



Submission to the Productivity Commission Review of National Disability Insurance Scheme Costs

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Allied Health Professions Australia
Level 13, 257 Collins Street
Melbourne VIC 3000
Phone: 03 8662 6620
Email: office@ahpa.com.au
Website: www.ahpa.com.au

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This submission has been developed by AHPA in conjunction with, and on behalf of, its members organisations and is designed to provide a consensus view on the key issues around NDIS costs for allied health professionals. Specific contributions have been made by Audiology Australia, the Australian Music Therapy Association, the Australian Physiotherapy Association and Occupational Therapy Australia.

1 INTRODUCTION

The Productivity Commission has been asked to look at a range of issues around the sustainability of current and future National Disability Insurance Scheme (NDIS) costs. More specifically, the Commission is attempting to answer:

- Whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- How the NDIS impacts on, and interacts with, mainstream services
- Whether efficiencies have been achieved within the scheme
- Whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with profound or severe permanent disability
- What funding and governance arrangements exist, including financial contributions, risk-sharing, and the 'escalation parameters', that define the annual increase in funding required by different jurisdictions?

Allied Health Professions Australia (AHPA) and its members welcome the opportunity to contribute to the Productivity Commission's review of NDIS costs. AHPA is the recognized national peak body for allied health, collectively representing 22 national allied health organisations and formally affiliated with a further 7 organisational friends. Together, we provide a national voice for Australia's 160,000 allied health professionals. While each of our allied health profession members may provide services to people experiencing disability, the following professions work most closely with people with disabilities and their carers: Audiologists, Dietitians, Exercise Physiologists, Music Therapists, Occupational Therapists, Orthotist/Prosthetists, Physiotherapists, Podiatrists, Psychologists, Social Workers and Speech Pathologists.

AHPA, and the broader allied health sector we represent, firmly support the development of a strong national scheme that provides the support and services people experiencing disability need in order to participate fully in their communities. We recognise the crucial importance of a system that is financially sustainable and the careful balance that must be struck between current and future needs. But AHPA is also acutely aware of the potential risks associated with too great a focus on cost minimization, particularly in light of the need to address a potential shortfall of allied health professionals available to meet the demands of this growing sector. We particularly note the importance of ensuring that the goals of the scheme are met and that the rationing issues that have beset previous disability schemes don't become part of the NDIS after so much hope and effort has been put into the system by consumers and providers.

AHPA and its members seek to ensure that the ongoing development of the scheme supports the sustainable delivery of services by allied health professionals across a range of professions and settings. We have been pleased to see increased access to therapeutic supports facilitating increased life choices and a better quality of life in the NDIS trial regions. As key providers of services in the disability sector, allied health professionals are important partners in the achievement of good outcomes for consumers. But as a sector that is primarily composed of smaller providers, allied health providers are highly susceptible to adverse effects and costs arising from undue administrative, accreditation and other burdens.

2 SCHEME COSTS

AHPA notes that cost and participation outcomes for the current implementation of the NDIS have been reported as broadly meeting NDIA expectations and overall costs less than budgeted. However, AHPA also notes that the cost and budget information available to AHPA and its members provide little in the way of detail about how costs are working within the current scheme. Given the scheme is still in the process of being established and significant challenges and complexity arise as part of the transition process from existing structures and systems, it is likely that a significant proportion of costs are likely to be transitional rather than structural. As such AHPA believes caution is required in making long-term decisions at this early stage of the scheme.

AHPA also has concerns that the narrow focus on cost reporting without also considering quality and participant outcomes may adversely impact the effectiveness of the review. While these elements may seem separate to the question of costs, AHPA and its members believe that it is essential to ensure that the goals of setting up the scheme are not lost through an exclusive focus on cost management or reduction. AHPA also believes that too narrow a focus risks ignoring key factors in judging the effectiveness of current expenditures by not factoring in elements such as the cost of insufficient or poor access to services that result in poor health and wellbeing outcomes and increased future costs to the NDIS and other systems.

2.1 Are there any cost drivers not identified above that should be considered in this study?

AHPA and its members submit that there is a range of potential costs to providers and consumers associated with delivery not explicitly covered in the scheme costs outlined in the Issues Paper. The current cost driver categories identified by the NDIA consist of access, scope, volume, price and delivery. AHPA notes that while the final of these categories relates to the cost of delivering services, we are not aware that it is capturing the costs of participation and registration for providers.

A significant proportion of AHPA members have noted the difficulties allied health practitioners experience when attempting to register as NDIS service providers and for specific support groups. The registration process is slow and complex, which is resulting in costs for practitioners, primarily in the form of significant time outlays required to address the bureaucratic requirements of registration. Audiology Australia (AA) notes that this is particularly the case for the Early Childhood Supports, even though audiologists are listed as one of the professions eligible for this registration group. The Australian Music Therapy Association (AMTA) similarly notes that there are currently low rates of Registered Music Therapists (music therapists registered with AMTA) signing on to NDIS, due to the time and effort required for registration, particularly to meet the additional requirements for early childhood support.

