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***Productivity Commission Issues Paper
National Disability Insurance Scheme (NDIS) Costs
Scope (Aust) Submission***

24 March 2017



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About Scope

Scope's mission is to enable each person we support to live as an empowered and equal citizen.

We support people with physical, intellectual and multiple disabilities and developmental delays to achieve their goals.

Scope's services - provided in metropolitan and regional Victoria - include therapy, supported living, respite and lifestyle options. We also work with corporate and community organisations to improve inclusiveness for people with a disability.

Scope is a strong supporter of the National Disability Insurance Scheme (NDIS). We embrace the benefits the NDIS will bring our customers and will actively contribute to its success.

We are one of the largest providers of services to people with a disability in Victoria, and one of the largest not-for-profit organisations in Australia. In 2015-16, Scope provided services to more than 6,000 people with a disability from 99 service locations with 1,527 employees. Scope provided supported living services to 291 residential clients and lifestyle options and individual support to 1075 clients.

Scope has a customer satisfaction rating of 90%.

Our foundations stretch back to 1948, when a group of parents who wanted better lives and options for their children with disabilities established the Spastic Children's Society of Victoria.

1. Key Messages

Scope brings a wealth of experience to the matter of National Disability Insurance Scheme (NDIS) costs which is informed by over 60 years supporting people with a disability. A summary of Scope's key messages is outlined below with more detail provided throughout this submission.

a. Pricing

- The NDIS pricing for participants with the highest support needs (complex support requirements) is insufficient to provide the reasonable and necessary supports.

b. Complex Support Requirements

- Complex disability encompasses support requirements resulting from high levels of physical support; concomitant medical conditions (e.g. epilepsy, chronic disease (e.g. diabetes), complex communication support needs (e.g. augmentative and alternative), the premature effects of ageing, psychosocial and behavioural support.

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- The NDIA's current approach does not adequately define and implement programs to support people with complex disability (e.g. pricing and benchmarking) and ensure that the planning process caters for and empowers these people.

c. Supported Independent Living

- Pricing does not reflect the additional costs to support a person with complex support requirements and/or ageing clients, for example a person with Cerebral Palsy affecting all limbs (spastic quadriplegia), epilepsy, intellectual disability with a percutaneous enteral gastrostomy for nutrition support.
- Pricing implicitly assumes clients are in employment or group programs or not otherwise at home during weekdays. Pricing states that supported accommodation is staffed 24/7 if required, but this is not costed into NDIS pricing.
- Pricing implicitly assumes residents sharing accommodation have the same level of complexity (in terms of NDIS pricing and requirements for overnight supports).
- Pricing does not generally allow for any vacancies due to client turnover, and does not include a sufficient establishment fee for new clients.

d. Assets

- Specialist infrastructure for in-community Group Programs to support people with complex support requirements is not currently available e.g. specialised premises and fittings required for higher needs clients.
- Scope and other providers offer these as part of their Group Program offerings but the cost of these is not included in the NDIS pricing.

e. Workforce

- NDIS Pricing does not provide for a highly qualified and trained workforce e.g. cost of compliance training which is mandatory is currently unfunded.
- NDIS pricing does not cover the cost of existing service provision, it is based on the Modern Award and most organisations, like Scope, don't employ based on this.
- NDIS pricing assumes a disability support worker is engaged in NDIS billable hours of activity for 95% of their employed time under the Efficient Price. However, 95% productivity is unattainable by most employers with a largely permanent disability support worker workforce.

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2. Overview

Scope has undertaken detailed and extensive analysis of the cost of delivery of individual support for an efficient service provider under the NDIS, informed by our experience of service delivery in the Barwon NDIS trial and the North East Melbourne Area (NEMA) rollout. This analysis has concluded that the NDIS Transitional Pricing is at least 25% below the actual cost of delivery for an efficient service provider providing Individual Support¹. Any move towards the NDIS Efficient Price would substantially worsen this cost-price differential.

The pricing for Supported Independent Living and Group Programs covers the cost of service delivery in only limited circumstances and even then is “priced for perfection”². It does not allow for costs such as the reality of cancellations and the impracticality of always scheduling clients with the same support requirements together. In addition, the cost of necessary facilities for Group Programs and transport into the community while engaged in these programs is not covered.

Across all areas of service provision there are cost drivers for people with complex support requirements that have not been factored in to the NDIS pricing. For example, where people with disability also have significant chronic health and medical conditions there are often substantially greater support requirements on an ongoing and episodic basis.

From a whole-of-sector perspective we believe that registered providers will be unable to achieve sustainable delivery of individual support under Transitional Pricing. These current pricing levels only allow for a direct employment model without corporate overheads. The resulting negative impact to service quality, participants’ choice and control, compliance and safeguarding and workforce retention present a profound risk to Scheme participants, the viability of the sector and the goals of the NDIS.

Scope supports a gradual move to deregulated pricing. This will allow prices to reflect the true cost of service delivery.

Scope and other Disability Services Organisations (DSOs) are well placed to move to full Scheme. We have transformed our service delivery and support functions to operate in a consumer driven market. We have also worked to ensure our support functions are scalable so that we can grow significantly under the Scheme, achieving additional economies of scale and reducing our overheads as a percentage of revenues.

Scope supports the withdrawing of state governments from service provision. This will enhance the operation of a consumer driven market by creating a level playing field for all competitors.

¹ Analysis validated by Grant Thornton Australia (2015).

