They aim to maximise people's independence and participation in the community.

Crisis/emergency support, following, say, the death of a family member or carer, or in other crisis situations, including emergency support, accommodation and respite services.

Guide dogs and assistance dogs, including the reasonable costs of being assessed for a dog, a dog, user training and veterinary costs.

Excesses ('front-end deductibles') are not appropriate. An excess is a fixed amount that a person must pay when making an insurance claim, with the remaining portion paid by the insurer. It is common in motor vehicle and health insurance. Excesses can reduce insurance costs where small claims make up a significant share of costs, or there is a risk that people make unjustified or trivial claims. However, the high needs basis for initial assessment, the rigorous nature of the assessment process itself and the fact that high needs will dominate NDIS costs means that there would be little need for an excess, or real scope for such an excess to materially reduce costs. Without specifying a dollar amount, the criteria for entry to the scheme would already have established a threshold level of need to warrant public insurance. However, there would be grounds for introducing some upfront charge if the regional rollout of the NDIS revealed that many small and unnecessary claims were clogging up the assessment process. These charges could take several forms, such as a small minimum threshold for funding by the NDIS, or the imposition of a small excess (say \$500) that would be progressively waived as people's total support costs rose (so that, for example, it would be zero for people needing more than \$3000 a year). Decisions about any excesses should be deferred until after the initial rollout of the NDIS.

Defining the boundaries of the scheme

Some services meet the needs of broader groups of people with a disability and Australians generally. These would continue to be provided outside the scheme (though the NDIS would provide referrals to them and, where appropriate, support the activity of people in them). Ultimately, there must be boundaries to the NDIS — it cannot take over responsibility for all services and supports that people with a disability use, or it would be too unwieldy and governments would be unlikely to implement it. The main complementary services are education, employment, health, housing, income support and public transport.

The Department of Education, Employment and Workplace Relations provides open employment services through Job Services Australia. This covers disability employment services (which are uncapped and include specific supports for people with disabilities) and generic employment services (which offer standard employment assistance to job searchers regardless of disability). The number of people with disabilities covered by Job Services Australia would be much greater than those eligible for NDIS-funded supports. Given that, and the significant benefits from having a single coherent system for open employment services, these services should lie outside the NDIS. However, the NDIS would fund specialised 'job readiness' programs (such as the 'Transition to Work' program in NSW) and Australian Disability Enterprises (currently funded by FaHCSIA), with a clear focus

on lifting employment outcomes. At the same time, the Australian Government should initiate further measures to achieve improved employment outcomes for people with disabilities, many of whom languish on the Disability Support Pension.

State and territory departments of education (supported by Australian Government funding) are responsible for disability support in schools. That might involve structural modifications for buildings to ensure better accessibility, aids and appliances to increase educational opportunity, teacher aides, development of new curriculum materials, and teacher training (for example, in sign language). Many of these expenditures are hard to attribute to a specific individual, since they often meet the needs of many students with disability. As such, they should not form part of the scheme. (Similar arguments apply for post-school educational services.) However, the scheme would cover goods and services used in employment or in education if these were also necessary for everyday living (such as personal care, a hearing aid or a wheelchair).

The NDIS would cover provision of specialised accommodation services (such as group houses) — net of the standard contribution from a person’s income for rent. When reasonable, it would also fund home modifications for privately-owned housing and the old stock of disability-unfriendly public housing, noting that such housing is often the key form of accommodation for people with a disability. In general, the NDIS would encourage the development of an accommodation model that gives people the capacity to unbundle the provision of the ‘bricks and mortar’ of specialised accommodation and the provision of services in those homes. That would allow people to choose to live in a dwelling owned by one provider and to purchase other services from another.

More broadly, shortages of public housing are often a major problem for people with a disability and can undermine the objective of independence. However, shortages are common to many prospective clients of public housing. Given that, there are strong grounds for the resourcing and locational decisions for public housing to remain a mainstream policy concern. Moreover, were the NDIS to fund any gaps in housing for people with a disability, state and territory governments might withdraw funding for public housing for people with a disability (‘cost shifting’ to the NDIS). The Commission has raised the possibility of an entirely new model for housing for people with long-term disability, based on ‘cashing out’ the costs of public housing and specialised accommodation. People could then decide where they might live and what type of dwelling they might like. They (and their families) would be able to add their own finances to any housing decision. This model would require cooperation with state and territory governments.

Primary care and hospital (in-patient and outpatient) based services, medical services, and pharmaceutical products should remain a mainstream concern. As is the case with the community more generally, people will continue to access the existing health care system as the need arises. However, the scheme would have a role in reducing disability specific barriers, such as where a person has difficulty communicating their symptoms to a doctor (and has no guardian to perform that function) or where they need care that a familiar personal support worker is best placed to provide.

Advocacy

Advocacy plays an important role in the disability system. Systemic advocacy pushes for broad policy and social change, while individual advocacy promotes the interests of particular individuals by acting on their behalf to resolve specific issues. These functions should lie outside the NDIS, reflecting the potential conflict of interest that would arise were the NDIS to fund advocacy bodies whose role was to challenge the disability system overseen by the NDIS. Current funding arrangements through FaHCSIA and various state and territory governments should continue.

Significant and enduring psychiatric disability should be included in the NDIS

The Commission took wide soundings on the best way to support people whose primary disability reflects a mental health condition. In particular, the Commission requested feedback on which system was best placed to meet the non-clinical, support needs of individuals with a significant and enduring psychiatric disability.

The dominant view of participants in this inquiry, consistent with the advice of experts independently consulted by the Commission, was that the NDIS should meet the disability support needs of individuals with significant and enduring psychiatric disability. This reflected the similarities in support needs and the broad principles underpinning the community mental health system and disability supports generally:

- Many people with significant and enduring psychiatric disabilities have the same day-to-day or weekly support needs as people with an intellectual disability or acquired brain injury. These can include assistance with planning, decision making, scheduling, personal hygiene and some communication tasks. Regular support and, in some cases, supported accommodation, allows such people to live successfully in the community.

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- The NDIS is the more appropriate vehicle for managing community supports. The NDIS would be underpinned by support and planning that helps people achieve their goals and maximises their participation in the community. Only a small part of the existing mental health system — the community mental health system — shares similar approaches and philosophies to the NDIS. However, this part is placed in a broader mental health system that, given its clinical orientation, has been slow to recognise these approaches, and has given priority to managing and funding the clinical, rather than the community needs, of people. The poor fit of the emerging community mental health system and the traditional clinically-oriented mental health system, means that the NDIS would be a more appropriate umbrella for the provision of community support. Community mental health services would be strengthened by the extra resources provided through the NDIS.

In the light of the evidence, the Commission determined that the NDIS should meet the community support needs of people under the pension age who have significant and enduring psychiatric disabilities and who have scope to be supported in the general community.

Supports would include expert support in people's homes and provision of group-based accommodation, but not of clinical facilities. As with other instances, where clinical supports are also important for good outcomes — such as degenerative diseases or stroke — a memorandum of understanding and coordination would be needed with the clinical services of the mental health system. In particular, there would need to be:

- clear lines of responsibility and strong communication between the NDIS and the mental health system, given the ongoing need for clinical support. New arrangements announced in the Australian Government's 2011-12 budget are an attempt to address this need and will require some adjustment as the NDIS is established
- agreement from state and territory governments that they would provide complementary supports, such as public housing and clinical care, which are essential in achieving better outcomes for these groups
- the recruitment of a trained workforce to give high quality daily supports to this group (the workforce will typically require more complex skills than those providing many forms of attendant care).

Overall, the Commission estimates that there would be 57 000 people with enduring and significant psychiatric disabilities who would meet the eligibility criteria described earlier (and, as such, would comprise around 15 per cent of the group, 3(a) in figure 1). The gross cost of their inclusion would be around \$1.85 billion per

annum, but there would be offsets of around \$600 million from existing government expenditure, so that the net cost would be \$1.2 billion.

Income support measures — in or out?

The Mobility Allowance is a fixed amount paid to certain people with disabilities who need transport for (primarily) employment and training purposes, but who cannot readily use public transport without substantial assistance. However, a flat rate of Mobility Allowance is inconsistent with the individualised approach of the NDIS. Where people were entitled to a funded package in the NDIS, they would not be eligible for the Mobility Allowance, but instead would have their reasonable assessed mobility needs met by the NDIS (but they would retain the health care card were they to meet the Mobility Allowance eligibility criteria). This change would provide more funding for necessary transport requirements. Others outside the NDIS would still get the Mobility Allowance if they were eligible for it.

The Disability Support Pension (DSP) should be outside the NDIS. It is an income support payment, like unemployment benefits, and covers a broad group of people with disabilities. There were 793 000 recipients in June 2010 of which around 250 000 would be eligible for the NDIS. DSP recipients include people whose incapacity for work is due to illness or injury and people without a lifelong disability, who do not need the individualised supports that the NDIS would provide.

There are strong grounds for (further) reform of the DSP, given that its design can significantly undermine the NDIS's goals of better economic, employment and independence outcomes for people with a disability. Some people have disabilities so severe that they could not realistically ever work — and the DSP would continue to be the major source of long-term income support for them. However, some people receiving the DSP have the potential for employment — with the associated gains of higher income, social connectedness, health benefits and the contribution they could make to the Australian community (and the evidence for such benefits is strong).