The transition from existing services to new services under the NDIS can result in significant initial costs for providers as NDIS service providers may also need to bear upfront (and often significant) costs involved in the transfer well before the fee for the service rendered is paid. These costs may not fall directly on the scheme but they do directly impact on the ability of service providers to participate in the NDIS marketplace. Smaller providers in particular for whom the provision of NDIS-funded services may only represent part of their overall workload may choose to focus elsewhere leading to fewer options for consumers.

AHPA also notes the absence of quality and outcome measures in these categories, factors which could be captured by a focus on the value of services. The value of interventions is a crucial measure of both outcomes and expenditure and allows the reporting process to identify the impact of ineffective and poor quality services, particularly where these result in increased costs either within or outside the scheme. Given downward cost pressures and the use of lower skilled labour such as allied health assistants in place of allied health practitioners, a focus on ensuring that the services provided are achieving the right outcomes for the money spent will be essential as will an understanding of where additional costs arise. An example of this may be that a lack of sufficient therapeutic care in the community results in a preventable hospitalisation. While these types of unintended costs can be difficult to quantify, a focus on the value and quality of services should drive the development of the scheme and associated monitoring and reporting on service delivery to ensure that price isn't the only performance driver.

2.2 Why are utilisation rates for plans so low? Are the supports not available for participants to purchase (or are there local or systemic gaps in markets)? Do participants not require all the support in their plans? Are they having difficulty implementing their plans? Are there other reasons for the low utilisation rates?

The reported underutilisation of packages is of particular concern for AHPA and its members. Anecdotal evidence from across the allied health sector suggests there have been a range of recent issues for allied health practitioners including payment system issues, challenges meeting inconsistent and questionable accreditation requirements and other factors related to providing services under the NDIS. As such there is strong reason to believe that a significant contributor to underutilisation is poorly functioning systems and processes limiting access to services. The NDIA's own figures show that only around a quarter of recent eligible participants were able to access approved plans due to ICT system issues and it is reasonable to expect similar issues may constrain the use of funding within approved packages.

There is also significant reason to believe that workforce limitations may limit access. A range of workforce issues exist including the aforementioned accreditation issues which may limit the availability of specialised services. Allied health practitioners across a range of professions may work in small or solo practices making it more difficult for them to meet the requirements to become NDIS providers. Some specialty services are largely absent from the private market with some highly specialised services more typically available only through hospital-based services. Here again funding and jurisdictional issues can come into play reducing access.

The Australian Music Therapy Association has received numerous reports of participants being told by NDIS staff that they could not receive funding for music therapy, a support that they (the participants) had specifically requested and used previously under previous funding schemes. This led some participants to hold off transition to NDIS funding packages until this was rectified.

A further systems related issue identified by allied health practitioners is the delay in service providers signing off on plans. Feedback from providers suggests that these delays are occurring in situations where there is uncertainty about whether services fall within the scope of NDIS funded supports or whether those supports fit within an organisation's existing mandate. This appears to be a particular issue for state-Government operated services. Closely related to this issue is the inability to access NDIS funded supports where scheme rules attempt to force the cost on to other schemes such as when a person is hospitalised.

The intention in such a case appears to be to make all care the obligation of the hospital; however the hospital may lack the capacity or expertise, particularly around routine activities of daily living and has a different function and responsibility than the NDIS.

Feedback from some practitioners also suggests in some situations assistive technology items with which the participant is experienced and familiar, are being changed to another, lower cost, product. This can result in participants and their families choosing not to take that piece of equipment.

Given the high degree of variation across regions and the range of different issues being identified it is difficult to pinpoint precisely what is causing underutilisation. The lack of focus on quality and outcome reporting for participants involved in the trials makes it particularly difficult to accurately assess the effectiveness of the current scheme in meeting the needs of participants. However AHPA and its members do not believe underutilisation is resulting from participants not requiring the allocated support in their packages.

2.3 Why are more participants entering the scheme from the trial sites than expected? Why are lower than expected participants exiting the scheme?

A range of factors are likely to contribute to the larger than expected number of participants entering the scheme. Allied health practitioners frequently experience people with genuine need struggling to access their services due to inadequate funding through Medicare and other schemes. As a result it is reasonable to imagine that where there is an absence of appropriate alternatives, people are seeing the NDIS as a means of access to the services they require. A more appropriate question might be why participants aren't receiving the support to access the care they need from other sources. A further contributor may be the overall complexity and crossover between the health, social, disability and other systems that provide support for people with disabilities. Anecdotal evidence suggests people may be bounced between programs and jurisdictions due to a lack of clearly defined borders between systems and restricted resources and the pressure on costs in every system.

The Australian Music Therapy Association notes that mainstream and community supports in music programs are currently limited and capacity building for community musicians, educators and others will take time and resources. The Information, Linkages and Capacity Building funding at this stage does not look like it will be able to meet this need.