² NDIA Personal Care and Community Participation 2016/17 Price Review (2016). Scope (Aust) Submission.

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Scope's submission provides information on NDIS costs and analysis as it relates to Individual Support, Supported Independent Living, Group Programs, overheads and complex support requirements. This submission also responds to various matters raised in the Productivity Commission Issues Paper - February 2017.

3. Scheme Costs and Cost Analysis

The interplay between complex issues that require high levels of physical support with concomitant medical conditions, chronic disease, complex communication support needs, premature effects of ageing, psychosocial and behavioural support requires a skilled workforce with access to specialist support.

Complexity drives cost in the provision of support in terms of intensity, duration, staff ratios (e.g. OHS requirements for safe transfers), training and supervision and the regularity of interface with other service systems (e.g. acute health and primary health).

These are enduring costs that need to be met as they are not necessarily responsive to time-limited goal directed intervention in the form of capacity building.

The big risk is that these enduring costs become the subject of cost-shifting between state/territory governments and the NDIA. Whilst the interface with universal health services is significant for this cohort, the cost of support to live an ordinary life remains a priority.

Scope's analysis of NDIS Transitional Pricing for individual support, Supported Independent Living, Group Programs, overheads and complex support requirements is informed by extensive analysis of the costs of service delivery by efficient service providers.

Our findings have been supported by our experience of service delivery in the Barwon NDIS trial and the North East Melbourne Area rollout, and extensive discussions with sector participants and consultants.

There is a need for greater transparency of the NDIS price calculations for all service lines which in turn would provide guidance to service providers about their cost structures. This would also provide clarity to Scheme participants as to what is and is not included in the price of a service e.g. facilities costs and transport.

3.1 Individual Support

Our analysis shows a number of issues with the Individual Support reasonable cost model. Allowing for additional costs (listed below) not covered by the NDIS pricing, Scope's analysis indicates that the cost of service delivery is, at a minimum, 25%³ greater than that allowed for under the NDIA Transitional Pricing for Individual Support.

³ Analysis validated by Grant Thornton Australia (2015).

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Table 1: Additional costs not covered under NDIS pricing

Cost component	Comment
Personal leave	The Modern Award minimum is 10 days p.a. NDIS pricing assumes 5 days. Scope and others experience is closer to 10 days.
Public holidays	NDIS pricing assumes no public holidays. An allowance for public holidays must be factored into hourly pricing as has been done for personal and annual leave.
Productivity	NDIS pricing assumes 95% of available hours are client-facing. We believe the maximum should be 90%. Benchmarking could establish an even lower maximum is applicable outside institutional settings.
Vehicle costs	No allowance for motor vehicle costs and fuel for travel between clients are allowed for in NDIS pricing.
Communications costs	No allowance has been made for the use of mobile phones by support staff.
Span of control	The assumed 15:1 FTE span of control is quite aggressive especially in light of the high levels of part-time employment in the sector.
Staff turnover	No allowance for staff recruitment and onboarding has been allowed for in NDIS pricing. Allowance for 15% staff turnover is required to reflect sector experience and accommodate the costs of staff recruitment, induction, shadow shifts and supervision of new staff.
Client turnover	Allowance for 10% client turnover is required to reflect sector experience and accommodate the costs of onboarding new clients including quoting, intake and establishment of administrative records. Establishment fees appear to be insufficient. No allowance has been made for marketing to new customers.
Agency staff costs	No allowance has been made for agency staff costs. An allowance for 7% agency staff is required to reflect sector experience.

While the NDIS pricing reflects the Modern Award, many providers are unable to move their staff to the Modern Award. This particularly impacts the ability to provide services when penalty rates are applied that cannot be recovered through higher NDIS pricing.

There are additional areas of concerns specific to other services and to supporting people with complex support requirements detailed below.

3.2 Supported Independent Living

Scope's typical cohort in Supported Independent Living accommodation has complex support requirements and key findings 'identified that 92% of residents as having needs, not currently considered as cost drivers by the NDIA'⁴.

There are several substantial cost drivers not factored into the NDIS pricing for Supported Independent Living including:

- Pricing does not reflect the additional costs to support a person(s) with higher complex support requirements and/or ageing clients, for example a person with Cerebral Palsy affecting all limbs (spastic quadriplegia), epilepsy, intellectual disability with a percutaneous enteral gastrostomy for nutrition support.
- Pricing implicitly assumes clients are in employment or group programs or not otherwise at home during weekdays. Pricing states that supported accommodation is staffed 24/7 if required, but this is not costed into NDIS pricing.
- Pricing implicitly assumes residents sharing accommodation have the same level of complexity (in terms of NDIS pricing and requirements for overnight supports).
- Pricing does not generally allow for any vacancies due to client turnover, and does not include a sufficient establishment fee for new clients.

The criteria to qualify for higher support needs pricing for Supported Independent Living should be broadened to include a range of factors. 92%⁵ of Scope's Supported Independent Living residents have needs not currently considered as cost drivers under NDIS pricing but which can act as cost drivers. This is despite the factor that the same clients have been independently assessed by the Victorian Government under the Support Needs Assessment (SNA) to have support needs at the highest categories for support (SNA levels 4, 5 and 5+).