Reforms would aim to encourage the view that the norm for many people should not be the long-term use of the DSP (unlike the current 'until death or the aged pension us do part'). Those changes would be mainly oriented to people with typically non-permanent conditions and at people who could have much higher hopes for longer-run employment participation with appropriate supports. The Commission has proposed several options for the Australian Government to explore, including:

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- creating tiers within the disability income support system that recognise the varying prospects for economic and community participation by people with disabilities
 - a ‘transitional disability benefit’ could be paid for people who currently go onto the DSP, but who have some current work capacity or where their work capacity is hard to assess. These people should be assisted in getting a foothold in the job market. The changed name of the payment recognises that the ‘pension’ terminology is not appropriate for this group, as a pension implies a permanent need for income support when that is counterproductive for the genuine economic engagement of people with disabilities
 - the pension would continue for those with very low employment prospects, but even in these cases, the system should encourage and facilitate employment. The Commission has seen examples of innovative arrangements that have led to employment for people with severe disabilities
 - reducing the financial barriers to work posed by the high effective tax rates on wages for those on DSP who work. The Commission suggests that:
 - while a 15 hour work test for entry to the disability benefit is probably appropriate, it may be desirable to relax or remove altogether the work test for people already on the pension (without this being a temporary exemption as is currently proposed). It would then effectively become an in-work benefit
 - there are grounds to reduce the rates of withdrawal of the disability benefit as people work. This would act like a working credit and encourage people to work while remaining eligible for at least a part pension
 - more targeted wage subsidies and support for employers to overcome obstacles to jobs for people with disabilities
 - innovative arrangements for engaging people on the DSP with work, such as social bonds, in which a business or not-for-profit organisation forms a contract with the public sector to pay for and generate improved social outcomes that result in public sector savings.

Reduction in DSP numbers would also provide a financial offset for the NDIS, noting that the present value of 30 years of one person’s entitlement to the DSP is around \$500 000 and that the budgetary costs of the DSP were around \$12 billion in 2009-10. But the prime motivation would be to improve people’s genuine participation in society, their wellbeing and to raise their lifetime income — consistent with the goals of the NDIS.

Other payments — Carer Payment, Carer Supplement, Carer Allowance and the Child Disability Assistance Payment — encourage the provision of informal care. These payments apply to a broader population than that covered by the NDIS (particularly care for the aged). In theory, these payments could be transferred to the NDIS and directed more flexibly to people’s support needs, while reducing the poverty traps that sometimes apply to carers from such payments. However, the issue is complex. The gains may be small relative to the disruption created by the change, especially if carers viewed the change as undermining or diminishing recognition of their critical role. In these circumstances, it could inadvertently impose higher costs on the NDIS. There may be better options for addressing the work disincentives posed by the Carer Payment (such as by changing the work and education tests in the payment). The Australian Government should investigate these options. Either way, the NDIS should share information about carer payments with Centrelink and take into account the receipt of such payments when assessing people’s needs.

How would people be given greater control and choice?

There is a strong rationale for people with a disability to have much more control over what and how support services are delivered. As one participant said: ‘This scheme is for people with disability, not for service providers. Not for governments, not for empires or private agendas. This scheme is for people who are as individual as their fingerprints.’

The Commission agrees that a new scheme should reflect this goal. The Commission proposes an ‘individual choice’ model, in which people with a disability (or their guardians) could choose how much control they wanted to exercise. There would *not* be one model that forced people to take full control or none. So people could:

- (a) after consultation and assessment, receive a package of supports (not a budget amount) from the NDIS. People would be able to choose their service providers, and, if they wished, have the support of disability support organisations acting as brokers. People could switch disability support organisations and service providers if they did not meet their needs well. They might choose one service provider for one support need and another service provider for another need, or choose one provider to meet all their needs. They might ask a disability support organisation to bring together the package of supports and the best service providers on their behalf. A disability support organisation or service provider would only act for a person with a disability where that person had chosen to assign them that responsibility

(b) have the choice (subject to some conditions — see below) to cash out their support package and manage it at *the detailed level*, allocating it to specific supports they assemble themselves (so-called ‘self-directed funding’). Under self-directed funding, people could employ the support workers they want (and when), and choose to trade off some services against another. For example, the Commission knows of one case where a person with an intellectual disability used some of her funding to go to a movie weekly as her form of community access (replacing much more expensive and less enjoyable specialist day services). Self-directed funding is already partly implemented in some Australian states, and common in the United Kingdom and the United States. There is widespread and compelling evidence that it leads to good outcomes (in life satisfaction, confidence in their care, feelings of control, health, employment, a variety of other wellbeing dimensions, and potentially all at lower cost). There would be no obligation for people to use self-directed funding, and many would find it too bothersome or complicated, or would be happy to choose the disability support organisations and service providers and let them bundle supports for them. Moreover, the experience in the United Kingdom suggests that take-up may be initially slow. In England, just over 10 per cent of people aged less than 65 years completely manage their own funding. The share has been growing rapidly and some local councils have much higher rates than this. Under the NDIS, the pace of adoption of self-directed funding can be expected to grow as people gain confidence in the new system, as the market evolves, and as the system provides more support for exercising choice (for example, through disability support organisations).

The difference between the two ways of achieving choice is that the first is like consumers finding a restaurant. They do not cook the food, but they do get to choose the restaurant that suits their preferences. They will not go back if the food or service is poor. The second is like a person cooking the meal. He or she would have the freedom to choose the exact recipe, cooking methods, utensils, and when to cook, but it would involve a lot of work and they could make mistakes.

Of course, there is also the third option of taking personal charge of some aspects of support (say, hiring of attendant carers), but choosing a broker or service provider to handle other matters (akin to eating at home and at other times in a restaurant). The point is that the person with a disability would ultimately be in charge.

Model (a) is relatively easy to implement and probably the most common way in which people would exercise power (at least initially). Self-directed funding (model b) involves some complexities. To use self-directed funding:

- People would be told their individual budget — an outcome of the National Disability Insurance Agency assessment process — and would be told what parts

of that budget could be ‘cashed out’ to use flexibly. (For example, they could not cash out essential therapies.)

- People would create a personal plan and develop a concrete funding proposal, which if accepted by the National Disability Insurance Agency, would be the basis for spending the money. They would have a lot of choice. As shown to be effective overseas, people could hire the workers they want, including neighbours and friends, rather than going through specialist disability agencies. The agency would run a trial to assess the risks and benefits from paying family members for some of their care and support. This has been a successful innovation overseas, particularly in the United States, but would need to be tested carefully, given its evident risks and some concerns about its effects in one recent Australian study.
- The National Disability Insurance Agency would help by providing videos, written material and other guidance, as occurs in Victoria already.
- Disability support organisations (or indeed service providers) would help people (if they wanted) to handle the administrative and accountability requirements of self-directed funding (keeping receipt records, and dealing with workers’ compensation, any required insurance, tax withholding, superannuation obligations and police checks) for a fee. Such agencies might also develop short training sessions in people skills and confidence to self-direct, especially as so many people with a disability have been used to a system in which they only had a passive role.
- There would need to be strong accountability measures. The National Disability Insurance Agency would not allow some people to self-direct if it gauged that the risks were too high, for example, past fraud or if there were concerns about coercion. People could spend within the bounds of their plans, but would have to spend on and attend agreed therapies. They would not be able to shift money earmarked to essential long-term assets (like a wheelchair or home modification) to current consumption, and there would be some blanket prohibitions, such as gambling with the funds.
- The National Disability Insurance Agency and its local area coordinators would monitor the use of self-directed funding. (The Victorian Government requires that the funds be placed in a separate bank account that can be monitored by the relevant department.) Self-directed funding would be formally evaluated three years after the commencement of the NDIS.

How should the NDIS be financed?

Whatever its exact form, the financing mechanism must give people with a disability certainty about getting reasonable supports over their lifetime. Moreover, a stable revenue stream is needed to underpin a proper governance arrangement for the NDIS (see below). Accordingly, funding for disability must move away from the uncertainty underlying the annual determination of government budgets for disability support.

While private voluntary insurance policies can provide useful cover for income loss for people experiencing disability (and would not be affected by the NDIS), they are not suited to universal coverage of the population against the potential costs of long-term care and support associated with disability. The private insurance market does not operate well in this area, the costs would be prohibitive and many people would not get full coverage.

This suggests some sort of compulsory insurance contribution — effectively a claim on general revenue or tax. There are several options, but some are not appropriate. Savings-type models — like compulsory additions to superannuation levies or mandatory savings accounts — are ill-suited to disability support because disability can occur at any age (as compared with the need for aged care or retirement income), and fail to pool risks appropriately. The general design of so-called ‘social insurance’ schemes, in which employees and employers make compulsory contributions, is usually centred around income replacement related to people’s previous wages, rather than focused on financing long-term care and support.

These concerns suggest that either an agreed amount of revenue or a new specific tax should be dedicated exclusively to long-term disability support (‘hypothecation’).

The exact form of taxpayer-funded arrangement is dependent on the roles of the Australian Government compared with state and territory governments.

One funder would be the preferred approach

The Commission recommends that the Australian Government would take responsibility for meeting the entire funding needs of the NDIS. This would provide certainty, clear lines of funding responsibility, avoid the inefficiencies of the Commonwealth-State ‘blame game’ that afflicts some shared funding arrangements, and reflect the Australian Government’s unique capacity to raise efficient and sustainable taxes of the magnitude required. The Australian Government would

direct payments from consolidated revenue into a National Disability Insurance Premium Fund using a *legislated* formula to achieve transparency and certainty.

This approach means that the Australian Government could use several financing options, including:

- the scope to partly finance the NDIS by cutting some other spending, noting that the ongoing commitments to the NDIS required by funding of the full cost of the NDIS would represent around 4 per cent of total Australian Government spending. The potential for shifting from other spending areas to the NDIS recognises that were government to be starting with a blank slate in determining its funding priorities, provision of disability services would be one of its highest spending priorities.
- whatever was the most efficient tax financing arrangement at the time (recognising that there may be further tax reform).

A hypothecated tax imposed on personal income to meet the needs of the premium fund would be an alternative source of revenue, but would lack the flexibility and efficiency of a legislated contribution from consolidated revenue. Were the Australian Government to introduce a new disability insurance levy, it should implement it by adding an increment to existing marginal tax rates, rather than using different income thresholds or new complex tax schedules.

