

National Disability Insurance Scheme (NDIS) Costs

**An evidence base regarding the support needs of
people living in a Shared Living Arrangement in
Specialist Disability Accommodation, including
Short Term Accommodation and Assistance
(Centre-Based Respite)**



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1 Executive summary

1.1 Respondents

Ability First Australia is a strategic alliance of Australia's leading disability organisations and one of Australia's largest, national, not for profit organisations. The service providers that form the core of Ability First Australia are some of the oldest and most respected not for profit service providers. They have been providing outstanding services to people with disabilities from as early as the 1920's when the polio epidemic affected many children around the globe. Today, Ability First Australia (AFA) organisations provide innovative and responsive services to meet the needs of people living with a wide range of disabilities.

Importantly past investigations of the support profiles of some of our members' clients and the clients of other service providers lends credence to our contention that our members support a disproportionate percentage of people with the highest support needs. For this reason we are especially interested in the issue of client complexity and resultant response intensity.

1.2 Submission purpose

This submission seeks to provide information to the Productivity Commission in relation to the pricing of both Supported Independent Living and Short Term Accommodation and Assistance to support the long-term viability of the NDIS and its capacity to best deliver on its legislated objectives.

1.2.1 Supported Independent Living

Our members are broadly supportive of the NDIA pricing for Supported Independent Living. Our point of tension relates to the current Needs Categories, the profiling of people with the very highest of support needs and the complexity of their needs. Specifically our purpose is:

1. To describe our investigations of the support needs of a sample (n = 714) of our members' clients living in Shared Living Arrangements in Specialist Disability Accommodation who are receiving, or will receive, NDIS funding for Supported Independent Living.

2. To describe specific client complexity factors that affect service delivery in centre based respite (temporary Supported Independent Living) and are affecting the sustainability of centre based respite.
3. To discuss the Scheme risks associated with continuing use of the current Needs Categories for ongoing Supported Independent Living
4. To suggest options for developing and improving the funding model for Supported Independent Living

1.2.2 Short Term Accommodation and Assistance (Centre-Based Respite)

Our members seek to demonstrate that the current NDIS pricing with respect to Short Term Accommodation and Assistance, particularly when applied to centre-based respite, does not adequately address the variation in support needs of people who seek to use these supports, nor legislated staffing cost variations. If these issues are addressed the NDIS will avoid market failure and maximise choice for Scheme participants.

1.3 Cost drivers, context and Scheme risk

1.3.1 Cost drivers

The Productivity Commission issues paper identifies five cost drivers (*'access', 'scope', 'volume', 'price', 'delivery'*). In this submission we focus on a particular aspect of *'scope'*, being the effect of client complexity on costs and the medium to long term liability risks associated with current NDIA complexity management.

1.3.2 What is Supported Independent Living?

NDIA's term *'Supported Independent Living'* (SIL) refers to the assistance with and/or supervision of tasks of daily life in a shared living environment (also referred to as a Shared Living Arrangement), which is either temporary (respite) or ongoing.¹ The NDIA has not defined a Shared Living Arrangement but it is not unreasonable to conclude that SIL is typically delivered in Specialist Disability Accommodation (SDA).

SDA is accommodation for participants who require specialist housing solutions to assist with the delivery of supports that cater for their very high support needs. SDA does not refer to the support services, but the homes in which people live and support services (SIL) are delivered.¹

This submission addresses both temporary (respite) and ongoing SIL. Temporary SIL is dealt with under the heading of Short Term Accommodation and Assistance (Centre Based Respite). A separate submission (Emerging Issues) addresses, amongst other things, some specific issues in relation to SDA.

1.3.3 NDIA needs categories

NDIA recognises that different ability/disabilities generate different support needs and responses in shared services such as SDA. These differences are recognised by SIL being funded to different Needs Categories. SIL Needs Categories may be regarded as benchmarks by which NDIA determines SIL funding. An individual's final SIL funding is a function of Needs Category and the number of people sharing SDA.

We note that Short Term Accommodation and Assistance is currently funded at a flat rate, irrespective of the needs or complexity of the participants.