- Scope's Shared Independent Living Services support many people with significant and often multiple disabilities. Scope recently used a valid and psychometrically sound support needs assessment instrument - the Inventory for Client and Agency Planning (ICAP) - to assess the support needs of our current residents. 43%⁶ of Scope residents that are expected to meet the NDIA's existing definition of 'standard needs', were assessed as having higher support needs. These results indicate that the current NDIA definitions of low, standard and higher needs and their current support needs assessment process may require some revision.

⁴ Scope Shared Living Arrangements (2016). Dyson Consulting Group.

⁵ Ibid.

⁶ Ibid.

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- Pricing should also consider the cost of interdependencies between residents in a household, which increase costs beyond assessed on an individual client basis.

The current Supported Independent Living pricing structure incentivises grouping of clients by complexity (i.e. standard or higher needs clients only in a house) and selecting clients without chronic health problems or ageing that may require them to stay home on a regular basis.

- Pricing needs to be adjusted to reflect that in some houses some participants may require an active overnight while others will not.
- Additional payments need to be available to cover the cost of supporting some participants who choose to stay home for periods of the day or are unable to leave the house during week days for extended periods of time, primarily due to ill health and/or ageing.
- Participants should not need to have at least one instance of assistance per shift to manage challenging behaviours to qualify for higher supports funding. This effectively financially penalises service providers who support a participant in a way that minimises instances of challenging behaviours.

Detailed financial modelling and Scope's experience in Barwon shows that current NDIS pricing does not allow for mixed support needs. Pricing incentivises higher needs clients being housed together, which places stress on support staff. This does not afford the participants the level of choice and control that underpins the NDIS.

3.3 Group Programs

With Scope's 60+ years of experience supporting people with complex support requirements, we know that the specialist infrastructure is not currently available in-community to support this cohort.

The necessary infrastructure related expenses includes specialised premises and fittings required for higher needs clients which are not explicitly included in the NDIS pricing.

There are several substantial cost drivers not factored into the NDIS pricing for Group Programs including the transport costs within programs for community access for clients unable to use public transport are not included in the NDIS Group Pricing or the individual transport allowance. This reduces a Scheme objective of greater community participation.

NDIS group pricing is "priced for perfection"⁷ and as such does not adequately reflect the reality of providing group based activities to a range of clients with varying support needs, interests and goals. With the variation in support ratios between clients and for individual

⁷ NDIA Personal Care and Community Participation 2016/17 Price Review (2016). Scope (Aust) Submission.

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clients at different times of day, it is not possible to match staff rosters and client schedules to achieve the 90% plus productivity required to be financially viable.

A 100% in-community model is not always feasible for people with moderate-to-high physical needs that require access to suitable hoists and adult changing facilities. In practice, if it is consistent with the person's goals and preferences higher complexity clients may require a mix of in-centre and in-community support.

- Pricing needs to incorporate the cost of premises and specialised facilities.
- Pricing needs to incorporate the cost of transport within an activity session.
- Pricing needs to incorporate the cost of client cancellations.

3.4 Overheads

The NDIS Transitional Price assumes a 15% overhead. The definition used for overheads is extremely broad, and essentially includes all costs other than salaries for support workers and direct supervisors.

Both corporate and service delivery overheads and some service delivery operating costs must therefore be recovered from NDIS prices. Even for a large, efficient service provider, the 15% is not sufficient.

Given the very high level of sophisticated systems required to match staff rosters and client scheduling, and the associated billing requirements, recovery of ICT costs stands out as an overhead that is unlikely to have been fully factored into NDIS pricing.

Quality and safeguarding are other significant overheads that are not adequately covered in the NDIS pricing.

For registered disability service providers, inadequate allowances for corporate overheads would directly risk the delivery of quality services and significantly limit the sector's capacity to achieve:

- Workforce quality
- Employee retention
- Staff supervision
- Achievement of required sector quality standards
- Risk management
- Recording and reporting of service delivery
- Reporting against outcome measurements.

Delivery of services under a financially unsustainable pricing model will ultimately lead to provider failure, with the current pricing levels only allowing for Group Programs and/or a direct employment model without corporate overheads.

3.5 Complex Support Requirements

Many cost drivers applicable to people with complex support requirements are not covered by the NDIS pricing.

The current NDIS pricing - price structure and price points - does not adequately reflect the cost of supporting people with complex needs.

Some cost drivers, not adequately reflected in the NDIS pricing, include:

- Behaviours of concern
- Chronic/acute/complex health issues
- Co-existing mental illness
- Age
- Clients at home during the day
- Clients that require two people for morning/evening preparations
- Clients that require a two-person lift
- Clients that require meal time assistance
- Alternative communication system
- Legal order in place
- Lack of natural supports.

Scope recommends that prices be amended to incorporate the additional costs of supporting people with complex support needs, including recognition of:

- additional staff required due to additional hours of support required
- additional staff required due to higher support ratios required
- the higher cost of staff with the skills required to support people with complex needs
- the cost of providing the required systems and safeguards
- the cost of providing crises support
- the cost of facilities and transport required to support people with complex needs in group activities.

In addition, Scope recommends the NDIA makes an additional allowance for the cost of supporting people with complex needs. An additional allowance would more accurately reflect the costs associated with supporting people with complex needs.

This allowance could be used to increase support on an as needed basis, including crisis support that would be consistent with organisations' duty of care obligation.

4. Response to Questions in the Issues Paper

4.1 Measures to Reduce Costs

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 simple answer is - confusion.

Families are struggling with the complexity of the planning process and transition. There are so many roles and responsibilities identified that are either the direct responsibility of the NDIA or those that they have outsourced via contract. Families are struggling to navigate a system that continues to evolve and change.