The extra amount of revenue required for funding the NDIS would be around \$6.5 billion (given present funding of about \$2.3 billion by the Australian Government and \$4.7 billion by state and territory governments). Were the Australian Government to be responsible for the *entire* (gross) costs of the scheme (of just over \$13.5 billion), and were state and territory governments to deflect their existing disability spending to other areas, then Australians would face tax rates that were higher than necessary.

In that context, the Commission proposes that the *quid pro quo* for the exclusive funding role of the Australian Government would be some relief for Australians generally from inefficient state and territory taxes. The Commonwealth would reach agreements with state and territory governments to reduce their inefficient stamp duties by the amount of own-state revenue they used to provide to disability services (a ‘tax swap’). Some state and territory governments have rejected this idea. However, it still has merit. All jurisdictions would be able to point to a much better system for disability care and support (in which they would play a major role — see later).

The funding of the scheme is feasible and manageable

The Commission considers that the funding of the scheme along the above lines would be feasible and manageable, taking into account that:

- Australia is a wealthy country (with \$7700 billion of net national wealth) with a large economy (\$1300 billion GDP) and the prospects of strong projected growth
- Australian taxpayers only need to finance the additional amount of resources needed to fund a proper disability system
- the full fiscal implications of the scheme would only be felt by 2018-19, reflecting the need for a careful transition
- there would be some savings over the longer-run from the fruits of early intervention, the fiscal gains from reduced income support as people with disabilities and carers increase their economic participation, and from the likelihood of increased productivity in the current, disjointed, disability system.

Payments into the premium fund would meet immediate costs and would build up reserves to spread the costs of the scheme over time and for prudential reasons. The revenue formula may need to be periodically adjusted if the reserve position deteriorated, but only if the cost increases did not reflect poor cost management. The quid pro quo of revenue certainty would have to be strong cost management in the NDIS (see later) and tightly defined and appropriate assessment arrangements.

This approach would need to be strictly monitored by transparent accounting and clear indications to state and territory governments that if they reneged on their commitments, they would face reduced future transfers or other financial penalties. An intergovernmental agreement would spell out the obligations of all jurisdictions.

Regardless of the choice of financing model, it would be critical that the revenue requirements of the National Disability Insurance Premium Fund were fully met.

A pooled funding approach is a weaker alternative

An alternative but weaker (and therefore less preferred) funding option would rely on ongoing contributions from both state and territory governments and the Australian Government. This would still involve the creation of a National Disability Insurance Premium Fund with a legislated formula for determining contributions to the fund. The only difference would be that each year, state and territory governments would need to contribute a clearly formulated and agreed amount to the premium fund. The Australian Government would fund the remaining

share. This formula-based approach would provide clarity about the long-run obligations of both levels of government (unlike some other agreements between governments).

How should the NDIS be structured and governed?

A single system or a federated model?

Any governance arrangement for running an effective *national* system would need to be structured so that it had several core features, including:

- the same national eligibility criteria, assessment toolbox, arrangements for assessors, and access to the full range of necessary supports. That would mean that regardless of location, people with equal disability status and traits/natural supports would receive the same entitlements based on need
- certainty of future resourcing
- the model and management of an insurance scheme, including the sophisticated collection and analysis of data to measure the outcomes and performance of the system, and a national research capacity. That would maximise efficiency and underpin a framework for decision-making that considers the whole-of-life costs of support for a person, with the capacity to make early investments that save future costs
- a shift from block funding and a service centred model to one in which people with disabilities and their carers would wield the greatest control, whether that be to cash out their package, or to have it met in flexible ways by providers. Under any arrangement, people could choose their providers, which would have to conform to common quality standards, compete on a competitively neutral basis and be remunerated using efficient prices. Informed choice would be supported by providing nationally consistent and publicly available measures of the performance of service providers
- a focus on individual needs and outcomes, allowing people with disabilities to reach their potential through funded supports and/or active interaction with the community. In many cases, this will include supporting individuals in understanding how to take advantage of choice and options
- the inclusion of local area coordinators, disability support organisations and a wider community role for current not-for-profit specialised providers
- a national service provider strategy (capacity building and attitude change) and workforce development strategy.

The Commission’s strong view is that these core features would be best organised using a single agency — the National Disability Insurance Agency — that would oversee a coherent system for all Australians, regardless of their jurisdiction. The national model and its overseeing agency would learn from the best arrangements in place around Australia (such as local area coordinators in Western Australia and the accident schemes in Victoria, NSW and Tasmania).

A less preferred, but clearly workable, model would be to roll out the NDIS to those states and territories that saw the advantages of a better-funded and coherent system, with other jurisdictions joining later if they wished to gain the advantages of that system. The advantages of such an arrangement would be that the reforms would not be delayed for all of those in need, and the logistical exercise would be made easier. The clear downsides would be the continuation of fragmented and inadequate arrangements in some states.

The third and most inferior option would be a ‘federated’ NDIS. In this model, the Australian Government would provide additional disability funding to state and territory governments and stipulate some common national features, but would otherwise leave state and territory governments in control of their own systems. This approach would recognise that federalism can generate useful experiments, and that state and territory governments would still have control over complementary services (such as housing, health and education). This would be better than current arrangements. However, the system would remain fragmented, and the support received would retain features of the postcode ‘lottery’. Moreover, such an arrangement could easily revert to the current dysfunctional and unfair system, with ‘agreements’ breaking down into disputes about relative contributions, special variations and carve-outs. In particular, a loose arrangement would expose Australians to the significant risk of:

- divergence rather than convergence in the essential aspects of a coherent system (such as jurisdictions adopting their own unique assessment tools and eligibility criteria over time)
- undermining the core requirement that funding be sufficient to meet people’s entitlements for their assessed needs. This would occur, for example, if governments’ funding contributions started to again reflect the vagaries of their budget cycles or were based on arbitrary criteria (such as maintaining real per capita spending levels, despite growing needs).

A federated scheme would not offer people the *assurance* of high-quality long-term care and support.

A single agency model avoids many of the disadvantages of a federated model, has many other unique advantages, and structured properly, can emulate the apparent advantages of a federated model. The national model proposed by the Commission would:

- better facilitate the achievement of the core features above, recognising that it can be hard (and slow) to get agreement about national approaches in even minor areas (such as disabled parking permits which took three years) from eight jurisdictions
- explicitly encourage innovation and test its benefits. The historical reality is that innovation in the current nationally fragmented disability system has not been rapid or uniform across jurisdictions, and not all have embraced the importance of people with disabilities as the centre of a disability system. Genuine cultural change across all Australian jurisdictions will only be achieved by disrupting existing institutional arrangements
- be responsive to local needs. The Commission envisages that the National Disability Insurance Agency would have a strong regional presence. There would be local area coordinators, based in, and with close connections to, the local community, with knowledge of local providers and not-for-profit organisations, and with some scope to respond flexibly to people's needs. (Kununurra is going to have a different set of local issues compared with North Sydney and local managers will need to have some common sense discretion.) The Agency would get input from all jurisdictions
- coordinate well with other critical supports outside the NDIS (disability employment services, income support, education, public transport, housing and health). Indeed, one of the advantages of a NDIS is that expectations about, and measurement of, the performance of these complementary services would be nationally consistent and equitable
- reduce the number of bureaucracies across the eight jurisdictions
- involve independence in decision-making from any governments (such as avoiding political advocacy for special arrangements for given clients or for the investment decisions of the scheme fund).

The Commission's recommendation for a single agency model does not stem from any inherent hostility to federalism (hence our recommendation for a federated injury scheme — see later). Rather, it stems from an analysis of the benefits that would derive from a unitary scheme. Moreover, the Commission sees considerable risks that a federated NDIS would revert to the current flawed and fragmented system.

Structuring the National Disability Insurance Agency

What happens ‘behind the scenes’ will be critical to the success of the National Disability Insurance Agency. Assessment and funding would be undertaken by the agency but services would be provided by not-for-profit organisations, state and territory service providers and businesses. The Commission opposes setting up a big new Commonwealth bureaucracy whose costs would eat up resources that should be allocated to people with disabilities. So instead, the NDIS would use a corporate model of governance, as in other insurance arrangements in the private and public sectors. Government accident insurance schemes, like the Victorian Transport Accident Commission, and the NSW Lifetime Care and Support Authority, also use a corporate insurance model.

The agency would have responsibility for supervising key aspects of the scheme. It would provide information to people generally (‘tier 1’ users); undertake research to identify best practice interventions; oversee assessment and the ongoing development of assessment tools, and would authorise individuals’ assessment results (and funding proposals for those managing their own funds). It would provide support to people through local area coordinators and to providers through capacity building, workforce development and sharing of best practice innovations. It would determine efficient prices.