1.3.4 What are the SIL costs and liabilities?

NDIA Quarterly Reports to the COAG Disability Reform Council do not include information as to spend on SIL, other than we have found a note (2016) that *'The largest amounts overall have been paid for assistance with daily life at home, in the community, education and at work (includes supported independent living) (\$577 million)'* (p.31).²

The available evidence would suggest that SIL is likely to be one of, if not the highest, Scheme cost and liability driver. The evidence includes utilisation and cost data from the Australian Institute of Health and Welfare and the Productivity Commission report on Government services thus:

- The Australian Institute of Health and Welfare (AIHW) reports in the most recent data set (2014-15)ⁱ 23,400 people as living in the equivalent of residential SDA (*'Large residential/institution (> 20 places)—24-hour care, Small residential/institution. (7–20 places)—24-hour care'*)³ and 16,700 as living in group home SDA (*usually < 7 places*).³

ⁱ <https://reporting.aihw.gov.au/Reports/openRVUrl.do>

- Jurisdictional needs registers (waiting lists) evidence that demand for SDA currently exceeds supply. Therefore the numbers of participants receiving SIL funding will continue to grow for the foreseeable future.
- The average cost for services per user per annum ranges from \$63,479 (non-government residential) to \$166,438 (government group homes) (Table 1-1).⁴

Table 1-1 Service costs

Sector	Spend per service user ⁴	
	Institutional/residential	Group homes
Government provided	\$184,745 (p.14.56)	\$166,438 (Table 14A.84)
Non-government provided	\$63,479 (p.14.53)	\$121,124 (Table 14A.84)

- In the 2014-15 period, approximately 13,400 persons (+- 200 rounding error) were reported to have used government funded (NDA) '*Centre-based respite/respite homes*' across Australia.⁵

As is typical of the Australian and New Zealand personal injury insurance sector, the highest cost, liabilities and risks sit with the relatively few people with the highest of support needs.

1.3.5 Short Term Accommodation and Assistance (Centre-Based Respite)

Centre-based respite is included in the definition of Short Term Accommodation and Assistance in the NDIS Price Guide: "*Integrated support for self-care, accommodation, food and activities in a centre or group residence for short periods*". The service is priced at a flat rate of \$480.11 and includes "*all expenses within a 24-hour period*".

Evidence gathered from AFA members delivering services in NDIS trial sites across several States has revealed the cost of operating centre-based respite exceeded the regulated maximum price in the NDIS Price Guide even at 95% occupancy rates. The absence of applied needs categories for participants (as exist for Supported Independent Living) and time-of-week rates (in line with Award conditions) exacerbated the effect, especially for people with higher and more complex support needs.

1.4 The submission

In our submission we provide empirical data demonstrating that the NDIA's SIL Needs Categories (lower needs, standard needs and higher needs) lack the necessary statistical validity and the sensitivity by comparison with a 'gold standard' instrument for the profiling of support needs.

Our submission then addresses consequent Scheme risks, in particular market failure. We conclude that, given the price differential between government and non-government, provided like services that market failure in the non-government sector would have profound effects on participant choice and control and Scheme costs, liabilities and viability.

We then propose a different methodology by which support needs should be identified and benchmarks developed.

We also provide evidence to support our assertions with respect to the cost of providing Short Term Accommodation and Support in the context of centre-based respite to those with higher and more complex support needs.

1.5 Conclusion

As noted our members are broadly supportive of the NDIA pricing for Supported Independent Living. On the basis of the evidence in this submission we conclude that:

A. Supported Independent Living

- The NDIA Supported Independent Living Needs Categories (lower, standard, higher) lack validity and as a three tier construct are insufficiently statistically sensitive to the needs of people supported in a Shared Living Arrangement in Specialist Disability Accommodation
- In particular the current Needs Categories model, in our studies have:
 - Over classified people with higher support needs as having standard needs
 - Over classified people with lower support needs as having standard needs
- Over classification of people with higher support needs as having standard needs poses risks of financial failure for organisations supporting people with higher needs
- Over classification of people with lower support needs as having standard needs means NDIA is over-paying for SIL for some participants

- We argue that these findings provide a compelling case for the NDIA to adopt a funding model that is based on validated needs assessment tools and that therefore supports allocation of funding with sensitivity to the actual support needs of individuals. Any assessment tool used needs to be carefully vetted to ensure it effectively captures support needs to enable pricing aligns with support costs.