Similarly there are several factors likely to be contributing to the low number of participants exiting the scheme. Practitioners report that longer periods of specialised support are often needed for transition to mainstream and community supports. While this issue is not new, short programs (sometimes 10 sessions or less) continue to be allocated by the NDIS despite these frequently being unrealistic timeframes and insufficient for meeting the goals and needs of participants. Reports from allied health practitioners also suggest that the current systems underpinning the NDIS do not have the necessary agility and responsiveness to get people enrolled and accessing supports quickly. The experience of slow entry to the NDIS combined with previous experience of the rationing and long waiting periods associated with access to state- and territory based disability funding packages means a cautious approach based on staying enrolled is likely to seem far more secure than relying on the ability to quickly re-connect as a person's condition and needs change. This may improve as the system matures and the experience of new enrollees improves.

Participants may also benefit from formal transition processes to alternate systems, such as state and local Government services, to ensure there is no loss of those services that the participant may still require and to streamline entry and eligibility processes for other schemes and programs.

2.4 What factors are contributing to increasing package costs?

One factor that may be impacting on growth in the cost of packages is that participants with higher needs who may historically have needed high cost services but been unable to access these due to lack of resources in state and territory systems are now entering into the scheme. It is also likely that continued funding limitations in other schemes are resulting in NDIS funding packages being utilised to address these shortfalls, such as when excessive waiting periods in state systems mean participants cannot access supports elsewhere. Allied health practitioners consistently report that the levels of subsidy from other schemes are systematically inadequate, leading to a series of mechanisms such as cross-subsidisation and queuing.

AHPA also notes that while it is important for participants to direct their packages and have a genuine role in defining the supports they need, the current NDIS structure allows people to purchase services for which there is little evidence of benefit. This issue has been explored previously by the Australian Government. It may be that participants when identifying their support needs are increasingly using services that may not be providing effective outcomes and with low evidence of benefit, approved by planners who do not have sufficient expertise and do not seek the advice of allied health professionals about what is effective.

2.5 Why is there a mismatch between benchmark package costs and actual package costs?

AHPA and its members have found that there is significant variation both within particular regions and across the different NDIS sites. Audiology Australia in its submission to the Joint Standing Committee on the NDIS's Inquiry into the Provision of Hearing Services under the NDIS, reported that access to funding through the NDIS was found to be inconsistent within and across regions and dependent on many factors that may not relate to individual participants' needs and goals. These factors included:

- The level of advocacy participants and families were able to invest time and money into
- The NDIS planner's knowledge of and attitudes towards hearing services
- The location and/or jurisdiction in which the package was allocated.

Audiology Australia members noted significant funding discrepancies for participants with similar needs and goals with some participants receiving funding for higher technology hearing aids or assistive technology to meet their needs at work or university, while others did not. Similarly, only some participants were funded for aural rehabilitation aimed at capacity building. While it is likely that costs are not going to be the same in each region, it will be important to ensure that there is greater consistency in training and skills of planners, and in information shared with participants, to ensure that funding for supports and assistive technology is based on individual goals and needs and comparable across Government-funded programs.

The Australian Physiotherapy Association also notes that participants receiving first plans may need to 'catch up' in order to establish the supports and environment they need to optimise their ability to function effectively, particularly where prior support has been inadequate (see 2.4). As a result, the costs of support needs such as equipment, renovations, and other supports may be underestimated in benchmark packages.

AHPA also notes that there is little in the way of transparency around the figures underpinning benchmark packages. If providers and participants do not have access to information about benchmarking costs and are not sufficiently involved in the larger benchmarking project currently under way, there is an increased likelihood that the benchmarking process does not align with the needs and expectations of consumers.

3 SCHEME BOUNDARIES

Defining the boundaries of the NDIS is rightly seen as one of the crucial challenges in its large scale implementation and in ensuring its long-term sustainability. Despite the size of the scheme, it remains only part of the complex systems in place to provide for the needs of people experiencing disability in Australia. These systems are delivered across the different levels of Government, collectively aiming to address social, educational, housing, health and other needs. Managing the appropriate intersection between these systems is a crucial factor in ensuring adequate service delivery and preventing duplication. As noted previously, there is also strong reason to believe that shortfalls elsewhere will impact the scheme's cost and utilisation. There is also significant risk that there will be continued cost and responsibility-shifting between systems.

3.1 Are there other aspects of the eligibility criteria of the NDIS that are affecting participation in the scheme (to a greater or lesser extent than what was expected)? If so, what changes could be made to improve the eligibility criteria?