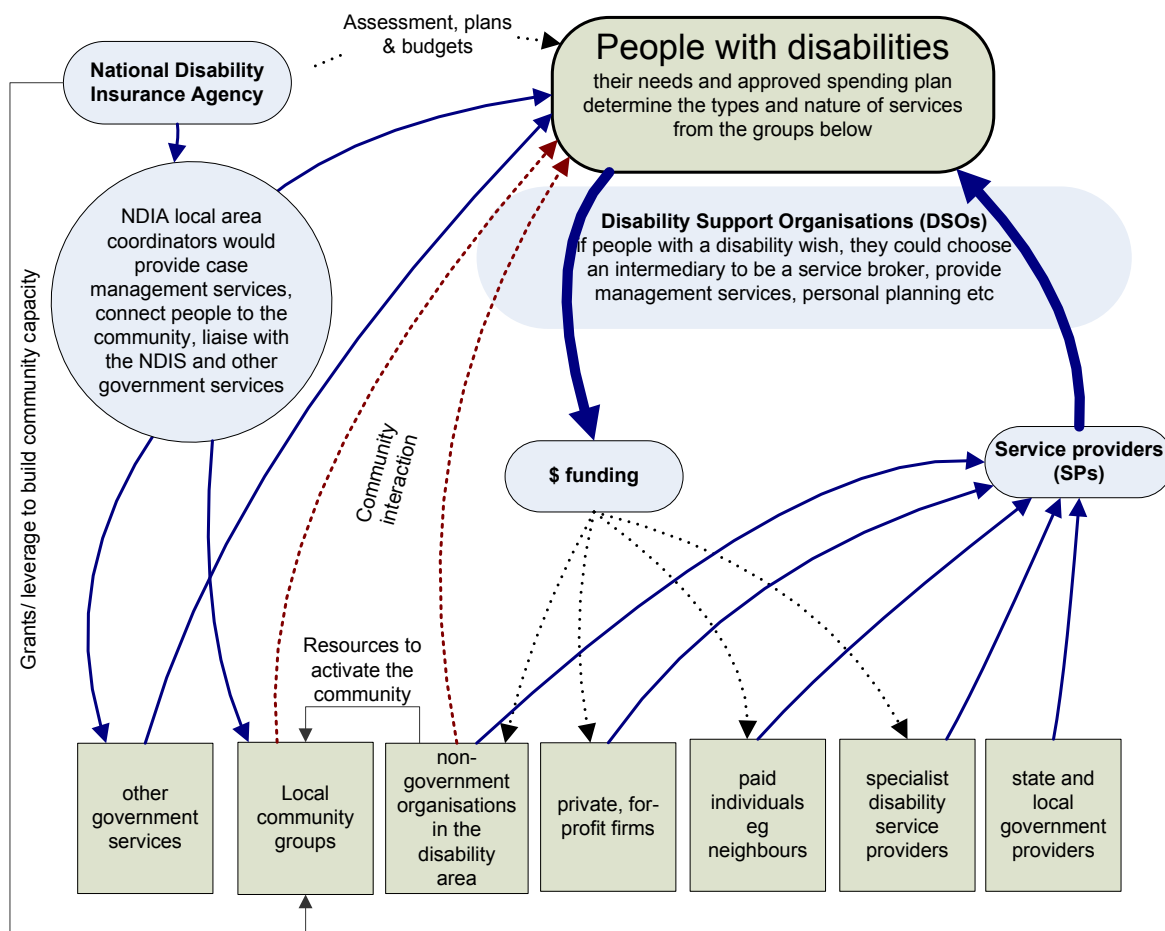
A critical part of its function would be strict management of the NDIS, supported by systematic national data collection for actuarial analysis. As discussed earlier, effective ongoing commercial management is essential to avoid a blowout in assessment outcomes (and the funding associated with them) and to ensure appropriate service utilisation and costs. Poor management is the largest risk to the scheme’s sustainability, and thereby the largest risk to long-run reasonable support of people with a disability and their families.

The National Disability Insurance Agency would be free to subcontract functions to third parties — for example, research.

Some of the most critical aspects of the NDIS would lie outside the National Disability Insurance Agency. In particular, people funded by the NDIS would be at the centre of the new scheme (figure 3). They, rather than just a few governments or suppliers, would largely control their individual support packages. Indeed, from day to day, a person with a disability and their family would mostly have direct contact with the service providers they have chosen, just like most consumers. Much of the complex business of managing the NDIS would (and should) be invisible to them. In the main, people’s contact with the National Disability Insurance Agency would be through their local area coordinator.

In addition, some key features of the NDIS would be structurally separated from the National Disability Insurance Agency (figure 4). Funds management would be integrated with existing Australian Government arrangements for investing in long-term assets (the Future Fund). The agency would still have a role, setting broad guidelines for acceptable levels of risk and return on the scheme's investment funds.

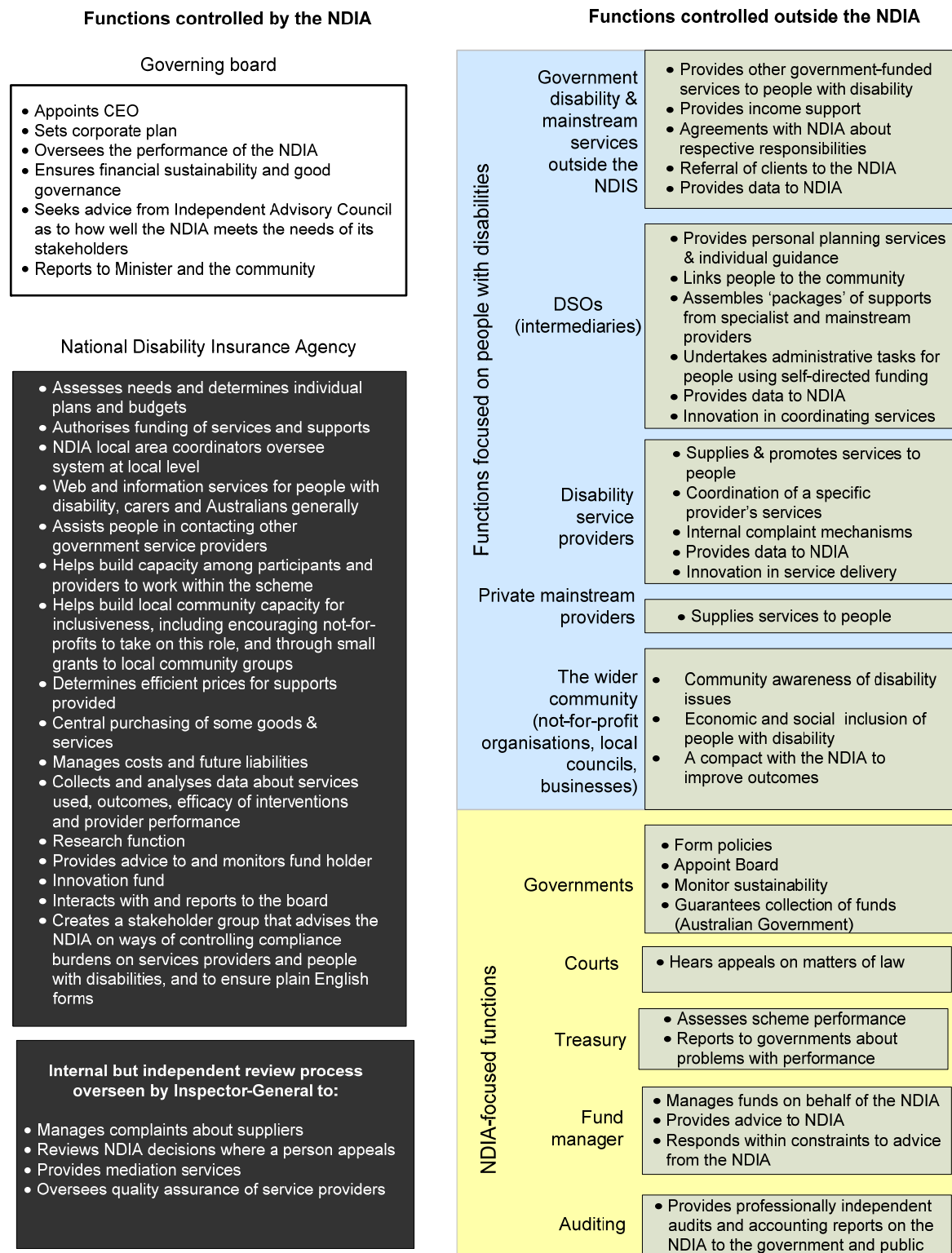
Figure 3 From a consumer's perspective, the NDIS will give them the means to choose supports that best meet their needs



The agency would not deliver mainstream services or provide specialised services, since it would be unlikely to be proficient at this and it would be inconsistent with a consumer choice model.

A new form of organisation, 'disability support organisations', would offer people brokering services, the skills and confidence to practically exercise choice, management services (such as dealing with the administrative aspects of self-directed funding, were a person to go down that route), personal planning, and orientation supports for people who are suddenly faced with the unfamiliar world of severe disability.

Figure 4 Who does what in the NDIS?



They would also develop linkages with mainstream local community groups (such as Scouts or Rotary) so that these were receptive to the inclusion of people with

disabilities generally — in effect, a community capacity building role. Disability support organisations and local area coordinators would then be able to match specific people to such community groups, depending on the preferences and personal plans of the person.

People with disabilities and service providers would need to be able to complain to, and contest the decisions of, the National Disability Insurance Agency. The Commission proposes that there would be an Office of the NDIS Inspector-General to hear complaints by people with disabilities and providers about the conduct of the Agency, and reassess contested decisions on a merit basis. While located within the NDIA, the legislation for the National Disability Insurance Agency would ensure the independence of the Office. The Inspector-General would be separately appointed by the Australian Government, and the legislation would specify that the Inspector-General be independent (an ‘independent statutory officer’), would act fairly and impartially, would base decisions on the available evidence, and could not be directed in his or her decision-making. The Inspector-General would be required to follow complaints made, and would have the power to undertake investigations and to direct the National Disability Insurance Agency to alter contested decisions. The legislation would require that regard be given to the legal entitlements of the individual and the sustainability of the scheme. The Inspector-General would report publicly to Parliament and to the board. People could appeal decisions to the courts on matters of law in the usual way.

The NDIS would not represent an Australian Government takeover of disability services. Rather, the goal would be to create a new federal social and economic institution that would be independent from all governments in operational matters. In consultation with state and territory governments, the Australian Government would draft legislation setting up the National Disability Insurance Agency and defining its functions. (At the practical level, the Australian Government would have carriage of the legislation through the Australian Parliament and Senate.) As founders of the scheme, all Australian governments would oversee the appointment of a skills-based board.