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

This reflects the long-term impact of a rationed system where people with a disability had identified support needs that were unfunded.

What factors are contributing to increasing package costs?

A lack of understanding of the cost drivers of support for people with multiple and complex disability who have concomitant acute, acute on chronic and chronic disease conditions that require additional support.

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

Benchmark packages are set on price not cost of delivering the supports giving consideration to the industrial settings, Worksafe compliance requirements, workforce training and supervision, quality and safeguarding requirements.

Nor do the packages adequately recognise the additional costs incurred in enabling the person with a disability to actively engage in the participant journey. For example, the additional physical, communication and decision making support required to enable the participant to exert real choice and control.

4.2 Eligibility for the NDIS

To what extent have the differences in the eligibility criteria in the NDIS and what was proposed by the Productivity Commission affected participant numbers and/or costs in the NDIS?

The inclusion of participants with psychiatric conditions and children with global developmental delay has led to a substantial increase in the number of eligible participants.

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?

There is perhaps insufficient focus on hard to reach cohorts e.g. CALD, ATSI, people who are homeless who have dual disability, people who do not relate to a label of disability and children of these hard to reach cohorts who are eligible for support. It is important to recognise and leverage existing community connections through government and the community services sector to access and support these cohorts.

Many cultural groups do not wish to acknowledge disability publically and do not see it as an issue that should be dealt with outside the family circle. The way in which eligible participants are identified and approached does not lend itself to the cultural and religious beliefs of some of these groups.

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

State and territory governments have struggled to provide the NDIA with robust data. The Agency has attempted to fill some of the gaps via pre-planning data collections using an external contractor. This has resulted in a great deal of confusion amongst participants and families who thought that they were engaging in a conversation about planning, rather than a data collection exercise. This has been made more confusing when the Local Area Coordinators commenced planning by phone for first plan as an efficiency measure to try to meet contractual targets.

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?

From an operational perspective it is. However, it is premised on an assumption that the residual specialist children's services remain funded in each respective state and territory. These funds have been transferred to the NDIA under the bilateral agreements. What is left is a primary, secondary and tertiary health system that is not designed to deliver a social model of capacity building and support.

What impact will the ECEI approach have on the number of children entering the scheme and the long-term costs of the NDIS?

The approach appears to have been effective from an Agency perspective in diverting children to state funded programs.

Are there other early intervention programs that could reduce long-term scheme costs while still meeting the needs of participants?

Group based capacity building programs have been underutilised to date. Based on a playgroup model therapist and early childhood educators are able to assess, monitor and enhance the acquisition of developmental milestones.

4.3 Intersection with Mainstream Services

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?

No. The health service system is designed to deliver time-limited, goal directed therapeutic intervention and rehabilitation to address health needs which include:

- Acute illness
- Acute on chronic medical condition e.g. epilepsy
- Chronic disease e.g. diabetes
- Acquired disability e.g. acquired brain injury.

The health system is not equipped nor is it funded to deliver medium and long terms core support and capacity building for people with permanent significant functional impairment as a result of their disability.

Similarly, the justice system struggles to meet the needs of people with a disability. Figures released in the AIHW Health of Australian Prisoners Report ⁸ show that:

- 1 in 3 prison entrants had a long-term health condition or disability limiting daily activities, or restricting participation in education or employment.
- 1 in 4 prisoners received medication for mental health related issues while in prison.

Education services are naturally focused on providing the reasonable and necessary accommodations to the school environment to allow the student to participate in the school curriculum.

⁸ AIHW Health of Australian Prisoners Report (2015). <http://www.aihw.gov.au/publication-detail/?id=60129553527>

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The focus is on two primary areas:

1. Support provided by a direct support worker or integration aide
 - a. Support: core support to meet the personal care needs of the student
 - b. Support to enable the student to participate optimally in the education program.

2. Support provided by an allied health professional
 - Capacity building: therapeutic support/intervention to optimise the student's ability to learn
 - Therapeutic support/intervention focused on a child's personal goals identified in the participant plan that may incorporate educational goals but may also have a broader scope.

The interplay between the four roles, outlined above, is not well understood and is at risk of being fragmented as the educational system tries to accommodate the interface with the NDIS.

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?

The issues identified in the above response signal the complexity of managing the interface effectively from the perspective of participants and families; state and territory governments and the services they fund and the NDIA. Whilst strong bipartisan support for the NDIS remains, there is an inevitable rising tension as the Agency carves out what it will and will not fund and the states and territories seek to understand what residual obligations remain.

The provision of community mental health services appears to be an example where transition has the potential to result in adverse outcomes for people with psychosocial support needs in terms of the model of support and access to appropriate expertise.

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

State and territory governments have largely been left to resolve the effectiveness and scope of the interfaces between the NDIS and universal services with varying degrees of success.

4.4 Information, Linkages and Capacity Building (ILC) and Local Area Coordination

Scope is concerned about the level of investment in the ILC activities. \$132 million has been allocated nationally to provide information, linkages and capacity building services. This is a significant reduction in the current funding levels provided to deliver services which have

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been effective in creating welcoming and inclusive communities for people with disabilities. Community capacity building requires long term investment and the current funding rounds available are focused on short term grants.