B. Short Term Accommodation and Assistance (Centre-Based Respite)

- There are particular circumstances associated with the complexity of need of people using our members' centre-based respite, the delivery of centre-based respite itself and Short Term Accommodation and Assistance respite funding that is leading members to withdraw, or consider withdrawing from, the delivery of centre-based respite based on the current maximum price for these services in the NDIS Price Guide.
- No consideration in the NDIS price for complexity, nor for legislated variation in pay rates for weekends and public holidays undermine full choice for Scheme participants.
- We argue that the introduction of needs categories is an appropriate response. We further argue for the adoption of pricing that reflects the reality that short term accommodation can and should be available every day of the year. This means pricing that acknowledges that service providers carry underlying, unchangeable staffing costs that increase on weekends and public holidays.

Failing to address the matters of client complexity, whether for ongoing Supported Independent Living or for Short Term Accommodation and Assistance (centre-based respite) carries risks of increased Scheme costs in the short to medium term and driving perverse market behaviours; in particular '*skimming*' (preferentially providing services to people whose needs are categorised as standard but whose needs are in fact lower). There is risk of market failure where providers withdraw from financially unviable markets. There is also risk in the longer term in relation to NDIS and health sector costs due to the potentially large numbers of people whose support needs are underestimated and therefore receive inadequate support for their needs over an extended period of time.

2 Our investigation

2.1 Introduction

Ability First Australia (AFA) supports the development and implementation of statistically valid Needs Categories as means by which NDIA can promote choice and control, more consistent and equitable decisions, manage Scheme liabilities and financial sustainability and reduce the administrative burden for participants, the NDIA and providers.

To prepare for individualised funding of SIL under NDIS, five of our members completed a detailed study, designed and analysed by Dyson Consulting Group (DCG), of the support needs of ongoing SDA residents. The five agencies agreed to DCG aggregating de-identified data and completing analyses for the purpose of this submission.

2.2 Methods

A survey methodology was used with trained house supervisors completing a questionnaire. The first part of the questionnaire was developed by DCG to include information as to:

- The configuration of a residence (SDA)
- The nature of overnight support
- Demographic information for each resident (e.g. age, nature of primary and secondary disability)
- Information as to each resident's specific skills and needs (particularly those that indicate lesser support needs and those that increase a need for support over and above that which might be described as '*standard*' e.g., two person transfers)
- Staff comments as to support needs and outcomes.

The DCG-designed instrument then uses sections D & E of the Inventory for Client and Agency Planning (ICAP) to derive a support level on a nine support level ordinal scale (five anchor points and four intermediate points, Table 2-1).

The ICAP was selected for its demonstrated capacity to validly profile support needs to inform the parameters of individuals' budgets (Wyoming DOORS model).⁶ The developmental age component of the ICAP is not used as the concept of a developmental age is not necessarily consistent with the nature of the various conditions of people living in SDA.

Sections D & E of the ICAP yield a total score with associated level of support from 1-9 (Table 2-1).

Table 2-1 Levels of support

Support levels	Support description
1	Total personal care and intense supervision
2	
3	Extensive personal care and/or constant supervision
4	
5	Regular personal care and/or close supervision
6	
7	Limited personal care and/or regular supervision
8	
9	Infrequent or no assistance for daily living

Note: each even numbered level is intermediate between its adjacent levels

2.3 Analyses

All data were checked and cleaned prior to analysis. In particular, the reasons as to why a particular ability/complexity indicator has been applied to a person were checked against the construct definitions. Where an indicator seemed inconsistent with the description, DCG contacted the organisation for clarification and amended the data. Questions regarding behavioural support needs are asked at several points in the questionnaire and the responses were cross validated to ensure data integrity. Standard confidentiality, security and privacy practices were applied in data management.

Using qualitative data, the standardised measure, complexity indicators and the NDIA Price Guide¹, data were analysed and reviewed with regard to:

- The pattern of support needs as determined by analysis of sections D & E of the ICAP
- The Needs Category likely to be assigned (derived Needs Category) using the Needs Category rules in the Price Guide¹
- The presence of complexity factors that increase resource demands and that are not addressed or insufficiently addressed in the Price Guide¹
- The sensitivity of the Needs Categories

- The variance in the standardised measure of support levels explained by the derived Needs Categories.

