



# National Disability Insurance Scheme Costs

March 2017

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 6000 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the National Disability Insurance Scheme (NDIS) Costs consultation by the Productivity Commission.

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## **DAA interest in this consultation**

The DAA is concerned about the lack of recognition of the importance of nutrition across the spectrum of disability. This results in the wellbeing of people with disability being compromised by inequitable access to services provided by Accredited Practising Dietitians (APDs). The advent of the NDIS brings potential for people with disability to obtain care and support from APDs that help them live an ordinary life.

APDs are the health professionals with nutrition and dietetic knowledge who work with people with disability to realise their personal goals of wellbeing. The APD program is administered by DAA as the platform for self-regulation of the profession in Australia to provide an assurance of quality and safety.

## **Responses to questions posed in the Issues Paper**

### ***What factors are contributing to increasing package costs? P12***

Some people with disability are not able to swallow food and fluids safely or to consume sufficient food and nutrition to meet their needs. They may need nutrition support in the way of enteral nutrition (tube feeding). DAA has been concerned for many years about inequities in access to nutrition support products within and across jurisdictions.

The advent of the NDIS has enabled some people to gain access to products where products are considered reasonable and necessary and the formula and equipment required is more than the cost of normal food.

However the introduction of a market based approach in the NDIS has resulted in some changes to price structures for products. DAA has had reports from members that the price charged by product distributors may be more when payment is processed through the NDIA portal than when participants pay personally for products. Distributors may be covering administrative or delivery requirements or may be trying to manage uncertainty in the market. To date it has been difficult for dietitians, distributors, manufacturers or wholesalers to engage with the NDIA to discuss approaches to product supply to the market which supports competitive but acceptable pricing and certainty of supply.

### ***Why is there a mismatch between benchmark package costs and actual package costs? p12***

DAA considers a contributing factor are inappropriate assumptions made in benchmark package costs. For example, APDs are not included in Early Childhood Intervention packages because the evidence used to determine packages was incomplete. This is at odds with the fact that many children with complex needs such as cerebral palsy or autism spectrum disorder require nutrition therapy (Ptomey 2015) alongside other therapies which are included in the Early Childhood Intervention packages. DAA understands some participants have been able to get

APDs included in their packages as a separate item. DAA considers that if the NDIA engaged with allied health practitioners to better understand the needs of people with disability, more realistic packages could be negotiated.

**Are there other aspects of eligibility criteria of the NDIS that are affecting participation in the scheme? p15**

While some participants are able to include APDs in their packages, DAA is concerned about frequent reports of the exclusion of APDs from packages for participants even though nutrition therapy is highly relevant to the participant's disability, and the participant requests the inclusion of APDs in their package. In some cases hours are included, but far less than required by the participant to achieve their goals.

*"I am looking for guidance for appealing a decision by a regional planner (after appealing the decision to the planner who sent me the decision)... as my understanding is that a review is initially internal to NDIS and the person who gave me this feedback would be the person to review it" (APD SA March 2017)*

*"I note in my area that dietitians are not routinely being added to NDIS plans." (APD VIC February 2017)*

*"I am in a region where the NDIS is rolling out. My experience so far has not been good as far as Dietitians are concerned. I have had several of my clients who have been given a NDIS plan, specifically ask for Dietetics and been refused. Some have been told that Dietitians aren't covered, others that they should see an OT. These are mainly ASD clients who I have been providing SOS therapy" (APD VIC December 2016)*

*"They just got a new planner and the planner has refused to include both dietetics and physio on the grounds that they are health needs and the family can get a CDMP from the GP. Our client support co-ordinator was at the meeting and tried to tell the planner that the enteral feeding was only required due to dysphagia which is as a result of CP but to no avail." (APD NSW October 2015)*

*"I also had another 14yo girl with CP (quad) with a BMI of 9 who recently had a plan review, in which mum was confident that she would retain all hours so didn't ask for therapy reports, but when she went into the review they practically lost everything in their plan. I had previously diagnosed this girl with malnutrition."*

The decision about what is included or excluded is made by planners, many of whom have limited training and no previous experience as a health professional. Allied health professionals, including APDs, have found it difficult to engage with the NDIA to discuss approaches to training to improve this situation. Greater

engagement between the NDIA and stakeholders would be helpful. It might also be helpful for the NDIA to engage a panel of experts to provide advice, in the way that the Department of Veterans Affairs operate.

**To what extent is the speed of the NDIS rollout affecting eligibility assessment processes?**

**P15**

Problems are occurring because of the inadequate training of planners who may have little experience of either the disability presented by some participants and little knowledge of the comprehensive therapy required to support the participant.

DAA members report inconsistency between planners. They also report inconsistency in plans despite similarity in the profile of participants. Offering standardised packages with insufficient hours is being used to deal with the numbers of participants entering or renewing plans but the packages are not sufficiently resourced. DAA would like to see greater engagement with stakeholders such as allied health professions to guide package design until such time that a genuinely personalised package can be put in place.

**Is the split between the services agreed to be provided by the NDIS and those provided by mainstream services efficient and sufficiently clear?**

DAA has received reports from members about the various interpretations of guidelines. Despite efforts to provide guidance about what responsibility is carried by the NDIS, by health, education and housing, there continue to be problems.

*“an NDIS client with Huntingtons Disease who has been refused service by NSW Health dietitians (documented in emails to Speech Pathologist) and whom NDIS has also refused to fund dietetics. I have cc'd the case manager (name supplied) from (provider name) who has been liaising with NDIS and requested funding multiple times only to be denied again and again.” (APD NSW January 2017)*

*“Yes. NDIA are saying clients who need dietetics services is a ‘health issue’ and they must use ‘mainstream services’ while NSW health are saying the opposite...that leaves clients and us in the middle” (APD NSW August 2015)*

DAA would like to see better mechanisms to resolve disagreement about which service will meet the needs of participants more quickly because such cases involve vulnerable people who are at risk of harm from lack of access to services.

