



# National Disability Insurance Scheme (NDIS) Costs

July 2017

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 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 NDIS Costs study by the Productivity Commission (the Commission).

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## **DAA interest in this consultation**

DAA supports the implementation of the NDIS and acknowledges the potential of the NDIS to improve the wellbeing of people with disability. DAA considers that the various nutrition needs of people with disability have not been well recognised in the past and that improved access to nutrition products and services through the implementation of the NDIS will enable people to reach their goals, to increase their social and economic participation, and to develop their capacity to actively take part in the community.

The Accredited Practising Dietitian (APD) program administered by DAA is the platform for self-regulation of the profession and provides an assurance of quality and safety to the public. APDs are food and nutrition experts who translate the science of nutrition into practical solutions for healthy living. APDs assist people with disability to make positive lifestyle changes tailored to their unique needs.

## **Recommendations**

The experience of DAA members is consistent with many of the draft findings documented by the Commission and DAA agrees with many of the recommendations which are discussed in the Position Paper.

## **Discussion**

DAA provides responses below to a number of *Draft Findings, Draft Recommendations* and *Information Requests*.

### *DRAFT FINDING 2.3*

Underutilisation of supports in plans partly explains the NDIS coming in under budget at the end of trial. DAA suggests another contributing factor is the limited hours included, or total exclusion of providers, such as APDs, from participant plans even though it would be ‘reasonable and necessary’ to include APD services in plans.

Regarding modelling of costs for the NDIS, we acknowledge that this would have been a difficult exercise given the complex needs of people with disability and the various means of support they have previously accessed through health, disability, and other sectors. For example, we consider it likely that home nutrition support costs have been underestimated because there was no national system in place prior to the NDIS. In fact the situation was inequitable, with each state and territory having its own approach to access and pricing, and even within jurisdictions there were different methods of access in operation. We fear that disruption by the NDIS of previously well-functioning systems will disadvantage NDIS participants, at least in the short term. For example in Victoria, people with long term nutrition support needs were able to access products at no personal

cost, however they are now being told (erroneously) that they will not be able to include consumables and formula in their NDIS plans.

It seems that inequity will be multiplied not lessened where NDIS participants receive lesser, or no, support under the NDIS for their nutrition support needs. We are particularly concerned about continuing inequities for people aged over 65 years.

#### *DRAFT FINDING 3.1*

DAA agrees that data collection and analysis will be essential to inform service improvements and to guide workforce development. We suggest that data collection includes more detailed descriptions than the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* because the activity domains are too general to assist with detailed review and planning. Also, the activity domains do not directly map to the *Outcomes* or *Support Categories* listed in the *Price Guide*. Ideally the data recorded in planning and billing derived from the *Price Guide* would be accessible to really inform progress and improvements.

#### *INFORMATION REQUEST 4.2*

More clarity is needed about the application of ‘reasonable and necessary’. DAA does not have a view on whether legislative direction is required, but certainly operational improvements are needed which are documented and disseminated to all stakeholders, including planners, participants, and providers.

#### *DRAFT RECOMMENDATION 4.2*

DAA strongly agrees that planners should have a general understanding about different types of disability. Given the number of planners required as the NDIS is being implemented it may not always be possible to recruit someone to a position with an appropriate level of knowledge. This means initial and ongoing training is essential.

We agree that there is a place for specialised planning teams and we suggest that the NDIA employ providers such as Accredited Practising Dietitians and other allied health staff in each jurisdiction to act as a resource to planners and other NDIA staff for advice on profession specific issues in plans and to provide training. This model has been in place for some time in the Department of Veterans Affairs although we suggest that the role in the NDIA be wider than the DVA model because of the magnitude of the NDIS and the low knowledge base from which many planners are working.

Professional organisations such as DAA would welcome the opportunity to engage with the NDIA to share industry knowledge and expertise to build a strong and sustainable NDIS.

### *DRAFT RECOMMENDATION 5.3*

We agree with reporting details around how boundary issues are being dealt with, including practical examples. More importantly, this should not just be a matter of reporting on boundary issues after the fact, but rather stakeholders should know what resolution mechanisms are available to them resolve problems in a timely fashion.

### *INFORMATION REQUEST 6.1*

Measures to meet the needs of participants in thin markets may need to vary according to the reason for the thin market, i.e. measures to address lack of providers in poor urban areas may be different to those applied in remote Australia or Tasmania. Solutions will need to involve local communities, professional associations and other stakeholders.

Block funding has a role in ensuring a solid platform on which individual disability supports may be delivered. For example, there seems to be variability in investment in food and nutrition systems in group accommodation. Many participants in group accommodation experience wellbeing issues related to diet. Not addressing these issues exposes participants to risks which shorten their lives, as documented by the NSW Ombudsman. Individual plans may enable an allied health provider to work with the participant and support workers but this may not be effective without a whole of house approach on a continuing basis. Service providers may consider pricing of services only allows service delivery, and they may not invest in training which is essential for ongoing safety and quality, and to realise the value of individual professional advice to a participant.

ILC grants may be one way to meet training needs, but project based approaches of limited duration will not meet industry needs where staff turnover is a factor, where participant needs change over time and where the evidence base for care changes over time.

### *DRAFT RECOMMENDATION 6.1*

DAA and other professional organisations would value the opportunity to contribute to research and public consultations related to price regulation for scheme supports. Stronger engagement with industry will enable more realistic testing of modelling assumptions about price and workforce structures for long term success.

Collection of data on costs should include consideration of various sources, for example a participant purchasing nutrition support products, such as enteral nutrition consumables or formula, might purchase through a pharmacy, or through a distributor, or through a manufacturer.

#### INFORMATION REQUEST 6.2

Entry of APDs and other allied health professionals to the NDIS market will be facilitated by streamlined processes for registration. Processes should recognise that these professions generally have a low risk profile and that costly and burdensome certification/verification processes will deter registration. Already some practitioners are preferring to work with self-managed participants rather than dealing with registration processes.

Similarly, minimising the administrative burden for presenting quotations is desirable. Practitioners report having to complete forms which comply with NDIA requirements but add no real value to the process of quotation.

#### INFORMATION REQUEST 7.1

Governments and the NDIA need to engage with service providers, such as APDs through professional associations and other peak bodies, to develop a holistic workforce strategy to meet the workforce needs of the NDIS. Vocational and university education providers should also be at the table.

#### DRAFT RECOMMENDATION 7.2

DAA agrees that the NDIA should publish more detailed market position statement on an annual basis. It would be most helpful if that detail was at the level of *Support Items*, not just *Support Categories* or higher.

If the ABS were to collect information on allied health professionals working in disability, it should include those professions registered under the Australian Health Practitioner Regulation Agency and those regulated under the National Alliance of Self Regulating Health Professionals. Professional associations would value the opportunity to contribute to the design of the data collection methodology. In addition to the items noted in Draft Recommendation 7.2 for data collection, we suggest it would also be useful to identify the number of years the professional has been working in their profession, and the number of years working in disability specifically.

#### DRAFT RECOMMENDATION 10.3

While in-kind arrangements might not be in keeping with the philosophy of 'choice and control', it is important that people with disability should be assured of access to the products and services they need before withdrawal of services. Already withdrawal of services has imposed unacceptable risk on people with disability.