With this evidence-base it is possible to draw conclusion as to the extent to which the current Needs Categories are consistent with '*... material improvements to the value received by participants*' and delivering on an '*insurance-based approach*' and '*financial sustainability*'⁷ (NDIS).

3 Key findings and implications

3.1 Organisations

Four of the five organisations submitted data for all ongoing SDA residents; one organisation selected a sample of clients (n = 62, 8.7%). The respondent organisations provide a range of SDA options (e.g. group home, cluster development, one or two bedroom living units adjacent to a group home etc.). Consistent with the support needs of the residents the SDAs typically include design features for '*high physical support*', '*robust*' and '*fully accessible*' (Scheme Rules, Specialist Disability Accommodation, 4.3 [b] to [e])ⁱⁱ.

3.2 Demographics

Data were collected regarding 714 clients living in 199 group homes and co-located units. In summary:

- Ages range from 11 - 89 (mean = 44.6, median = 45, SD = 14.0) at the dates of data collection.
- Years resided in a SDA ranged from <1 – 65 years (mean = 12.3, median = 10, SD = 10.8) at the dates of data collection.

ⁱⁱ https://www.legislation.gov.au/Details/F2017L00209/Html/Text#_Toc256000045

Box 1 Implications of findings

The SDA cohort is an ageing cohort whose needs will increase.^{8, 9}

To ensure *'reasonable and necessary responses'* the NDIA Price Guide¹ Needs Categories must be sensitive to changing needs that materially affect support requirements.

3.3 Disability descriptions

The problems with disability taxonomies are well known (e.g. non-mutually exclusive groups, a poor relationship between the nature of the impairmentⁱⁱⁱ and/or diagnosis with activity limitations & participation restrictions and accordingly quantum of support needed).

However, to provide an insight into the nature of the disability of SDA residents, and in an effort to overcome at least some limitations in these taxonomies, six categories (five defined and one *'other'*) were developed to describe the primary (select one only) disabilities. Data collected as qualitative data (prior to 2016) were re-coded to the six primary disability categories.

Table 3-1 Primary disability descriptions

Category	N	%
Intellectual disability	277	38.8%
Cerebral palsy	255	35.7%
Brain injury (TBI or ABI)	64	9.0%
Autism or related disorder	50	7.0%
Progressive neurological condition	19	2.7%
Other (e.g. dementia, deaf/blind)	49	6.9%
Total	714	100.0%

All participants also had secondary conditions, most frequently there was an association between intellectual disability and cerebral palsy and vice versa.

ⁱⁱⁱ The notable exception to this is spinal cord injury but even then there is important unexplained variance in support needs linked to factors such as weight, health, SCI co-morbidities etc.

3.4 Support levels

Unsurprisingly, given the cohort needing support of the extent and nature delivered in SDA, the support levels derived from the standardised measure (ICAP) skew towards highest need with the most frequent support level being Level 1, 2 and 3 (n = 351, 49.2% (Table 3-2).

Table 3-2: Distribution of support levels by standardised measure

Support level	N	%
1	119	16.7%
2	118	16.5%
3	114	16.0%
4	83	11.6%
5	94	13.2%
6	79	11.1%
7	53	7.4%
8	37	5.2%
9	17	2.4%
Total	714	100.0%