AHPA and its members note that contradictory and incorrect nature of information regarding the eligibility criteria for participants with some conditions, including auditory and balance disorders, may be contributing to participation in the scheme. Issues around eligibility for hearing and related disorders were exacerbated by the delay in the release of the NDIA's access (eligibility) work package which was originally planned to be released in the first half of 2016, and by the varied and contradictory information provided by NDIS Planners and other NDIS staff regarding the eligibility criteria for people with hearing loss. Audiology Australia notes its concern that the Hearing Services Voucher Scheme Minimum Hearing Loss Threshold or other 'threshold-based' criteria are being enforced by the NDIA and believe personal and psychosocial factors as well as degree of hearing loss should be considered when determining eligibility.

AHPA is also concerned about the limited capacity of NDIS eligibility criteria to address the needs of people with psychosocial needs, dual diagnoses or comorbidities, autism spectrum disorder and chronic conditions resulting in functional disabilities. Occupational Therapy Australia has noted that current eligibility criteria do not take into account the relapsing/remitting nature of mental illness due to the requirement to 'have an impairment or condition that is likely to be permanent'. This directly conflicts with principles of recovery oriented mental health practice.

AHPA notes that people with co-occurring conditions currently experience barriers to accessing integrated support through the NDIS, instead needing to rely on separate pockets of funding. Access to integrated services should be facilitated through an NDIS Local Area Coordinator (LAC). This would require an increase in the number of LACs and a greater focus on recruiting people who have experience working with clients with a dual diagnosis or co-occurring disorders.

AHPA members report ongoing issues for people assessed as falling on the lower end of autism spectrum with these frequently deemed ineligible for the NDIS, despite the fact that their condition has impacted their

functional capacity. A lack of definitive eligibility criteria means that there can be significant variation in the assessment of eligibility and increased risk of people with genuine need not receiving support.

AHPA has also had reports that people with chronic health conditions resulting in a functional disability are experiencing inconsistent eligibility assessments. One recent example provided was a person with obesity who uses a power wheelchair had their application declined and was advised that their condition was considered a temporary one.

AHPA believes the NDIS access requirements should be refined to provide greater clarity for prospective participants to reduce the scope for inconsistent decisions around eligibility. The access requirements need to clearly articulate situations where a person would be eligible for the NDIS (such as particular conditions, severity level and degree of functional impairment), and where they would be better supported through an alternative funding source. Appropriate training and skill building among NDIS staff is also crucial to ensure that these access requirements are consistently applied across different regions.

3.2 Is the ECEI approach an effective way to ensure that those children with the highest need enter into the NDIS, while still providing appropriate information and referral services to families with children who have lesser needs?

AHPA and its members support the role of early intervention but note that the early childhood early intervention (ECEI) approach may risk excluding children with a need for support, increasing the burden on other systems and schemes. If the scheme doesn't meet the child's needs there is the risk that this may result in higher levels of support in the future negating the purpose of early intervention programs. A focus on identifying where flow-on costs related to reduced access to ECEI services might arise, particularly in the longer term, may show benefits in a broader application of eligibility criteria.

AHPA also notes that some providers may misunderstand the key worker model underpinning the ECEI with the consequence that they may provide access to only a limited range of therapy disciplines, or fail to ensure adequate input to the key worker from specialist disciplines such as physiotherapy. Effective delivery of the ECEI approach will require appropriate professional input (including input to key workers) from allied health professionals with the necessary skills and experience.

3.3 Is the current split between the services agreed to be provided by the NDIS and those provided by mainstream services efficient and sufficiently clear? If not, how can arrangements be improved?

AHPA and its members are concerned that there is insufficient clarity around the split between NDIS and mainstream services. A number of allied health practitioners have noted the impact of the NDIS on access to therapy supports in the education sector. Currently therapy services often integrate school participation and assisting students to access the curriculum with support for participation in activities outside school, however there is currently no policy and funding clarity around how the implementation of the NDIS in educational/school settings will work and an increasing lack of continuity of services.

Occupational Therapy Australia notes that therapy supports, including behavioural strategies, environmental adaptations, and assistive technologies, typically have application in a range of life areas but that certain

therapeutic interventions (such as assistance with handwriting) have not been funded by the NDIS because they are considered to be 'school skills' rather than 'life skills'. AHPA recommends that a specialist taskforce is convened to determine how a consistent therapy approach can work across NDIS-specific and education-specific goals, how to ensure consistent access to assistive technologies used across different settings, and how to best realise choice and control for the child and family in both the education and broader NDIS settings.

Audiology Australia has also noted inconsistency between schemes with the NDIS participants sometimes receiving lower levels of funding than that available through the Australian Government's Hearing Services Program Community Services Obligations (CSO) scheme, resulting in an incentive for them to 'shop around' for the best funded program. Work should be undertaken to ensure consistency across government funded schemes.

3.4 Is there any evidence of cost-shifting, duplication of services or service gaps between the NDIS and mainstream services or scope creep in relation to services provided within the NDIS? If so, how should these be resolved?

AHPA members have reported a range of situations in which consumers are being turned away from state-funded services. Audiologists have also reported confusion around the funding of services for people experiencing tinnitus, with one practitioner being told that supports for tinnitus would no longer be funded by South Australia Health as this program would move over to the NDIS. However, their young and adult clients with severe tinnitus are being advised that they are ineligible for the NDIS.