The scheme would particularly benefit from having some board members who also have direct experience with disability, and also with the management of long-term care or insurance schemes, since this is how the NDIS should be structured. Governments could sack the board if it failed to perform. All jurisdictions would also be involved in appointments to a disability advisory council to advise the board on the performance of the NDIS and its scope and activities from the perspectives of people with disabilities, carers, suppliers of equipment and services, and state and territory service providers. The agency would provide reports about its financial and other performance to all governments.

What about accident insurance arrangements?

The Commission is proposing a separate ‘federation’ of accident insurance schemes for catastrophic injury (the National Injury Insurance Scheme or NIIS), drawing on the best arrangements already in place around Australia, and extending their scope. Catastrophic injuries mainly comprise major acquired brain injuries, spinal cord injuries, burns and multiple amputations. In most instances, people need lifelong supports and, particularly in the initial post-injury phase, have intensive clinical needs and require post treatment supports, early interventions and rehabilitation services. A key focus of the NIIS would be coordinating these services and supports.

Currently, there is a range of state and territory arrangements for insuring people for disability arising from accidents, including workers’ compensation schemes throughout Australia, hybrid no-fault third-party motor vehicle insurance arrangements in some states and territories (Northern Territory, Victoria, Tasmania and New South Wales), limited provision for people suffering disability as a result of crime (a major and rising source of catastrophic injury) and fault-based medical indemnity and public liability insurance.

There is little rationale for the striking differences in state and territory arrangements for dealing with catastrophic injury. Only no-fault accident compensation schemes meet people’s lifetime care and support costs efficiently. The major flaw in the remaining fault-based arrangements is that people who cannot establish the legal liability of another party in a catastrophic accident get inadequate supports. Even when an at-fault party *can* be identified, the processes for securing compensation for support through litigation are drawn out and costly in fault-based regimes. Nor is there evidence that the common law right to sue for compensation for care costs increases incentives for prudent behaviour by drivers, doctors and other parties. The Commission recommends no-fault insurance arrangements — operating at the state and territory level — for the long-term care and support of people experiencing catastrophic injuries from all types of accidents. Acting collaboratively, the state and territory no-fault schemes would ensure national coverage. People would retain the right to sue for care costs for less severe injuries, and for economic loss and pain and suffering for all injuries.

The creation of a national injury scheme would avoid many of the deficiencies of common law compensation systems and improve outcomes for people with catastrophic injuries. It would comprise a system of premium-funded, nationally-consistent minimum care and support arrangements for people suffering catastrophic injuries. It would reduce the legal and frictional costs associated with

the current fault based adversarial arrangements. It would promote rehabilitation and adjustment and, where possible, employment.

Ultimately, the NIIS would cover (nearly) all causes of catastrophic injuries, including those related to motor vehicle accidents, medical treatment, criminal injury and general accidents occurring within the community or at home. One exception to this would be cerebral palsy associated with pregnancy or birth. In this area, there are compelling grounds for funding future care and support from the NDIS rather than the NIIS. This reflects several factors:

- the scientific evidence suggests that most cases of cerebral palsy are not accidents in the typical sense of the word. Most do not involve cases where clinical practices could avoid the disability, but are more akin to other birth defects, which would be covered by the NDIS
- it is particularly hard to reliably determine medical treatment or care by the physician as the cause in any individual case. Individually risk-rated insurance is not an efficient way of moderating risks compared with other approaches, such as training programs, clinical protocols and other measures aimed at the relevant group of physicians.

As in other areas of catastrophic injury, common law rights for suing for the future care and support needs for cerebral palsy would be removed. This would give people immediate support, whereas currently the particularly complex issues arising from determining fault in this area and the associated protracted litigation processes mean people can face significant delays in receiving adequate services. People would still be able to sue for economic loss and pain and suffering. However, people may decide not to pursue such litigation given the difficulty in establishing fault and the fact that their most important need — adequate long-term care and support — would have been met by the NDIS.

While existing workcover schemes would stay in place, there are strong grounds for state and territory governments to transfer the care and support of catastrophic workplace claims to the NIIS through a contractual arrangement with their respective workers' compensation schemes. This reflects the fact that the incidence of catastrophic injuries under workcover schemes is low and that their systems are not well geared to provide coordinated lifetime care for such cases. Notably, Victoria has already transferred such cases to its motor vehicle scheme. (Existing no-fault workcover arrangements would continue to cover the management of non-catastrophic workplace injuries.)

The appropriate funding for full no-fault coverage of lifetime care depends on the source of the injury, and should include:

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- maintaining existing revenue sources for funding catastrophic injuries (mainly premium income from mandatory insurance policies)
 - compulsory third party premiums for motor vehicle accidents in those jurisdictions without no-fault motor vehicle schemes
 - a small surcharge on passenger tickets of all rail transport regulated under the new rail safety national laws
 - a modest levy on domestically registered passenger carrying vessels regulated under the Australian Maritime Safety Authority (as the proposed new safety regulator for all commercial shipping in Australian waters by 2013) and a small levy on existing state-based registration for privately owned ‘pleasure’ vessels
 - contributions from the insurance (including self-insurance) arrangements of hospitals and the medical indemnity premiums of physicians for medical treatment accidents
 - If the removal of the insurance costs associated with the lifetime care and support of cerebral palsy cases does not sufficiently outweigh the additional costs associated with the inclusion of no-fault catastrophic injuries, then any premium increases should be modest and could gradually be phased in. State and territory governments should fund any gap between premium income and catastrophic medical injury claims.
 - Regardless, the Australian Government subsidy schemes would continue to safeguard the affordability of medical indemnity cover.
 - state and territory governments’ funding of catastrophic injuries arising from criminal injury or general accidents in the community and in people’s homes. One efficient avenue for doing this would be through a small impost on municipal rates. While local governments are opposed to such a funding approach, such taxes are economically efficient and recognise that local governments can adopt practices to reduce injuries (for example, through planning rules and by-laws). If the states do not support a small increase in rates as the means to fund this reform, they should fund such catastrophic accident costs by other means. Regardless, the capacity to reduce the risk of such accidents is greatest at the state, territory and local government level, which is why they would be the most appropriate funders of the NIIS in this area.

In all cases, one source of revenue would be savings in legal costs (which account for a significant component of premiums in fault-based systems).

Overall, a ballpark estimate is that the net annual costs of a comprehensive no-fault scheme covering all catastrophic injuries would be around \$35 per Australian.

It would take some time to introduce no-fault arrangements for all catastrophic injuries, but fast progress could be made in some areas.

- State and territory governments would set up no-fault catastrophic injury schemes for motor vehicle accidents by the end of 2013 (table 2). All catastrophic injuries would be covered by 2015, but funding for the scheme should commence in 2014 to establish a funding pool prior to any claims.
- The NIIS would be structured as a federation of separate, state-based injury insurance schemes. The purpose of federation membership should be to ensure consistency in assessments and to provide certainty around a benchmark minimum standard of care. Benchmarking would need to be transparent and agreed. Jurisdictions would learn from existing no-fault schemes — making progress quicker. New schemes would include well-developed and coherent models for rehabilitation and care, funds management, cost control — emphasising management of long-run expected liabilities — and information collection and analysis (just as in the NDIS). There should be a national arrangement for reinsurance coverage of high risks among the separate schemes.
- Jurisdictions with a small client base or without sufficient expertise could choose to sub-contract scheme management to another state (or to a private sector insurer operating across jurisdictions or to the NDIS) to reduce the fixed costs of establishing their own schemes.
- Over the medium to long term, and after the NIIS is well established, governments could consider whether the NIIS should eventually provide coverage for care and support for all significant severities of accidental injury, except where the only care needed could be provided by the health sector.
- Similarly, over time, there may be logic in extending coverage of the NIIS to provide no-fault cover for economic loss and general damages. However, this would be a radical shift, and its practicability, costs and efficiency would have to be carefully tested. The Commission proposes a review of the NIIS in 2020, of which a part would examine these issues.

The National Disability Insurance Agency itself would play an important role in the NIIS (figure 5). It could act as a host for cooperation, assist in and publish benchmarking information for both schemes, and encourage diffusion of best practice.

Other than in its role in the National Disability Insurance Agency, the Australian Government would be a less important party in the NIIS than state and territory governments. The Australian Government may also need to contribute to premiums in the Northern Territory, where the injury risks are higher. (This reflects the same equalisation principles underpinning the Commonwealth Grants Commission's

distribution of the GST.) Moreover, the Australian Government would push the establishment of the NIIS as a quid pro quo of its very large additional revenue contributions to the NDIS.

Table 2 Implementing the NIIS

<i>Date</i>	<i>Milestone</i>
Second half of 2011, or early 2012	COAG would: <ul style="list-style-type: none"> • agree to the establishment of the NIIS, whereby states would implement no-fault accident insurance schemes for long-term care of new cases of catastrophic injury • agree to have these arrangements in place in all jurisdictions for motor vehicle accidents by the end of 2013 • establish a full-time high level taskforce to help implement this The taskforce would report back regularly to Heads of Treasuries meetings and COAG on milestones reached
end 2013	NIIS to cover catastrophic injuries from motor vehicle accidents in all jurisdictions on a no-fault basis
2015	People suffering catastrophic injuries from other causes should be covered by at least 2015
2020	Independent review of the NIIS

Why two schemes?