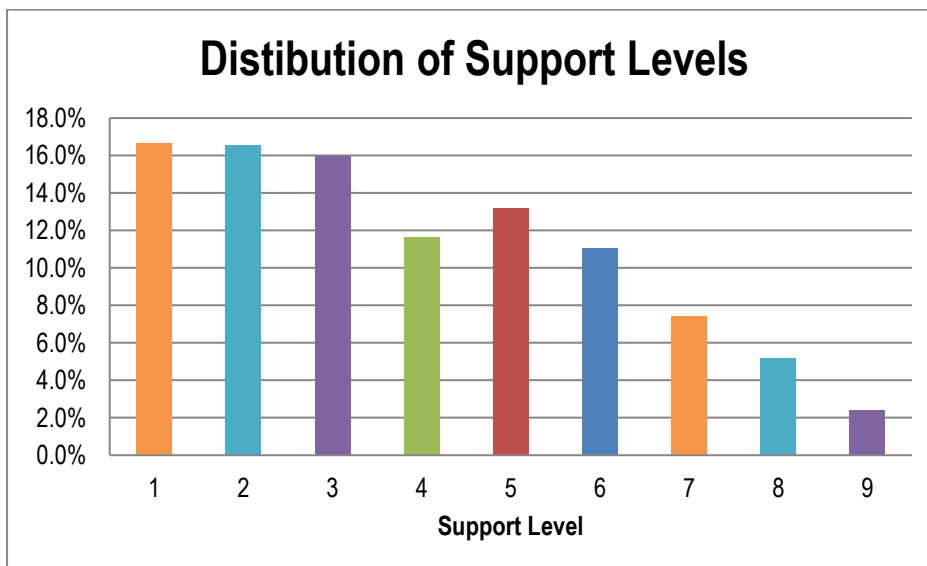


Figure 3-1 Distribution of support levels by standardised measure (ICAP)

Box 2 Implications of findings

Our members' clients receiving SIL typically have very high support needs.

Findings as to some clients having support levels of 7 or greater demonstrates what has been anecdotally reported in the sector for some time, that is some people are likely to be living in SDA as there was no other option available at the time they needed to leave the family home.

Early investment in identifying these people and commencing planning for more independent living, where appropriate, will have a positive impact on participants' choice and control, demand management and Scheme costs and liabilities.

3.5 Needs Categories

The NDIA Price Guide¹ Needs Category that would be applicable was then determined on the basis of DCG interpretation of NDIA criteria (derived Needs Category) (Table 3-3). In deriving the Needs Category DCG:

- Has assumed that each Need Category criterion is sufficient to warrant the Need Category being assigned over a lesser Need Category as almost no NDIS participants would meet all criteria conjunctively
- Has chosen a range of ICAP measures and DCG questions, with cross validation, to approximate the apparent intentions of NDIA. For example, DCG assumes that '*... challenging behaviours that require intensive positive behaviour support*' (p. 21) are behaviours that occurs once per day. This has been necessary as the Price Guide criteria are not operationally defined (i.e., not defined in terms of how they should be measured or assessed).

Box 3 Implications of findings

The absence of operational definitions for the SIL Needs Category assignment risks NDIA idiosyncratic and therefore costly decisions errors.

Table 3-3 NDIA descriptions and interpretation

Excerpt from NDIA Needs Categories	DCG assumed predictors of NDIA categorization
Lower Needs	
<ul style="list-style-type: none"> Supervision of living arrangements with occasional or intermittent prompting to undertake household tasks and/or self-care activities Supervision is not usually provided 24/7, supervision may be provided via off-site monitoring if appropriate If the participant has had incidents of challenging behaviour, a behaviour support plan is in place and it is demonstrated that the participant can be supported effectively within the available support. Where a participant has additional support needs, they can be supported in this living arrangement through a mix of additional paid and informal supports 	Resident needs none of: <ul style="list-style-type: none"> Overnight staff presence Complex medical support Intensive Behaviour Support
Standard Needs	
<ul style="list-style-type: none"> 24/7 support which includes: <ul style="list-style-type: none"> o Active assistance or supervision of most daily tasks o Regular inactive overnight support (sleepover) Participants may be able to spend some time with their family or a friend without paid support and may call on them for incidental assistance or companionship If the participant has episodic or occasional challenging behaviours there is a behaviour support plan in place which has been demonstrated to effectively support the person within the level of support available in the selected accommodation 	Resident needs either: <ul style="list-style-type: none"> Overnight staff presence Complex medical support But neither of: <ul style="list-style-type: none"> Intensive Behaviour Support Active overnight support
Higher Needs	
<ul style="list-style-type: none"> Frequent (at least 1 instance per shift) assistance to manage challenging behaviours that require intensive positive behaviour support Continual, active assistance with all daily tasks Active management of complex medical needs such as ventilation Active support is provided 24/7 usually with an active overnight shift Inactive overnight sleepover may be included as an exception, for example when family or friends sleepover May include higher staffing ratios at peak periods, for episodic or incidental behaviour supports, or emergency medical needs (e.g. seizure management or discharge from hospital) 	Resident needs either: <ul style="list-style-type: none"> Intensive Behaviour Support Active overnight support

Following these criteria 471 clients' derived Needs Categories would be distributed as per Table 3-4.