The ILC Commissioning Framework outlines that the NDIA will not fund any activities or services that are the responsibility of mainstream services⁹. While this in principle is a reasonable approach, in practice we know that many mainstream services require information, education and incentives to ensure they make the necessary and reasonable adjustments to ensure they are inclusive of all abilities. There needs to be a coordinated approach between government and the NDIA to strengthen both policy and practice to ensure mainstream services are inclusive and accessible for people with disabilities.

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?

Largely yes. However, there needs to be greater clarity in regard to the roles and responsibilities of government funded mainstream services (health, education and justice systems) and community services organisations funded by state and territory governments.

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?

The real issue relates to the transition of existing state and territory funded programs that fulfil the objectives of the ILC. Many of these programs are being defunded before the ILC is rolled out nationally. This will result in a loss of resource, services, knowledge, workforce and capability. It will also lead to fragmented service delivery and connections for people with disability.

Is the way the NDIS refers people who do not qualify for support under the scheme back to mainstream services effective? If not, how can this be improved?

No. In many instances the services people with a disability were eligible for are no longer funded by the respective state or territory government as the funds were transferred to the Commonwealth under the bilateral agreements. The assumption that the primary, secondary and tertiary health service systems can adequately address the ongoing support needs of a cohort of people who have a diagnosed disability, but are not eligible for the NDIS, is flawed. The focus of the health service system is rightly on the delivery of time-limited goal-directed therapeutic intervention and rehabilitation, not on the provision of core support and the building of capacity within a social paradigm of services and support.

4.5 Intersection with the National Injury Insurance Scheme

How will the NIIS affect the supply and demand for disability care services?

The NIIS will by its nature, focus on acquired disability through injury. It will be more closely

⁹ Information, Linkages and Capacity Building Commissioning Framework (2016). NDIA.

aligned to the health service system through the diagnostic, therapeutic intervention and rehabilitation phases of recovery.

What impact will the full establishment of the NIIS have on the costs of the NDIS?

It is anticipated that over time we will see the transfer of costs of participants with acquired disability through injury transferred to the NIIS.

Are sufficiently robust safeguards in place to prevent cost shifting between the NIIS and the NDIS?

The term catastrophic injury in medical terms significantly limits eligibility and is well understood in existing insurance based schemes. On this basis, entry to the NIIS appears to be suitably constrained.

4.6 Planning Processes

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

The planning function is not well understood and hence on the whole has not been delivered well. We have swung from an onerous assessment and documented evidence based planning process in trial (sometimes taking up to 60 hours) to some would say a cookie cutter approach based on reference packages with constrained customisation. The requisite skill-set to undertake the planning process has been in short supply and the timelines for the on-boarding, upskilling and resourcing of planners has been unrealistic.

Agency contracted information gatherers have not always offered the opportunity to individuals or families to meet with them face to face. In some instances, individuals were actually overtly discouraged from attending a meeting and having input into their NDIS plan. There seemed to be an assumption by the information gatherers that families had the same goals for the individual as the individuals had for themselves. This was particularly the case with residential customers who were non verbal with complex needs.

Communication from the Agency and its contractors has been inconsistent and at times poor. The NDIA needs to communicate to participants and families that under the substantial pressure to on-board participants in a timely manner, the first planning process is actually an on-boarding process. Detailed and personalised planning will occur in subsequent plans. Realistically, it is hard to see that detailed individualised planning will occur during transition due to the pressure to meet targets agree under the bilateral agreements with state and territory governments. It is time to be clear with participants and families about the reasonable expectations and deliverables of the Scheme in transition.

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The planning processes and costs to reach children have not been considered under the NDIS pricing. We know that children need to be supported in their natural environment¹⁰, ¹¹and recommend that there is a need for collaborative and integrated planning between the universal service system, the NDIA and Disability Services Organisations.

How should the performance of planners be monitored and evaluated?

There are two groups of planners which are:

- NDIA planners – performance should be measured internally against established key performance indicators and best practice in terms of the evidence. Planners should have appropriate training to work with people with disability in a consistent way and possibly further training to work with and understand people with complex communication needs.
- Local Area Coordinator (LAC) planners - the existing contracts possibly were not realistic in terms of scaling-up planning capability within the timelines between finalisation of contract and the commencement of participant planning. Combining the planning role, with the linking and capacity building role, in the initial rollout phase of the NDIS appears to be ambitious. Given the high volume of participants being on-boarded to the NDIS, it might have been more realistic to separate the planning from the linkages / capacity building role of the LACs. This may have resulted in smoother and faster transition of participants into the Scheme and a reduced reliance on support coordination.

The key performance indicators for both groups need to reflect value for money in an insurance scheme; quality measures that are firmly grounded in the evidence; customer satisfaction and agreed targets under the bilateral agreements.

An independent audit of both NDIA and contracted planners should be undertaken annually.

Participants and families need access to the Agency to provide timely feedback that will be actioned via complaints management and mediation processes. Participants and families

¹⁰ Early Childhood Intervention Reform Project Revised Literature Review (2010). Department of Education and Early Childhood Development. Viewed 21 March 2017.

<http://www.education.vic.gov.au/Documents/childhood/providers/needs/ecislitreviewrevised.pdf>

¹¹ Early childhood intervention - an overview of best practice (2014). ACT Government. Viewed 21 March 2017.

http://www.communityservices.act.gov.au/_data/assets/pdf_file/0007/635695/Early-Intervention-Best-Practice.pdf.

require timely access for reviews of their plans and alternate access to their plans (other than through the portal). Using purely technological means for plan access is not equitable or appropriate for those with limited IT literacy or limited access to IT.