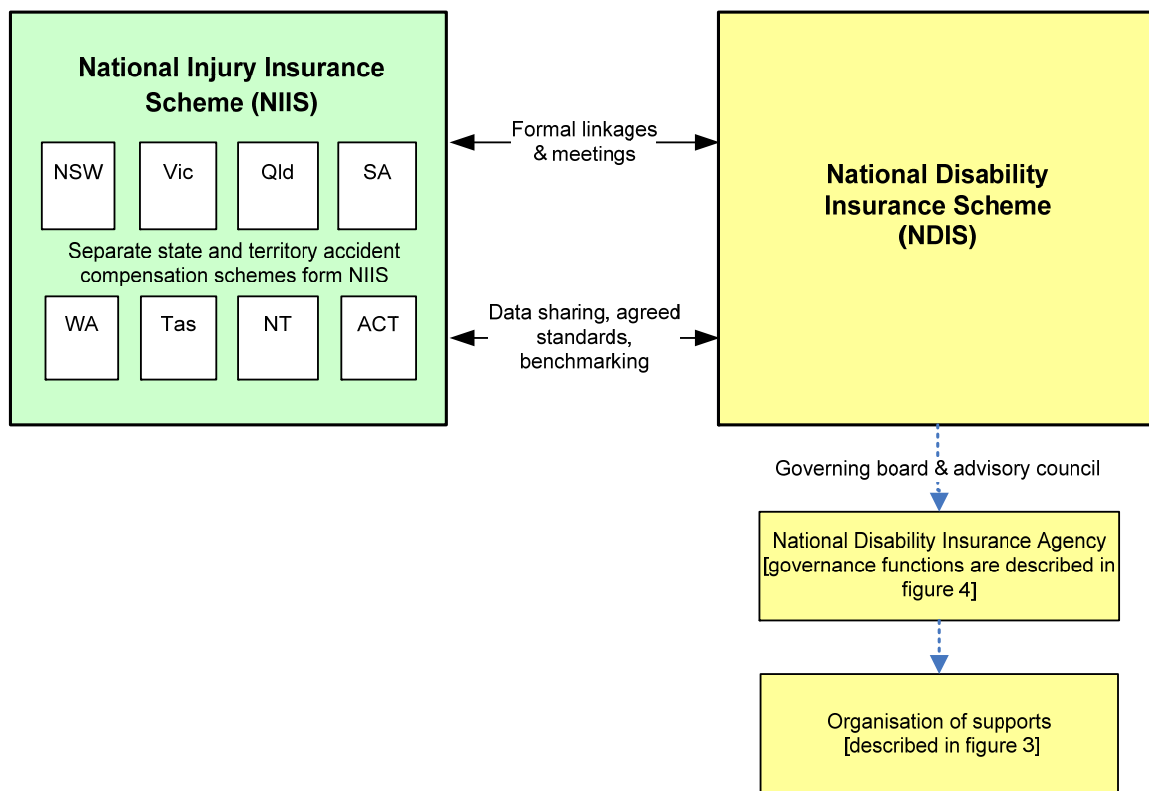
The Commission has deliberately recommended two schemes, rather than a single disability scheme. This reflects the distinctive characteristics of catastrophic injury schemes. The NIIS would:

- have as one of its goals, the reduction of local risks that can contribute to accidents. For example, state and local governments can affect public safety through local initiatives, and accident schemes can use premiums to deter high-risk behaviour. One of the reasons for using sources of funding (premiums and state and territory funding) different from the National Disability Insurance Agency is that these send price signals that encourage greater incentives for safety
- cover a variety of health costs associated with catastrophic accidents, such as trauma retrieval, acute care and rehabilitation services. A major rationale for this is that when setting premiums or determining optimum injury prevention approaches, it is important to take into account the full ‘external costs’ of catastrophic injuries, and not only those associated with lifetime care and support (an issue that does not apply to the NDIS). The knowledge gained by the NIIS in its coordination with, and development of, specialist health services

would help frame the NDIS’s memorandum of understanding with the health sector.

- draw on its revenue sources to cover the expected lifetime liabilities of new cases (it would primarily be a ‘fully funded’ scheme)
- be focused on a relatively small group of people subject to very particular and individualised intensive management. When the NIIS is fully operational, the caseload would be around 30 000 people, or about 8 per cent of the caseload of the NDIS.

Figure 5 Links between the NIIS and the NDIS



Moreover, it is a practical reality that there is already a nucleus of existing, well-functioning schemes, like those run by the Tasmanian Motor Accident Insurance Board, the Transport Accident Commission and the NSW Lifetime Care and Support Authority. There would be significant legislative change required to wrap up such accident schemes into a giant NDIS, and the resulting ‘neatness’ may not be worth the gains. That said, this issue should be revisited at the time of the proposed review of the NIIS in 2020.

Workforce issues

The expansion in the disability system will increase the demand for disability support staff. Workforce pressures will also rise as the aged care system expands (and as labour force growth subsides with population ageing). The capacity to provide expanded services will depend on attracting new employees and enabling workers in the system to work longer or more flexible hours if they want to.

The long-run response to shortages will be wage increases following competition between suppliers for labour (the current low wage levels are a major deterrent to staff working in the industry). The scope for wage increases associated with excess demand also affects how fast governments can implement the NDIS. Were governments to increase funding for disability services suddenly, the immediate effect would be significant wage increases, without the necessary expansion of supply. The phased implementation of the scheme proposed below would allow for both wage increases and a sustained increase in the workforce.

Apart from wage increases, other options for alleviating workforce shortages are:

- initiatives by service providers to adapt the work environment to increase workforce retention (such as shorter shifts, longer breaks between shifts, and greater certainty about shift arrangements)
- productivity increases from new technologies that cut the need for personal care
- supporting the current informal workforce, including using self-directed funding to allow the payment of friends, neighbours and, if justified by the trial results, relatives for some personal care and support
- a workforce strategy to retain and attract people with specialised skills where shortages are apparent or impending (such as orthotists)
- an advertising campaign for new staff (a successful initiative in New South Wales)
- identifying disability support as a career option for people seeking careers advice at school and other educational institutions
- using immigration of appropriate workers, but only if acute and persistent shortages are present. Ideally, wage increases would elicit a sufficient supply response within Australia.

Requirements for training and credentials should follow the ‘horses for courses’ principle, taking into account the needs of the person with disabilities and matching them to the skills required. Some support services will require extensive training, others not. To achieve good quality outcomes and reduce risks, regulations and

training — sometimes of a highly developed and specialised kind — are required for certain functions, such as manual handling, administering medication, and restrictive practices, therapeutic services, and fitting and creating prosthetics. Moreover, formal and on-the-job training would be likely to expand under the NDIS, because there would be more funding available for training and because it would be one of the competitive strategies used by service providers to attract customers (who will have more choice) and to retain or recruit workers.

While training is a critical element of a workforce strategy for the NDIS, governments should not require that *all* disability workers have minimum training. In some instances, the essential skills that workers need are intangible — empathy and a capacity for listening and social skills — and are not necessarily amenable to training. Moreover, the most important ‘training’ of attendant carers/support workers is often by the person with a disability and their families (but should sometimes be supplemented by orientation courses from service providers). It should also be emphasised that the overwhelming current source of care is unpaid and usually untrained family carers, who are usually preferred by people with a disability.

The NDIS should also undertake research to examine how training affects outcomes for people and ensures safety for workers. Where training was unlikely to respond quickly to market signals, the Australian Government should examine the obstacles to training and, if required, provide scholarships and subsidies in areas where impending shortages would undermine quality outcomes for people. This strategy may be particularly relevant for attracting staff into locations with acute shortages. Training would also have to emphasise the need to respect the rights and wishes of people with disabilities.

Overall, the creation of the NDIS (and the NIIS) would have significant positive impacts on the disability workforce. The new system will translate to greater pay, more jobs, better working conditions, the capacity for innovative practice, enough resources to do the job properly, recognition of the critical role of workers, more choice of employers, and greater satisfaction from working in a system that achieves better outcomes for the people they support. These outcomes will be critical to attracting the workforce needed to underpin the expansion of the NDIS.

What are the implications for delivery of support services?

The NDIS would have significant implications for service delivery. Under a consumer choice model in the NDIS, it would mean that:

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- service providers and (the newly created) disability support organisations would need to adapt to a new way of thinking and supporting people with a disability
 - block funding to service providers supplying individual supports would generally phase out. Providers would compete for custom, as people with a disability, or their agents, could ‘shop’ around for the service providers that best met their support needs, subject to the resources specified in people’s support packages. Providers would need to deal with competitive risks in the way most businesses do. The National Disability Insurance Agency would reimburse service providers or disability support organisations for those parts of a person’s support package that they supplied. The Agency would set prices for such reimbursement to ensure the long-run viability of efficient providers, which would include adequate returns for capital investments. (Only people using self-directed funding would pay providers directly.) Ultimately, the pricing role of the Agency would diminish as the market developed, and this could allow disability services to even more closely resemble the economy-wide service sector. However, block funding may continue in certain circumstances, such as in building community capacity, pilots of innovative services, in some rural areas where markets might not support the provision of any service, and where there is a need to build longer term capacity, such as Indigenous-specific services
 - people with a disability would more often use mainstream services, placing additional pressures for high quality performance by specialist agencies.

There would be significant IT infrastructure needs associated with an integrated disability system, in particular for obtaining access to clients’ assessments or other information relevant to their support needs, for financial management, and for collecting data and passing it to the NDIS. (Notably, the Australian Government employment department had to oversee the creation and deployment of a sophisticated IT system with the creation of the Job Network. The lessons learned from that exercise will be important for the National Disability Insurance Agency.) Moreover, the Australian Government is currently considering the adoption of standard business reporting for the not-for-profit sector to reduce regulatory burdens for that sector. This should make reporting of any required financial information to the National Disability Insurance Agency easier and less costly.

There are significant opportunities for service providers under the NDIS.

- Many not-for-profit organisations partly fund their current provision of services through volunteers and philanthropy, and with full funding of NDIS supports, could divert those resources to wider disability concerns. This would include enhancing employment opportunities, increasing community engagement with people with disabilities, research, or resourcing of complementary areas outside

the NDIS (such as supports for people who have been in the justice system or who are homeless).

- The amount of funding to disability would be much greater, and there would be strong incentives for innovative practice (with providers as well as people with a disability ‘unshackled’ from block funding).
- The Commission proposes that the National Disability Insurance Agency include an innovation fund that providers would use for developing and/or trialling novel approaches to disability services.
- There would be arrangements that encourage the diffusion of best practice throughout the disability sector.