Table 3-4: Distribution of derived Needs Categories

NDIA Needs Category	Derived N	Derived %
Higher	210	29.7%
Standard	438	61.7%
Lower	65	8.6%
Total	714	100.0%

The distribution is very different from the ICAP distribution (**Error! Reference source not found.**)

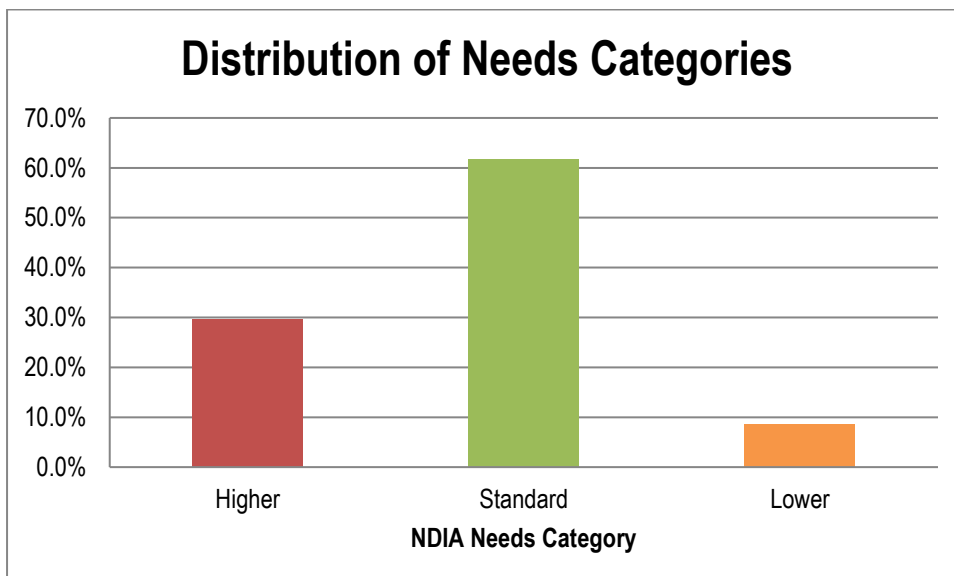


Figure 3-2 Distribution of Needs Categories

The derived Needs Categories were then aligned with the standardised measure of support needs (

Table 3-5).

Table 3-5: Support level by derived Needs Categories

ICAP level of support needs	Derived Needs Category		
	Higher	Standard	Lower
1	66	50	2
2	53	61	4
3	49	54	10
4	17	59	7
5	11	76	7
6	13	59	6
7	1	41	11
8		28	6
9		9	8
Total	210	438	65
Mean levels of support	2.5	4.3	5.5
SD	1.5	2.2	2.3

Aggregating the data in Table 3-4 and

Table 3-5 by treating ICAP Levels 1-3 as higher, 4-6 as standard and 7-9 as lower evidences that the Needs Categories, by comparison with a standardised measure of support needs:

- Over classifies people with high needs into the standard Needs Category
- Over classifies people with lower needs into the standard Needs Category.

Table 3-6: Aggregated ICAP and Needs Categories comparison

Needs	NDIA Needs Category	ICAP aggregation
Higher	210	349
Standard	438	255
Lower	65	104

Box 4 Implications of findings

The distribution pattern of the derived Needs Categories is inconsistent with the distribution obtained from a standardised measure of support needs.

This demonstrates that the Needs Categories lack criterion (concurrent) validity and are insufficiently sensitive to real differences in support needs.

The current Needs Categories risk NDIA under-funding some people with very high support needs and over-funding some people with low support needs

A core requirement of classification systems for the purposes of funding is that the classification system explains an acceptable amount of variance. The greater the amount of variance explained, the more robust the model. Variance explained in models as diverse as acute care, in-patient rehabilitation, age care (nursing homes), substance abuse and childhood therapy services range over 31% to 56%.^{10, 11}

Treating the support levels as an interval scale, an ANOVA was completed and an eta squared derived as a simple approximation of the proportion of variance explained.

This revealed that although the groups have statistically significant differences in means, only 22.0% of variance in ICAP support levels scores is explained by the estimated Needs Categories. This level of variance explanation sits at the lower limit of acceptable variance explanation and while such a level is sufficient to throughput systems (such as casemix funding of acute care) it is too low for stable SIL population where there are none of the '*swings and roundabouts*' on which throughput systems rely.