Similarly the Australian Physiotherapy Association reports feedback from consumers that rehabilitation services have 'closed their books' to NDIS package holders. In some cases these issues have been resolved through advocacy by participants and providers but it is important for there to be a clearer delineation of responsibility between different government schemes and for clear information and staff training to support better understanding of service eligibility.

3.5 How has the interface between the NDIS and mainstream services been working? Can the way the NDIS interacts with mainstream services be improved?

The current interface between NDIS and mainstream services is not working effectively and there is significant scope for failures in the handover process between services, resulting in safety risks for participants. The APA notes that reports from practitioners about situations where poor communication between the public system and the chosen NDIS provider results in inadequate preparation of the NDIS-funded service provider. This can be further exacerbated when rigid eligibility rules result in services being ceased by non-NDIS providers (often in the public sector) before new services are in place.

These issues are particularly concerning in those regions where State- and Territory-funded services have transitioned, or are expected to transition, to the private sector as part of the shift to the NDIS. As noted in 3.4, practitioners have reported that some State Governments have announced that they will be withdrawing from their role as a service provider, raising uncertainty around whether existing services will continue. In New South Wales, a number of staff from the Department of Family and Community Services (FACS) have moved across to the private sector following the transfer of the Home Care Service of NSW to Australian Unity. This can result in uncertainty for participants and staff and a reduction in the availability of

services and service continuity. The NDIA will have an important role to play in ensuring appropriate transition arrangements for service providers and the effectiveness of quality controls in the private and not-for-profit sectors.

3.6 How will the full rollout of the NDIS affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?

The mental health sector is still undergoing significant change with potential NDIS funding of services only one part of a complex system that includes different levels of government, various non-government organisations as well as Primary Health Networks. One challenge is that people with mental illness may experience significant variation in the level of disability caused by their condition over the course of a lifetime and may not meet the eligibility criteria for the NDIS. However there also remains confusion around the provision of services for people who have been diagnosed with multiple conditions—for example, autism spectrum disorder and depression—resulting in questions around where funding should come from and potential shifting of responsibility rather than a holistic care approach.

AHPA and its members are concerned that a significant number of people will be deemed ineligible for the NDIS at the same time as federal program funding is shifted to the NDIS resulting in gaps in service provision and increased pressure on state-funded services.

One way in which the Federal Government's commitment to ensuring continuity of care for those who are ineligible may be realized, is through ensuring that Federal Government programs such as Helping Children with Autism (HCWA) and Better Access to Mental Health (BAMH) are used more effectively. Practitioners currently report that the number of focused psychological strategies and/or interventions approved through these initiatives is very limited, particularly for occupational therapists. AHPA proposes adjusting the assessment and treatment services available through programmes such as HCWA and BAMH and increasing the number of claimable allied health services available through the Medicare Benefits Schedule (MBS) to allow for follow-up and other evidence based best practice interventions. This will ensure the Government is providing adequate alternatives to NDIS services.

3.7 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? What, if anything, can be done to ensure the ILC and LAC initiatives remain useful and effective bridging tools between services for people with disability?

AHPA believes the range and types of services proposed for funding under the Information, Linkages and Capacity Building (ILC) program does not currently fit well with the goals of the NDIS, particularly the intention to create and support small and innovative programs. Feedback from some practitioners suggests that the funding application process for the ILC may be overly favoring well-established, larger organisations with long term financial and deliverable track records. While this approach may be consistent with government approaches to ensure public funds are not misused, it is also not consistent with an approach that fosters new and creative options for participants. This initiative is also currently limited by the low frequency of funding rounds with Victoria not scheduled until 2019 and no current sign of additional National funding rounds.

4 PLANNING PROCESS

The planning process plays a crucial role in determining access to the supports and services needed by people with disabilities. It is also a key point at which costs can be constrained meaning that planners are faced with significant challenges and mixed priorities in ensuring both that participants receive the supports they need and that the scheme is staying within budget. The impact of this approach can already be seen in the application of the First Package approach whereby package design is driven by standardised approaches and a focus on the size of the budget. While the importance of managing the overall scheme budget and sustainability of the system cannot be understated, the risks of moving away from an individual, person-centred and outcome-oriented approach should not be disregarded.

Additional conflicts of interest arise when Local Area Coordinators (LACs) providing planning support for participants are employed by service providers. This is particularly the case for participants with less ability to drive their own care and decision-making. Some allied health practitioners have raised concerns about the extent to which participants are able to provide informed consent with feedback showing participants were not informed that their NDIS packages allowed them to choose other provider because the LAC 'managing' their funds is employed by an NGO providing some or all of the other services they need. This may have the impact of reducing choice and diversity in the market, particularly in terms of the involvement of private practices, because participants have been guided to join or continue with NGOs.