There are also significant delays with participants and families receiving their plans from the NDIA (sometimes up to 3 months in NEMA) resulting in a delay or unfunded service delivery. It would be useful if the planners could obtain a participant's consent to share relevant parts of their plan with service providers, chosen by the participant, to provide a more timely service delivery response. The service bookings on the portal are not always consistent with an individual's plan, with some supports coming on to the portal at a much later date than others in the approved plan.

4.7 Assessment Tools

Do NDIA assessment tools meet these criteria? What measures or evidence are available for evaluating the performance of assessment tools used by the NDIA?

The NDIS outcomes framework has been developed internally and has not been released. It is not known whether it meets the parametric qualities of reliability, validity, specificity and sensitivity in guiding the assessment process and outcomes measured.

The assessment tools appear to focus more on a participant's individual physical needs and goals and not sufficiently on mental health, behavioural support or transition to employment goals and supports. This seems to be the case for people with complex needs e.g. in NEMA and Barwon – particularly with first plans.

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

The references packages are based on insurance principles and are in many instances were untested prior to the implementation within the NDIS. Further refinement and validation will need to be undertaken over time.

The outcomes framework should be used to inform, shape and influence the transition from an outputs based model to an insurance based scheme focussed on delivering measurable outcomes and reducing Scheme cost over time. Greater transparency and input from families, participants, providers, peaks and academic bodies would enhance the long term impact of the outcomes framework.

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Are the criteria for participant supports clear and effective? Is there sufficient guidance for assessors about how these criteria should be applied? Are there any improvements that can be made, including where modifications to plans are required?

The criteria for participant supports are articulated in the NDIS Price Guide¹² however these do not always match supports outlined in a participant's plan. Sometimes items such as therapy, continence assessment and aids are combined in the participant's plan, and it makes it very difficult to assess what hours of what therapy a participant actually needs.

Additionally, a person may have complex needs and require high intensity support, but they have been assessed as 'standard'. If they have episodes of poor medical health where they require active overnight support for a short period, this is not funded under the 'standard' model. The participant can apply for a review but this again takes time (up to 3 months in NEMA). It would assist if there was access to a contingency pool of funding for those participants that required short term higher intensity support.

To what extent does the NDIA's budget-based approach to planning create clear and effective criteria for determining participant supports? To what extent does it lead to equitable outcomes for participants? What improvements could be made?

As per criteria on assessment, the planning is often constrained through the use of reference packages. This constrains the process for effectively determining participant supports e.g. the focus on first plans in NEMA (and Barwon) for people with complex needs have been to meet their immediate personal support needs and not necessarily their higher level goals of community participation, employment and independent living. Furthermore, the participants who are better able to advocate for themselves seem to receive more supports in their plans.

Issues also exist for participants with a disability accessing 'health' services as to what the role of mainstream health versus the role of the NDIS, and respective funding. There needs to be clear criteria based on key performance indicator and outcomes based research to guide the planning process in the future. The individual's first plan should also take into account their longer term goals.

What implications do the criteria and processes for determining supports have for the sustainability of scheme costs?

Plan reviews should be undertaken as required based on the participant's changing needs and/or requests for review. These should occur in a timely way to ensure responsiveness to changes in the person's circumstances, goals and required supports. There should be clear key performance indicators and standards that planners and the Agency need to meet as part of their reporting to governments.

¹² NDIS Price Guide VIC/NSW/QLD/TAS. Valid from: 1 July 2016. Version release date: 11 July 2016.

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

As per previous comments. Additionally, the process for resolving disputes or disagreements is not clear. The Agency rarely provides a contact name for appeals or provides a process by which participants can escalate their concerns. There is only one email address where the information and requests for review can be lodged. This is not customer friendly nor does it encourage participants to best advocate for their rights.

It might also be useful to establish an independent review panel as a final point of appeal if participants are concerned about the decisions made by planners. An example in Victoria could be the Victorian Civil and Administrative Tribunal as a mechanism for resolving disagreements.

4.8 Workforce

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?

Disability support worker remuneration and benefits are prescribed by the Modern Award (i.e. as the minimum) or in the case of medium-large existing providers, by enterprise agreements which provide above-award pay and/or benefits. A disability support worker is a relatively low paid job in Australian society, and supply of disability support workers is impacted by alternative unskilled employment at same or higher pay-points (for example in aged care, public health and non-health sectors such as hospitality).

As such, the NDIS reimbursement price is a critical “pivot point” impacting the supply/demand balance of labour in what will become a rapidly growing market. The following issues need to be carefully addressed:

- Whether the NDIS ‘Transitional Prices’ and ‘Efficient Prices’ address the real costs of labour and associated operating costs for providers. The objectives of the Scheme are best served by greater transparency of the make-up of the NDIS pricing. The NDIS pricing does not adequately cover the costs of training and a highly qualified workforce e.g. the cost of compliance training which is mandatory is currently unfunded. The NDIS pricing does not cover the cost of existing service provision, given the proportion of services provide by medium-large providers with existing enterprise agreements that are above Modern Award remuneration and benefits.

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A National Disability Services publication states that:

The NDIA's use of award rates as a starting point for price-setting can reduce the risk of low wage undercutting. However, award wages and conditions and employment standards need to be reflected more adequately in NDIA pricing to avoid risks to the financial stability of organisations and skill shortages for the not-for-profit sector¹³.