Box 5 Implications of findings

The Needs Categories do not explain a sufficient amount of variance in the support level to be applied in a pricing model for SIL.

An inadequate model, particularly for people with higher support needs, risks provider withdrawal from provision of temporary (respite) and ongoing SIL for people with higher support needs

3.6 Presence of complexity factors

3.6.1 Findings

Statistical models in human services never explain all variance. In disability support and responses variance explanation can be constrained by other factors such as personal and environmental factors.¹¹ In SDA and SIL delivery an important component of un-explained variance will be low prevalence factors that have a high impact on support responses (e.g. needing one-to-one meal assistance). Low prevalence factors will not weigh into a statistical model but will be legitimate reasons for an individual’s funding package to exceed NDIA’s funding envelope.² The NDIA Price Guide¹ does not consider a number of such factors and, at the time of writing, NDIA operational guidelines, which would guide staff and providers as to how such factors are to be treated, are not published.^{iv}

In Table 3-7 we have provided some examples of important complexity factors that are not considered and cross tabulated those with the derived Needs Category.

Table 3-7 Percentage of complexity factors within each derived Needs Category

Complexity factors	Derived Needs Category		
	High	Standard	Low
One-to-one meal assist	110	155	7
Alternative communication systems	51	84	9
Two worker assistance required	98	143	13

As noted, these complexity factors are low prevalence but they are complexity factors that increase the intensity of the response (duration of task and/or number of staff) required from the service provider.

^{iv} <https://www.ndis.gov.au/operational-guideline/overview-sitemap.html>

3.6.2 An exemplar case study

By way of example of the problems that arise when the Needs Categories are applied consider the data-based example of two clients 'A' and 'B'. Both met the NDIA Needs Category 'standard' needs, neither client met the definitional requirements for 'higher' or 'lower' needs.

However:

- Person A's ICAP support level (Level 1) demonstrated a need for 'total personal care and intense supervision'
- Person B's ICAP support profile (Level 7) demonstrated a need for 'limited personal care and/or regular supervision'.
- Person A had very high support needs and required one-to-one meal assistance, used an alternative/augmentative communication system and had behaviours that were largely effectively managed but sometimes posed a risk of harm.
- Person B had low support needs and no additional indicators of needs that affect staffing required.

Box 6 Implications of findings

The case study demonstrates the current Needs Categories insensitivity to complexity factors, associated higher support needs and response intensity required.

3.7 Behaviour support needs

3.7.1 Presence of behaviour support needs

For 303 of the 714 residents (42.4%) behaviour support needs were evidenced in each derived Needs Category (Table 3-8).

Table 3-8 Presence of challenging behaviours by derived Needs Category

Challenging behaviour	High		Standard		Low	
	N	%	N	%	N	%
Present	127	41.9%	153	50.5%	23	7.6%

3.7.2 Efficacy of behaviour support and the impact

The Price Guide¹ considers only the *efficacy* of the behaviour support plan and not the impact of the behaviour. Some behaviour, for example being withdrawn and some self-stimulating behaviours, if not well managed, are associated with adverse outcomes for the person but pose no risk of harm to the person or others. Other behaviours even when very well managed, when they emerge, pose a serious risk of harm to the person and/or others and need to be managed rapidly and effectively.

Table 3-9 provides data as to spread of behaviours that pose a risk of harm across the derived Needs Categories.

Table 3-9 Behaviours that pose a risk of harm by derived Needs Category

Behaviours that pose a risk of harm	High	Standard	Low
Present	109	121	8

Box 7 Implications of findings

Needs Categories ought to consider not only the efficacy of the behaviour support plan but the support needed to ensure safety should the behaviours emerge.

4 Scheme risks

4.1 Introduction

Although our study relies on ongoing SDA data we believe that there is no reason to assume that our findings and conclusions as to Scheme risks are not equally applicable to temporary SDA residents; that is people using Short Term Accommodation and Support (centre based respite). Indeed, AIHW definitions reference residential facilities and group homes in the definition of centre based respite.³

In relation to SDA ongoing and temporary (centre based respite) we are asserting that, without a valid and reliable means of determining need and developing a sufficiently sensitive resource homogenous group based funding model, there are risks of:

- Provider withdrawal and therefore non-government SIL market failure and
- Significantly higher SIL costs and liabilities

Given some particular circumstances relating to the support needs of people using centre based respite there are important additional risks.