AHPA and its members believe the role of planners must be more effectively defined and the potential conflicts in the role addressed. The question of whether the planning role is primarily a financial role acting for the NDIS to manage costs and determine the size of the support package or a service planning support role focused on assisting participants to fully participate in the community with the help of their support package is crucial. If service planning is to remain a key element of the role, then safeguards will need to be put in place to address conflicts of interest in identifying service providers and knowledge about services. More effective training and a higher degree of expertise in the specific field of disability relevant to the participant's need would help address issues around inadequate and inappropriate allocation of supports.

AHPA believes self-management should be a key goal, but with the intention of empowering participants rather than reducing costs. This will require a focus on providing appropriate support and education. Currently there appears also to be confusion about whether families require an Australian Business Number (ABN) in order to self-manage their NDIS packages with varied information provided by the NDIA and LACs.

4.1 Is the planning process valid, cost effective, reliable, clear and accessible? If not, how could it be improved?

Extensive feedback from across AHPAs membership suggests that there is a high degree of inconsistency across the planning workforce. The quality of NDIS plans varies considerably from person to person even where support needs are similar, and is highly dependent on the planner's level of experience and understanding of the different services available to participants. Allied health practitioners consistently report that the understanding of allied health professions such as occupational therapy is poor among planners, leading to these supports to be absent from participant packages. Planners also frequently

underestimate the hours of therapy required for a participant to achieve their goals, which subsequently affects the quality of their plan.

Participants and their carers also report significant frustration about the extent to which planning meetings are conducted by phone and the overall difficulty in accessing planners. Allied health service providers are reporting having to advocate on behalf of participants directly with planners and needing to request plan reviews where insufficient funds have been allocated to meet support needs. These reviews are currently taking weeks and even months to complete, resulting in added frustration for families and potential service gaps. These issues are likely to be the result of overly large caseloads and additional work should be undertaken by the NDIA to ensure planners are skilled to properly engage with their clients.

AHPA and its members note that appropriate involvement of allied health professionals in the planning process either directly or through appropriate assessments would be an effective means of ensuring that packages are appropriately designed. Audiology Australia notes that it is inefficient and inappropriate for plans to be approved which specify the funding available to hearing aids and equipment before a holistic assessment of the client's audiological needs has been conducted by an audiologist. Issues around conflicts of interest in such an approach can easily be managed by seeking additional opinions in the case that the planner or participant feel that the advice was incorrect or insufficient.

4.2 How should the performance of planners be monitored and evaluated?

AHPA and its members strongly believe planners need greater knowledge of the services (including music therapy) that they are approving (or not approving) for funding packages. Music therapy in particular appears to be poorly understood and practitioners report numerous refusals to fund music therapy because planners did not know the treatment existed or was supported by the NDIS or how it could be used by participants. AHPA is particularly concerned that an NDIA position paper was developed about music therapy for planners without consultation with the Australian Music Therapy Association and access to the position paper subsequently refused.

AHPA believes the training provided to NDIS Planners should be revised to ensure planners are better equipped to design appropriate packages with participants. The recruitment of staff with skills, knowledge and experience should also be prioritised to ensure better quality planning and peer support for planners. NDIS training should also be updated as current programs provided to planners appear to focus primarily on the policies and processes of the NDIA rather than the roles of health professionals who deliver supports. Planners should be required to have a minimum understanding of the therapeutic supports available to participants and their value in helping participants to develop key skills and enhance their independence.

AHPA believes that the NDIA should develop key performance indicators (KPIs) to monitor and assess the performance of planners and the overall effectiveness of the NDIS planning process in consultation with key provider and participant groups. These KPIs should include clear timeframes for planners to action requests for plan reviews and to respond to queries from participants and providers.

4.3 What are the likely challenges for monitoring and refining the assessment process and tools over time? What implications do these have for scheme costs?

AHPA notes that the monitoring and refining of the assessment process and tools is likely to be subject to both financial pressures to minimise scheme costs and pressure from the community as expectations around what is and is not supported develops. A key factor in managing costs and expectations will be ensuring that these processes and tools are developed and refined in a way that ensures they meet the expectations of participants and the service providers responsible for providing supports and result in well-designed packages of care. If this is not achieved, the NDIS will not only fail in its goals of improving the lives of people with disabilities, it is also likely to face additional costs in the form of additional planning reviews as well as more substantive administrative reviews where more significant issues have arisen. Effective ongoing engagement of participant groups and service provider groups including professional peak bodies as partners in improvement will be essential.

4.4 Are the avenues for resolving disagreements about participant supports appropriate? How could they be improved?

AHPA and its members believe there is a need to develop more effective methods to resolve issues. Current processes are slow and inefficient with practitioners repeatedly reporting a lack of response to phone calls and emails. This is resulting in providers having to invest significant time and energy to chase NDIA staff for responses. There is also some evidence to suggest staff involved in reviewing complaints may at times make mistakes in their decision-making due to a lack of knowledge about the eligibility of services such as music therapy. AHPA proposes the development of a formal process through which providers can submit supporting documentation and make recommendations about participant supports. This process should have clearly defined response time requirements and may need to be supported by the establishment of expert review panels.