- The NDIS pricing assumes a disability support worker is engaged in NDIS revenue-generating activity for 95% of their employed time under the Efficient Price. However, 95% productivity is unattainable by most employers with a largely permanent disability support worker workforce, in an NDIS-funded scenario. This aspect alone, if not addressed, is expected to affect demand for permanent employees and lead to casualisation of the workforce. The need for greater flexibility in the Modern Award (minimum shift length; roster changes) is also important.
- The consensus of the sector is that the overhead cost assumptions in the NDIS pricing are unrealistically and unsustainably low for real organisations. Provider organisations must undertake significant work not only in transitioning their service processes and workforces to the NDIS but on ensuring sustainability. Many of these organisational demands are addressed in an NDS Response to the Paper seeking advice on priority actions for workforce development¹⁴.

There is a risk of provider failure and potential market failure if such matters are not addressed.

Some of the factors relating to allied health professionals are similar. Public Health remuneration of allied health professionals is noticeably more than the disability sector based on existing enterprise agreement comparisons (all such professionals are paid above award levels). Again, the productivity assumptions in the NDIS pricing do not adequately address the realities of providing community-based therapeutic supports (as distinct from centre-based).

How will an ageing population affect the supply and demand for disability carers (including informal carers)?

Significant cohorts of disability carers are middle-aged and above with projections to 2021 showing that if trends continue, the 45+ age group will comprise nearly 60 per cent of all

¹³ International and Local Experience on the Workforce Risks Associated with Individualised Pricing of Social Care (2016). National Disability Services.

¹⁴ NDS Response to the Paper seeking advice on priority actions for workforce development (2016). National Disability Services.

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support workers, compared with 55 per cent in 2011¹⁵. This highlights the challenge of attracting younger people into the sector as carers, to ensure the workforce profile is balanced and sustainable. Otherwise the ageing disability sector workforce will, in time, have a negative impact on supply, as they transition to retirement or less physically demanding employment options at a greater rate than they can be replaced.

It should also be noted that the ageing population will also increase demand for carers, as it affects both supply and demand for carers.

Significant cohorts of disability carers are middle-aged and above, which over time will have a negative impact on supply (as they transition to retirement or less physically demanding employment options).

It should also be noted that the ageing population will also increase demand for carers affects both supply and demand for carers.

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?

Refer to response to ‘factors affecting the supply and demand for disability care and support workers’. In 2016, the Victorian Government announced an investment of \$26 million to prepare the disability sector for the NDIS¹⁶. While the level of government support is transitional in nature, the plan identifies many areas that providers in the sector will ultimately need to invest in, in order to attract and retain values-driven workers, grow their workforce, and ensure the workforce is well trained to deliver high quality supports and outcomes for people with disabilities.

Critical policy settings include ensuring the scalability of quality training available to the sector and, of course, the NDIS pricing as explained above.

What scope is there to expand the disability care and support workforce by transitioning part-time or casual workers to full-time positions? What scope is there to improve the flexibility of working hours and payments to better provide services when participants may desire them?

Refer to response to ‘factors affecting the supply and demand for disability care and support workers’. Where scheme pricing is based on an individualised support model, realistic assumptions need to be made about the proportion of hours a permanent employee (as distinct from a casual employee) can reasonably be engaged in revenue-generating work.

¹⁵ Roadmap to a Sustainable Workforce - A National Disability Services Report prepared for the Australian Government Department of Social Services (2014). National Disability Services.

¹⁶ Keeping our sector strong - Victoria's workforce plan for the NDIS (2016). Victorian Government.

Flexibility is important in this context, such as setting/changing permanent part-time hours and flexibility in rostering staff (including minimum shift duration) – these matters need to be addressed within the review of the Modern Award (in line with submissions made by service provider organisations and their peak bodies).

The primary issue is seen as creating more permanent employment (as a more desirable outcome than casual). The secondary issue is creating more full-time employment (as many people prefer/choose to work part-time).

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

Technology is expected to improve a range of areas including communication with workers, understanding availability of workers, matching workforce to support needs and client preference, and setting/changing rosters. These are expected efficiencies versus current processes with some being qualitative rather than quantitative in impact.

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?

It is assumed that “skilled migration” refers to roles at a higher level of qualification and skill than the role of entry-level disability support worker. For example, qualified therapists with opportunities to become locally accredited. Greater use of skilled migration would apply if all the above-identified Scheme matters are addressed and there is still an inadequate supply of labour.

It would be desirable to understand whether skilled migrants providing NDIS-funded supports were more likely to be independent contractors. An NDS publication¹⁷ highlights some risks associated with an ‘independent contractor’ service model.

4.9 Will Providers be Ready?

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

From a whole-of-sector perspective we believe that registered providers will be unable to achieve sustainable delivery of individual support under Transitional Pricing. These current pricing levels only allow for a direct employment model without corporate overheads. The resulting negative impact to service quality, participants’ choice and control, compliance and

¹⁷ International and local experience on the workforce risks associated with individualised pricing of social care (2016). National Disability Services.

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workforce retention present a profound risk to scheme participants, the viability of the sector and the goals of the NDIS.

Scope supports a gradual move to deregulated pricing. This will allow prices to reflect the true cost of service delivery.

Scope and other disability service organisations are well placed to move to full Scheme. We have transformed our service delivery and support functions to operate in a consumer driven market.