4.2 Additional risks in Short Term Accommodation and Assistance (centre based respite) and provider withdrawal

AFA members from several states who have delivered Short Term Accommodation (centre based respite) in NDIS trial sites have analysed the underlying costs of delivering these services. Examples of these analyses indicate that the current pricing is unsustainable for their businesses, even where these are delivered using minimum efficient scale.

Example 1

One of our members that provide centre based respite and meets overhead efficiency criteria (12% of revenue) reports that the average realised cost of delivering centre based respite services is \$872 per bed night, substantially higher than the Scheme's current rate of \$480.11. This assumes 90% occupancy rates.

Another member has modelled that their centre based respite is marginally viable at 95% occupancy, but that this is “pricing for perfection”, given their occupancy rates in trial sites has been in the 55% - 74% range.

Another member has calculated that their centre-based respite costs sit around \$1,200 per bed night. This cost does not take into account higher wage rates that apply at weekends and on public holidays, nor building running costs

The key drivers of this disparity between price and actual costs are:

- The complexity of some people’s conditions
- The need for some people to have active overnight support, alongside sleepover support for other people.
- Higher intensity manual handling requirements, typically two person transfers
- Higher capital costs associated with the building and the range of equipment needed to assist the diversity of need in a group using centre based respite (e.g. full ceiling hoists and building technology).

In addition, late client cancellations, typically due to illness, adversely affect the utilisation rate. Illness is an unsurprising characteristic of the market, given the complexity of the disabilities of people using centre based respite.

Several of our members are actively considering a withdrawal from centre based respite.

4.3 Significantly higher SIL costs

There are risks of providers withdrawing from, or financially failing, through a pricing model that is insufficiently sensitive to the support needs of people in receipt of SIL who have the highest support needs. Such failure will leave NDIA with few options, such as:

- Increasing costs for other core supports as centre based respite and/or ongoing SDA becomes less available
- Becoming a ‘price taker’ for SIL where people have the highest of support needs
- Governments, with their much higher costs (Table 4-1), becoming the service provider as not for profit providers withdraw from SIL for the people with the highest of support needs.

Table 4-1 Government and non-government comparative service costs

Sector	Spend per service user ⁴	
	Institutional/residential	Group homes
Government provided	\$184,745 (p.14.56)	\$166,438 (Table 14A.84)
Non-government provided	\$63,479 (p.14.53)	\$121,124 (Table 14A.84)

5 Conclusion

5.1 SIL Needs Categories

Our paper has demonstrated that there are important limitations in the NDIA SIL Needs Categories with particular reference to over-classifying people with higher or lower needs as having standard needs. There are critical risks that flow from this being:

- The risk of market failure of SIL with people with higher support needs
- Significantly increased costs and liabilities if the not for profit sector withdraws from the provision of SIL for people with higher needs and supports have to default to delivery by government
- Provider skimming, by preferentially providing services to people whose needs are categorised as standard but whose needs are in fact lower.

A range of options are open to the NDIA to manage this situation. These include (but are not necessarily limited to) the following:

- Use of a standardised tool, such as the ICAP, to profile the support needs of people who are to receive SIL funding. We note that this may be regarded as *'too costly'*, but given the costs associated with SIL and the costs of funding lower needs participants as standard, liability and market risks of inappropriate needs categorisation; the cost and liability impact of a better system are likely to be relatively marginal.
- Using a standardised tool and complexity indicators only when providers believe the person's support needs are higher and not standard.
- Re-designing the Needs Categories and conducting the necessary validation studies.

- Including low prevalence, high impact complexity indicators as objective criteria that must be evidence to increase individual funding beyond benchmark prices.
- Reviewing all people with lower needs for the appropriateness of their current living arrangement and their potential to live more independently.

Ability First Australia puts this forward to encourage a solution that delivers a financially stable, cost effective Scheme and a sustainable market that increases choice and control.

5.2 Short Term Accommodation and Assistance (Centre-Based Respite)

There are serious risks of market failure of centre-based respite services supporting people with higher and complex needs. Market failure carries risks of increased costs and liabilities as more one-to-one support will be sought for the purpose of respite.

AFA is recommending that centre based respite be funded with reference to the complexity of participant support needs and time of week rates for week-ends and public holidays.

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