5 MARKET READINESS

AHPA and its members note the difficulty in addressing the question of market readiness given the current issues with the NDIA's own systems, including payment systems, as well as the significant and varied bureaucratic burden providers currently face. Where these issues result in significant costs for providers, it is likely that providers cannot or will not provide services under the NDIS, leading to workforce issues and a lack of market readiness. AHPA notes that many providers in the allied health sector are particularly impacted by these burdens due to their small size. Allied health providers are currently in a situation where they must anticipate service demand and make decisions about accreditation, specialised ongoing training and education as well as recruitment, with little certainty about future income. This may result in providers waiting for the marketplace to mature before entering it, resulting in potential workforce shortages. The NDIA may be able to address some of these issues through engagement with peak professional bodies to ensure that it is not unduly placing burdens to entry for providers and to support education and training of providers.

5.1 What factors affect the supply and demand for disability care and support workers, including allied health professionals? How do these factors vary by type of disability, jurisdiction, and occupation? How will competition from other sectors affect demand (and wages) for carers? What evidence is there from the NDIS trial sites about these issues?

AHPA and its members note that unclear and inconsistent provider registration requirements are a significant barrier to entry into the NDIS marketplace for allied health providers. Third party verification in particular has been a frequent issue reported by providers. There is little evidence to suggest that allied health providers are a source of risk for NDIS participants. The Australian Physiotherapy Association notes that the small rate of physiotherapists subject to notifications to the Australian Health Practitioner Regulation Agency (AHPRA) and low cost of professional indemnity claims show physiotherapy is a comparatively safe service. Yet despite a lack of evidence of need there is continued inconsistency in the recommendations and requirements for quality markers at practice/organisation level, particularly the Third Party Verification requirements in New South Wales. There are also signs that the NDIS may move to require third party accreditation for all providers which increases cost and disadvantages smaller providers further distorting the NDIS marketplace.

The application of a mutual recognition model as proposed in the NDIS Quality and Safeguarding Framework that recognises the certification provided by the allied health professional peak bodies and registration boards, along with a tiered system of provider requirements proportionate to the support risk-level and the size of the provider, is a clear means of addressing current state-based systems that may be overly onerous, particularly for small providers of low-risk services. This approach should recognise not only registration with an Australian Health Practitioner Regulation Agency Board, but also recognise the practitioner certification provided by self-regulating allied health professions, such as the eight members of the National Alliance of Self-Regulating Health Professions (NASRHP). These issues must be fully considered now to ensure that they do not become structural during the full national rollout.

AHPA continues to have concerns about the availability of disability care and support workers in rural and remote areas, particularly in the Northern Territory. Providers working in these areas face significant barriers such as the requirement to travel long distances, lack of internet connectivity and more. However, more can be done to improve the quality of service delivery in remote Indigenous communities, such as consulting with Indigenous elders. Ensuring that providers are equipped to provide culturally responsive services to Indigenous Australians will remove many of the current barriers to servicing this client group.

5.2 Is increasing the NDIS workforce by 60 000-70 000 full time equivalent positions by 2019-20 feasible under present policy settings? If not, what policy settings would be necessary to achieve this goal, and what ramifications would that have for scheme costs?

AHPA and its members do not believe it will be possible to increase the NDIS workforce to the proposed levels without changes that address the previously identified registration and accreditation issues as well as workforce planning, education and training issues. Current demand for services is already exceeding the available supply of allied health providers and there is no evidence of short term changes to this workforce shortage.

The availability of mentoring and clinical supervision for new graduates is critical. Clinicians who have recently entered the workforce require access to professional development opportunities to enable them to build and maintain the specialised skills needed within the NDIS market environment. Ensuring access to these development opportunities will require the continued delivery of workforce readiness initiatives in the form of workshops and training programmes that promote evidence based interventions for people with disability. Initiatives such as the Sector Development Fund (SDF) and Innovative Workforce Fund (IWF), which allow individuals and organisations to apply for grants to support the development of the disability workforce, are valuable ways to ensure a ready and appropriately skilled workforce. Funding also needs to be provided for providers to become culturally responsive for their work with First Australian participants and their communities.

Initiatives may also be required that provide greater funding certainty for providers in the fee-for-service environment, both to ensure providers are available and to ensure that providers have the necessary certainty around service demand to make initial education and the maintenance of competencies in disability service provision worthwhile. It is also likely that initiatives to provide increased incentives for allied health and other providers will be required to encourage the growth of an adequate workforce in regional and rural locations.