A focus on quality

A quality framework for service providers would also include the development of complete, nationally consistent standards that would apply to all funded specialist service providers and disability support organisations. These would provide greater national consistency in service quality and equivalent treatment of service providers across jurisdictions. These standards should be complete, rather than augmented on a state-by-state basis — replacing state and territory equivalents for the purposes of the NDIS. A period of mutual recognition of state and national accreditation would be required to minimise the transitional impact on service providers.

Wherever possible, standards should be set in terms of directly observed outcomes, easily understood by people with disabilities, independently verifiable, and targeted at those most vulnerable or at risk of harm. The approach should focus on effective safeguarding and raising the quality of supports, rather than ‘paperwork’ initiatives, which would do little to ensure quality assurance but would impose compliance burdens on service providers.

Quality and outcomes would be tested through periodic audits (potentially triggered by complaints), consumer surveys and surveillance by local area coordinators (*not* by service providers themselves). Independent state-based statutory organisations (such as the Office of the Public Advocate) should continue to function as an avenue of complaint, investigation and recommendation, with an advisory role to the National Disability Insurance Agency. Official Community Visitors should play an important role in promoting the rights of, and overseeing the welfare of, the most vulnerable people in the disability system (and be introduced in jurisdictions where they do not already exist). Evidence of non-compliance with standards and breaches of contractual or other legal obligations would lead to enforcement by the National

Disability Insurance Agency using the typical enforcement ‘pyramid’ — advice, penalties and ultimately forfeiture of certification.

Empowerment of people with a disability — a driver of quality service provision — could be improved by giving people information about providers’ performance, such as auditors’ reports, the number of substantiated complaints, and the results of consumer satisfaction surveys. That information, along with the assistance of local area coordinators and the services of disability support organisations (such as planning and brokering), would help people make informed choices.

There has been a trend over the last 30 years towards provision of services by not-for-profit organisations, but government-run services still play a role, as do some for-profit agencies and local governments. As a funding and purchasing agency, the National Disability Insurance Agency would give no preferences to suppliers based on their ownership. Under a consumer choice model (supported by disability support organisations), the degree to which these different suppliers flourish or decline in importance would depend on their performance.

That said, in some cases, not-for-profit organisations and private operators may be unwilling or unable to operate (though presumably they would often do so if prices were set sufficiently high). In any such instance, state and territory government agencies may be the only tenable service provider (‘providers of last resort’). This may occur for clients with highly complex needs or challenging behaviours, as well as in remote settings. The National Disability Insurance Agency would need to fund such services on a fee-for-services basis, taking into account capital costs.

An Indigenous strategy

Indigenous disability rates are around double those of non-Indigenous Australians. Disability often coincides with other major problems with housing, health, substance abuse, poverty and community breakdown. Indigenous Australians also face significant barriers to accessing disability support services. This occurs due to remoteness (with typically only limited HACC and visiting services in very remote areas), social marginalisation, cultural attitudes towards disability and culturally inappropriate services.

These barriers to service delivery suggest that the service delivery model underpinning the proposed NDIS may not, on its own, deliver adequate care and support to Indigenous people with a disability. While Indigenous Australians would have access to individual support packages on the same basis as non-Indigenous Australians, it may also be necessary to block fund some services in order to overcome the additional barriers that Indigenous Australians face. In addition,

Indigenous people with disabilities often do not make claims for support. These distinctive aspects suggest that disability support for some Indigenous communities will probably need to take a different form.

Several other strategies may be useful in helping to overcome the barriers to service delivery, including:

- providing funding for early intervention and, in particular, working with local organisations to better resource preventative programs aimed at reducing the rate of disability in Indigenous communities
- fostering and building capacity in community-based operations, in consultation with local communities, and through the engagement of local staff. Larger experienced service providers would provide support. This strategy would apply across all parts of Australia — urban, regional and remote communities. But the strategy would need to recognise the particular challenges of adequate support in remote locations where even mainstream services are often absent
- employing Indigenous staff and providing appropriate training
- developing the cultural competency of non-Indigenous staff.

But ultimately, Indigenous disadvantage and the disability that is one component of it, reflect a complex set of linked factors that require a whole of government approach and community involvement.

What are the long-term benefits of the proposed schemes?

As a major reform, the proposed NDIS will generate profound economic benefits. These benefits arise from many sources:

- wellbeing gains to people with disabilities and informal carers, noting the very poor outcomes under the current system described earlier. While it is hard to assign market values for these intangible benefits, they nevertheless are still economic benefits, and likely to eclipse the benefits of many things that are counted as valuable in official statistics
- efficiency gains in the disability sector. Much of the existing system has been centred on the contractual relationships between service providers and governments, not supports chosen by people to suit their lives. As one participant noted, a support provided at the wrong time is like ‘sending a bald man to a barber’. A new coherent system would achieve much better value for

money. Every one per cent increase in productivity would lower scheme costs by \$130 million

- savings to other government services, such as reduced ‘bedblock’ in hospitals and savings in the justice system through better community support of people with significant and enduring psychiatric disability
- increased economic participation for people with disabilities (against a background of Australia’s low performance in this area compared with most other developed economies) and their informal carers
- fiscal gains, for example those associated with reduced use of income support by people who enter employment.

Moreover, in weighing up the above benefits against the costs, it should be emphasised that the net *economic* cost of the NDIS is not the budgetary cost of around \$6.5 billion (which is a transfer), but rather, the distortionary impacts of raising the revenue. That represents a cost of around \$1.6 billion. Given this, the NDIS would only have to produce a gain of \$3800 per participant to meet a cost-benefit test. Given the scope of the benefits, that test would be passed easily.

Some quantitative measures

The most important of the economic benefits are the welfare impacts for people with a disability and their carers. One, partial way of assessing these gains is the value of the implicit income transferred by the NDIS to people with disabilities. Commission estimates suggests net benefits of such transfers of around \$7.8 billion annually. This is likely to significantly understate the benefits.

It is harder to measure some of the other economic *benefits* of the NDIS, but it is possible to assess some of its economic *effects*. Were Australia to achieve employment ratios for people with disabilities equivalent to the average OECD benchmark — a highly achievable target given the proposed reforms — employment of people with mild to profound disabilities would rise by 100 000 by 2050. In fact, the package of measures, including through DSP reforms, would be likely to raise employment by considerably more than 100 000. Under a reasonable scenario, the Commission estimates that there could be *additional* employment growth of 220 000 by 2050 (including those without core activity limitations).

By 2050, the collective impact of these two employment gains would be around a one per cent increase in GDP above its counterfactual level, translating to around \$32 billion in additional GDP (in constant price terms) in that year alone. However,

it is important to note that there would be some offsetting reductions in unmeasured informal employment and output.

There would also be fiscal gains from reductions in DSP beneficiaries and an increase in part-rate DSP payments. These gains materialise slowly, but the value rises steeply. Taking account of the benefits over the longer run, the reforms would produce the equivalent of a \$2.7 billion (constant price) annuity with the gains less than that initially, but growing well above it in later years.

The bottom line is that the NDIS would have substantial economic impacts, and its benefits would significantly exceed the additional costs of the scheme.

How to implement the NDIS effectively

People want more supports urgently. But too much haste in structuring and commencing the NDIS could mean less speed and effectiveness. Governments cannot put a full-scale ‘well-oiled’ system in place in a year or two, but will need to plan carefully, develop systems, accumulate resources and build infrastructure. Implementation of the NDIS will have to confront the difficulties of reform in a system involving multiple jurisdictions and overlapping responsibilities. This means that present arrangements for state, territory and local government disability services will have to remain for a while and, after the introduction of the NDIS, coexist for a few years as people move over to the NDIS. In the interim, the Australian Government should supplement funding under the National Disability Agreement to reduce some of the worst rationing.

In the period up to the full operation of the NDIS, there would need to be:

- discussions between state and territory governments and the Australian Government about the legislation that would establish the National Disability Insurance Agency, set the boundaries for the NDIS, and the formula to finance the scheme. In consultations with all participating state and territory governments, the Australian Government would draft legislation
- finalisation of an intergovernmental agreement setting out the various obligations of governments
- development of linkages so that the NDIS would coordinate well with the supports that would lie outside it (education, housing, health, public transport, open employment services and income support)
- establishment of a National Disability Insurance Agency and appointment of a board (by all Australian governments)

-
- work undertaken on the detailed features of an effective and efficient organisation (IT, data systems, information dissemination strategies, research functions), and more broadly for an effective scheme (workforce strategies, arrangements to encourage the formation of disability support organisations, and systems for managing self-directed funding and providing development support for service providers).

To oversee this process, the Australian and state and territory governments would form a joint taskforce. It would be headed by a person with insurance and/or disability experience who has driven change successfully in a large organisation, appointed with the agreement of all jurisdictions. The taskforce would report back regularly to Heads of Treasuries meetings and COAG on milestones reached in the planning for the commencement of NDIS by July 2014. An expert project management implementation team would be tasked to plan the fine detail of the scheme and the transition arrangements.

The costs of setting up the NDIS, while significant, would be reduced by learning from the existing no-fault accident insurance schemes around Australia. And, in the past, large structural changes have been achieved in several years, for example, as with the introduction of the Superannuation Guarantee, and Centrelink. The Job Network — a sweeping change in employment services — took two years to implement. Medibank was implemented in one year after the passage of its enabling legislation.

The NDIS would begin at a manageable size. A workable way of proceeding must recognise that there would have to be enough people initially in the scheme for the National Disability Insurance Agency to learn about how the scheme works (and how to adapt it).