***Is there any evidence of cost-shifting or service gaps? p16***

DAA members report that NDIS participants are often told to access APDs through Medicare Chronic Disease Management items. This is inappropriate as many people with disability have complex needs which are not able to be met under the limited provisions of Chronic Disease Management items. We have also had reports that participants were told they could top up the difference between the Medicare rebate and practitioner fee, which is clearly in contravention of Medicare rules.

***Is the range and type of services proposed to be funded under the ILC program consistent with the goals of the program and the NDIS more generally? P 17***

DAA is concerned that ILC program funding will be stop/start and not support maintenance of systems which support individual interventions. For example, training of workers who support participants with various disabilities and chronic disease living in supported accommodation. If such training is considered the responsibility of service providers, then the price paid for providing the service must reflect the need for ongoing training of workers.

***How should the performance of planners be monitored and evaluated? p18***

Audits of the processes used by planners to identify participant needs and to develop plans would be one way. DAA would like to see publication of the deidentified profile of participants and the services provided in plans. This would show if there are gaps in service provision, and would provide the opportunity to compare performance across planners.

***What are the likely challenges for monitoring and refining the assessment process and tools over time? P 19***

DAA considers one of the challenges is providing more transparency in decision making and guidance by the NDIA. Allied health professional peak bodies would welcome the opportunity to work with the NDIA to develop better tools for assessment and to streamline processes.

***What factors affect the supply and demand for disability care and support workers, including allied health professionals? P24***

Ease of entry to the NDIS market is a factor for supply of allied health professionals. Requiring additional credentialing/third party verification presents an administrative and cost burden to sole or small group practitioners. This additional red tape is unreasonable and unnecessary. The review of the Australian Health Practitioner Regulation Agency showed that allied health professions registered under the Agency attracted a very small percentage of complaints to the Agency, relative to medicine or nursing. Self-regulated professional organisations, such as DAA, can also provide statistics from complaints and disciplinary processes that show that behaviours which poses a risk to vulnerable

participants in the NDIS rarely occurs. DAA is not aware of these statistics being considered in the project recently undertaken in relation to the Safeguarding and Quality Framework.

The conditions of operating in the NDIS have been very difficult for many practitioners to date. Procedures have changed frequently, notice of changes has been too little and too late, and there have been continuing problems with the functioning of the portal. Hours for allied health practitioners for participants are denied or downgraded, and practitioners have spent much unpaid time advocating for participants. None of this is conducive to retention of practitioners in the NDIS workforce. Improving communication by the NDIA, improving functionality of the portal and supporting planners to make consistent and well informed decisions would make staying in the workforce more attractive.

Building the allied health workforce will need some investment in entry level training and more investment in post-graduate training. Both coursework in a classroom or online and mentoring/supervision programs will be needed. The latter will require development to see what models will work when many practitioners are working alone.

Investment in developing models for clinical governance supports will also be needed for professional growth and for safety and quality assurance.

Simulation methods, some involving technology, may be used to prepare practitioners to maximise learning when working with participants in the NDIS.

There is a view that allied health assistants are the answer to a shortage of allied health. There is a role for allied health assistants, but they require supervision by qualified and credentialed allied health practitioners. Also, funding models will need to remunerate them sufficiently to attract them to the disability sector and to fit with business models developed by service providers. Similarly with allied health students, they require supervision and should not be seen as cheap substitutes for qualified and credentialed practitioners. It would be possible however to develop new models of working with students to build the workforce in cost effective ways.

## **Other comments**

### ***Costs not considered in the paper***

The Issues Paper mostly deals with costs of the scheme incurred by the Australian Government and state/territory governments. However the costs of not delivering intended benefits of the NDIS will be carried by people with disability and their families, in terms of financial costs and quality of life. For this reason transparency in eligibility is critical, and opportunity to access services provided by mainstream providers. At present there is unhelpful denial of services which may

in the long term lead to cost increases for both governments and people with disability.

### ***Market failure***

It seems to be recognised that there are 'thin markets' or 'market failures' in delivering some services such as allied health in both rural and urban areas. Also it seems that provision of services will be particularly difficult in remote areas such as Northern Territory and Palm Island. More investment will be needed to progress the NDIS in these areas, or alternate models will be needed.

### ***Prevention of disability***

The Issues Paper states that governments cannot influence prevalence of disability. This is incorrect, in fact Australian governments have implemented many measures to reduce prevalence of disability e.g. screening at birth for inborn errors of metabolism to prevent profound intellectual disability, legislation to make roads and motor vehicles safer to reduce injury and disability, legislation for the wearing of bicycle helmets to reduce risk of harm from head injuries etc. The government must continue to make these investments which can lower the prevalence of some types of disability.

This is why it is important for people with intellectual disability or mental illness who have higher rates of physical illness to be able to access services to meet their needs holistically. Where a person with disability has diabetes for example, or is at risk of developing diabetes due to the drugs used to treat their mental illness they should be able to access services of an APD and other allied health professionals to improve their wellbeing. Siloing responsibility for therapy into health or disability has the potential to reduce access of people with disability to much needed services with long term risk of greater prevalence of disability. More work needs to be done to clarify eligibility for NDIS. Where services are not covered by NDIS, then alternative routes must be available to support wellbeing.

### **Reference**

Ptomey L, Wittenbrook W. Position of the Academy of Nutrition and Dietetics: nutrition services for individuals with intellectual and developmental disabilities and special health care needs. *J Acad Nutr Diet* 2015 April; 115(4): 593-608.