5.3 What role might technological improvement play in making care provision by the workforce more efficient?

AHPA notes that a range of technologies have the potential to provide significant benefits to consumers and practitioners in streamlining access to information, simplifying reporting and administration, overcoming geographical access and mobility issues, and to improve the options and affordability of assistive technology. A key example is the delivery of services via telehealth/telepractice in areas where access to health care is limited. There is significant evidence to back the idea of telehealth as a means of delivery for some services and its widespread application could be a key means of addressing disparity in the availability of services as well as reducing the cost of unnecessary transport of participants with mobility restrictions or the time spent by practitioners travelling to remote community. AHPA believes telehealth and other online-based services should be fully funded where the provision of these services has been determined to be appropriate, safe and of good value.

Other initiatives such as My Health Record provide scope for better communication and improved decision making for the different health providers involved in delivering care for people with disabilities. It also has the potential to allow participants and their families to more actively involve themselves in the health of the participant. However, many of the providers providing services for people with disabilities do not currently have the necessary infrastructure and systems to utilise digital technology, particularly in rural and remote areas. It will be up to the NDIA or Government to ensure smaller practices are supported to address the significant disadvantage they are likely to experience in the high proportional cost of the adoption of technology, particularly in light of uncertainty about income.

5.4 What are the advantages and disadvantages of making greater use of skilled migration to meet workforce targets? Are there particular roles where skilled migration would be more effective than others to meet such targets?

AHPA and its members believe that skilled migration is a potential way of increasing the number of qualified allied health professionals available to provide services to the disability sector. However, AHPA notes that skilled migrants are unlikely to be familiar with local health and social systems and services and may not have specialised skills as required to provide appropriate support to many participants. As a result these skilled migrants are likely to have skills and knowledge at a level that is closer to entry level allied health professionals and requiring mentoring and support. Experience suggests that significant time is required for overseas-trained graduates to learn to navigate the complex interaction of systems and understand the various parties involved in providing support. These factors mean that there will need to be significant investment to ensure that skill migrants can provide services of equivalent quality and AHPA submits that it may be more effective to pursue alternatives such as incentivisation of Australian graduates and other workers.

5.5 Are prices set by the NDIA at an efficient level? How ready is the disability sector for market prices?

AHPA and its members are concerned that the term efficient is not well defined and may not focus on the longer term sustainability of service delivery. Practitioners frequently note the prevalence of ‘hidden costs’ associated with working in the NDIS, with many therapists working outside of normal working hours to complete tasks. The Australian Physiotherapy Association has noted that in other insurance schemes across Australia, price setting has involved the ‘bundling’ of a number of different provider service elements into the price. These elements can vary between travel (which includes the opportunity cost of providing other services and the direct cost of the transport), extensive report preparation for third parties, transaction costs involved in communications with the insurance scheme, and professional services costs such as liaison with other services. The way costs are set needs to be clearly communicated to participants and their family members, to ensure that they understand that costs may consist of a range of factors and these can reduce the length of the actual consultation. If these factors are not sufficiently addressed then it risks making the provision of NDIS services unsustainable for providers.

5.6 What is the capacity of providers to move to the full scheme? Does provider readiness and the quality of services vary across disabilities, jurisdictions, areas, participant age and types/range of supports?

AHPA and its members believe that allied health providers operating in private practice are generally ready to move to the full scheme, providing key issues outlined previously around provider registration, workforce development and planning processes are addressed. These providers already operate primarily on a fee-for-service basis where consumers are not eligible for programs such as Medicare or the Australian Government’s Hearing Services Program.

AHPA notes that it will be important to ensure that there is sustainable capacity amongst providers to deliver services and this will be related to ensuring adequate levels of remuneration. Participants and funders will need to understand the long term safety, quality, and sustainability implications of trying to drive down prices.

5.7 How ready are providers for the shift from block-funding to fee-for-service?

AHPA notes that the shift to fee-for-service does not impact most allied health providers as practitioners have not typically provided services through block-funding except by providing individually charged services to organisations that are block funded. However AHPA and its members are concerned about the capacity of the broader allied health sector to sustainably compete in an environment where vertically integrated providers have developed skills in tendering, and will be advantaged by a market in which service packages, purchased by intermediaries for participants, will be a substantial market segment.

5.8 What are the barriers to entry for new providers, how significant are they, and what can be done about them?

AHPA notes that the current implementation of the NDIS provides significant barriers to new providers. Registration issues, including third party verification, have been addressed previously. However there is also significant awareness among providers about issues with NDIS payment and other systems and little appears to have been done to inform providers when systems have been fixed. Where these barriers or technical issues are resulting in costs for providers, mechanisms need to be established to provide compensation.

AHPA notes that the provision of information for allied health providers generally is currently still inadequate, with practitioners reporting significant issues navigating the provider section of the NDIS website and understanding the requirements and guidelines relevant to them. There is also a lack of user friendly information for prospective providers who are interested in learning more about the scheme. AHPA recommends greater engagement by the NDIA with provider organisations and peak bodies to ensure that appropriate feedback opportunities are available and that the sector can help support the NDIA in its work.