The scheme would be launched in mid-2014 in a few suitable regions in different jurisdictions, providing high quality services to many thousands of people. These regional arrangements would incorporate all of the functions and structures of the NDIS, and offer supports to the full range of eligible people with a disability in those regions. This would allow ongoing fine-tuning to test and refine the new scheme structures with a population that is not overwhelming. It would also help build a robust and sophisticated resource allocation process that would serve people's needs appropriately, while reducing the risks of cost blowouts. In successive years, the scheme would be scaled up (table 4).

Table 3 Implementation of the NDIS

<i>Date</i>	<i>Milestone</i>
Second half of 2011, or early 2012	<p>COAG would:</p> <ul style="list-style-type: none"> • agree to an MOU that sets out in-principle agreement that the NDIS should commence in stages from July 2014 • create a high level taskforce with agreement of participating jurisdictions, to be headed by a person with insurance or disability experience who has driven change successfully in a large organisation (appointed with the agreement of participating jurisdictions) <p>The taskforce would:</p> <ul style="list-style-type: none"> • develop a draft intergovernmental agreement for final signing in 12 months • establish an expert project management implementation team with experience in commercial insurance and disability to work full time on planning the details of the scheme <ul style="list-style-type: none"> – including targeted consultation and early work on key operational arrangements, including assessment tools, risk management and transition arrangements • report regularly to Heads of Treasuries meetings and COAG on milestones reached in the planning for the commencement of NDIS in July 2014
July 2012 to June 2013	<p><i>During 2012-13</i>, the following need to be well underway:</p> <ul style="list-style-type: none"> • drafting of legislation • preparing MOUs with government departments • developing data collection protocols • researching appropriate IT arrangements • recruiting and training of staff • testing of assessment tools • preparing manuals • determining pricing arrangements • working with providers to identify likely areas of workforce shortage and strategies to address them, with a particular focus on regional launch sites • drawing up of tenders • developing communications strategies • detailed planning for the regional launch sites, including with new and potential service providers, DSOs, not-for-profit organisations and community groups <p>By Feb 2013: final consideration and agreement by COAG to the intergovernmental agreement, including an agreement on funding arrangements</p> <p>March to June 2013: Commonwealth to introduce legislation to create NDIS and NDIA, with an initial appropriation</p> <ul style="list-style-type: none"> • state legislation and further Commonwealth legislation to follow <p>Announcement of the NDIA board</p>

(Continued next page)

Table 3 (continued)

<i>Date</i>	<i>Milestone</i>
July 2012 to June 2013 (continued)	<p>The NDIA board to commence formally</p> <ul style="list-style-type: none"> • the board to appoint a CEO • the board to appoint interim staff from the taskforce executive, the project management implementation team, and/or from elsewhere, as determined by the board • staff recruitment to begin <p>The NDIA should be established by June 2013.</p>
July 2013 to June 2014	<p><i>During 2013-14:</i></p> <ul style="list-style-type: none"> • NDIA staffing levels would be rising (including regional offices) • IT infrastructure would be purchased • workforce strategy would be implemented • capacity building would commence, including providing information and assistance to service providers in preparation for moving away from block-funding <p>Intensive work for rollout of the scheme in selected launch regions, including:</p> <ul style="list-style-type: none"> • appoint and train NDIA regional managers (July – Dec) • establish local and regional offices for NDIA for the initial launch regions (July – Dec) • regional managers would engage with existing and potential service providers (Aug – Dec) <ul style="list-style-type: none"> – and check on their preparations for expansion in 2014, including recruitment, and testing of IT systems (early 2014) • intensive training of allied health professionals as NDIS assessors for the initial launch regions (early 2014) • recruitment and training of local area coordinators • public information campaigns and outreach in the initial regional launch sites by local area coordinators to local disability organisations, people with disabilities, existing and potential service providers, local community service groups and local media (early 2014) • information sessions in these regions for people with disabilities, their families and carers, service providers and the general community (early 2014) <ul style="list-style-type: none"> – what the NDIS will do for people – the assessment process – people’s rights and responsibilities • disability support organisations may also undertake group information sessions • call for interest and pre-registration of those participating in the initial launch

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Table 3 (continued)

<i>Date</i>	<i>Milestone</i>
July 2014	<p>In July 2014, the NDIS would commence providing full services in a few regions of around 10 000 clients per region</p> <ul style="list-style-type: none">• thereby providing high quality services to many thousands of people, while allowing fine-tuning of the scheme in the light of lessons learned <p>Throughout 2014-15, all local and regional offices would be established across Australia, with local staff engaged and trained</p> <ul style="list-style-type: none">• a national information campaign would be undertaken, including information sessions by local area coordinators to local disability organisations; people with disabilities, their families and carers; existing and potential service providers; local community service groups; local media; and the general community<ul style="list-style-type: none">– in all regions, work would commence with local groups on a compact to increase social participation and employment opportunities for people with disabilities <p>The NDIA would work with providers to monitor the developing workforce and to address emerging shortages.</p>
July 2015	<p>In July 2015, the NDIS would extend nationally to cover all of Australia</p> <ul style="list-style-type: none">• progressively it would be expanded to cover all relevant people with a disability, commencing with all new cases of significant disability and some of the groups most disadvantaged by the current arrangements.
2016-17	Second year of national rollout
2017-18	Third year of national rollout NDIA evaluation of effectiveness of self-directed funding
2018-19	Final year of national rollout: all current and new clients to be receiving NDIS services
2020	Independent review of NDIA and NDIS

In 2015-16, the scheme would be extended to all of Australia. However, from a practical perspective, the scheme could not immediately support the entire eligible population across all regions in just its second year of operation. This reflects the large scale of the scheme, and the fact that it will take time to:

- develop a high quality workforce
- develop capabilities in the National Disability Insurance Agency and specialist providers
- make assessments of around 410 000 people's reasonable needs.

Accordingly, the Commission proposes that over the period from 2015-16 to 2018-19, the scheme would progressively expand to cover all relevant people with a disability. In its first stages, the NDIS would cover all new cases of significant disability and some of the groups most disadvantaged by current arrangements, such as:

- children aged under five years who have substantial core activity limitations
- select groups for whom involvement in pilot early intervention programs looks promising
- people who are now cared for by ageing carers
- people who have been inappropriately placed in nursing homes.

The NDIS is a major reform requiring careful planning and a workable transition period, but given the risks of delay, there should be an early commitment to future resourcing and a sense of urgency to deliver in the timescale proposed by the Commission.

Table 4 Progressive costs of the NDIS, 2011-12 to 2018-19

<i>Year</i>	<i>Stage of implementation</i>	<i>Likely annual costs</i>
remainder of 2011-12	} getting agreement planning the details of the scheme	\$10 million
2012-13		\$50 million
2013-14		\$550 million
2014-15	bedding down administrative arrangements	
2014-15	scheme begins with regional rollouts	\$900 million (net)
2015-16	first full year of national rollout	\$2.4 billion (net)
2016-17	second full year of national rollout	\$3.9 billion (net)
2017-18	third full year of national rollout	\$5.4 billion (net)
2018-19	final year — rollout now complete	\$6.5 billion (net)

Box 3 What are the main changes since the draft report?

- *The economic benefits of implementing the NDIS.* The scheme would substantially increase the personal wellbeing of many people with disabilities and their carers. Such benefits are economic gains, even though they cannot be measured with any accuracy and do not show up in conventional measures such as GDP. There would also be beneficial employment effects, increased efficiency and fiscal offsets (which would grow over time). The benefits are sufficiently large to exceed the estimated costs of the scheme.
- *The benefits of greater community engagement with people with disabilities.* There should be concerted efforts to support 'community capacity building' and 'social inclusion' initiatives.
- *Options to reform the Disability Support Pension to align its goals with those of the NDIS.*
- *Special arrangements for cerebral palsy.* The NDIS should fund all cases associated with pregnancy or birth that meet the NDIS eligibility criteria. Most cases of cerebral palsy cannot be avoided through clinical practices, and it is very hard to determine whether clinical care was the cause.
- *Revised criteria for obtaining assistance under tier 3.* The NDIS should provide supports for people under the pension age who have significant and enduring psychiatric disabilities, and who have scope to be supported in the general community.
- *The criteria for eligibility do not separately identify people with intellectual disabilities.* They are grouped with other people with 'significantly reduced functioning in self-management' (this criteria would also capture some people with acquired brain injuries and those with significant and enduring psychiatric disability). There is full coverage of intellectual disability.
- *There is no longer a requirement for a front-end deductible.* However, one should be considered if, after the implementation of the NDIS, small claims clog up the NDIS assessment process.
- *Qualifications for the disability services workforce.* Professional development involves both experience and formal training, but while formal training is important, it should not be compulsory for all employees.
- *Revised estimates of the numbers of people likely to be receiving supports, and of the costs of the scheme.* About 410 000 people would meet the criteria to receive funded individualised supports under tier 3 of the scheme. The increase principally reflects the inclusion of people with significant and enduring psychiatric disability, who would benefit from community supports. When fully operational, the scheme would cost about \$6.5 billion more than is currently spent by all governments.
- *Net costs of the NDIS.* Despite the inclusion of people with significant and enduring psychiatric disability, overall net costs have only risen slightly compared with the draft. This mainly reflects greater analysis of the spectrum of people's needs and associated costs.
- *Approaches to funding of the NDIS.* The Commission's first preference remains that the Australian Government should finance the entire costs of the NDIS by directing payments from consolidated revenue into a 'National Disability Insurance Premium Fund', using an agreed formula entrenched in legislation. An alternative but inferior option would be that all governments could pool funding, subject to a long-run arrangement based on the above formula, and with pre-specified funding shares.
- *Governance models.* The Commission still strongly favours a national approach through the NDIA, in which all governments would play a role. The NDIA should still be used as the model if some governments decide not to participate. An alternative but inferior option would be a 'federated' NDIS. This would give state and territory governments control over their own systems, but with some common core features. The risk is that disagreements could see it revert to a broken and inequitable 'system'.