We have also worked to ensure our support functions are scalable so that we can grow significantly under the Scheme, achieving additional economies of scale and reducing our overheads as a percentage of revenues.

Scope supports the withdrawing by state governments from service provision. This will enhance the operation of a consumer driven market by creating a level playing field for all competitors.

How do 'in-kind' services affect the transition to the full scheme and ultimately scheme costs?

The extended reliance on in-kind funding to allow the state and territory governments to continue to provide services whilst not being exposed to the NDIS pricing framework acts to distort the market. The flow-on impacts of these decision is the recent change in the Rules to ensure that participants in receipt of supported independent living under the NDIS are not able to change to a non-government provider. This decision is designed to optimise the in-kind funding arrangement by ensuring that no government operated beds remain vacant during transition. The outcome of this agreement is that community service providers are unable to fill bed vacancies and bear the cost of the vacancy.

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?

Many providers do not understand the working capital requirements to transition from payment in advance to payment in arrears. Delays with provider registration with the NDIS, planning process, activation of plans and payment through the myplace portal have exacerbated the stress on the service system. Providers are not advised of the date of plan completion for existing clients. This is the date when the state government ceases payment to the provider.

The provider continues providing services in good faith but is unable to bill for those services until the participant activates the plan and advises the provider that they will or will not continue to use their services. In order to bill for the services delivered, the participant

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must sign off on their delivery. Many refuse to do so believing that the provider is gouging them for services that were funded by the state government. This process can extend beyond 3 months in some cases depending on the rollout schedule and number of plans being approved. Salary and wage costs contribute to 80% of provider costs. Providers are left scrambling to meet these liabilities, often relying on lines of credit with banks. In a corporate environment, this simply would not be tolerated.

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

The provision of disability services across Australia has differed in the role of government, amount of funding, quality and safeguards compliance standards, number and size of disability support organisations to name but a few of the variations. It is therefore unsurprising that readiness varies considerably across the nation. The National Disability Services State of the Sector Report 2016¹⁸ shows a sector under stress.

Underinvestment over many years in a rationed environment has meant that ICT systems, business processes and business intelligence systems are underdeveloped. There is limited ability to aggregate, interpret and use data to drive strategic decisions.

Disability Service Organisations are trying to understand new and evolving market dynamics and to shift from a client centred to a customer driven model of service delivery. The investment in sector readiness and transition has varied across jurisdictions and has largely been left to the state and territory governments to fund and drive.

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

The main barrier to new entrants to the market is the ability to attract participants. Given the scale of growth, this is a low barrier to entry. New entrants are in fact advantaged by not being constrained by existing industrial agreements and can adopt the Modern Award or establish a business model that relies upon direct employment.

What are the best mechanisms for supplying thin markets, particularly rural/ remote areas and scheme participants with costly, complex, specialised or high intensity needs? Will providers also be able to deliver supports that meet the culturally and linguistically diverse needs of scheme participants, and Aboriginal and Torres Strait Islander Australians?

Thin markets lend themselves to an approved provider panel approach. Organisations on the panel must be able to demonstrate their expertise and ability to respond to the needs of rural and remote communities, including a demonstrated ability to deliver culturally sensitive services and supports.

¹⁸ National Disability Services State of the Sector Report (2016). <https://www.nds.org.au/news/sods-report-2016>.

Given the costs of service delivery and the pricing framework, sustainability relies upon scale and geographic density. In the absence of both, a weighted price is necessary to both attract market development and sustainability.

How will the changed market design affect the degree of collaboration or co operation between providers? How will the full scheme rollout affect their fundraising and volunteering activities? How might this affect the costs of the scheme?

The disability services sector continues to demonstrate a collegial and mission based approach to problem solving. There is little awareness of what anti-competitive practice means. Providers are focussed on delivery of mission and transforming their business to build a sustainable future.

Fundraising was impacted as soon as the Scheme was announced. The community, philanthropic organisations and bequestors assumed that everything was funded and that there were no gaps. This has occurred at a time when investment in research, innovation, process re-design and workforce development has never been more needed.

It is wrong to assume that fundraising dollars subsidise core services. What they did do was enable disability services organisations to invest in workforce training, equipment, research and community capacity building aligned with mission.

4.10 Governance and Administration of the NDIS

Do existing administrative and governance arrangements affect (or have the potential to affect) the provision of services or scheme costs? What changes, if any, would improve the arrangements?

The governance of the NDIS is overly complex with multiple layers of political and bureaucratic oversight. It is one of the largest businesses in Australia in terms of budget and impact. The newly appointed Board will seek to bring commercial skills to the governance of the Scheme but will also need to do so within a larger governance structure.

In 2040, the current half share of the total contribution from the states and territories will shift to the Commonwealth having an estimated 75% of the financial risk for the NDIS. This may be the time to consider transitioning the governance of the Scheme to a Government Business Enterprise under the *Public Governance, Performance and Accountability Act 2013*.

Does the way that the NDIA measures its performance affect the delivery of the NDIS?

It is hard to determine whether published measures represent an accurate and useful picture of performance to date. Many are output measures rather than strategic or operational

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outcome measures. Understanding what to measure and doing so in a manner that drives performance and delivers strategy is vital for success.¹⁹

To what extent do the existing regulations provide the appropriate safeguards and quality controls? Can these arrangements be improved?

Set at the right level but they continue to evolve which itself has been challenging.

Are there appropriate and effective mechanisms for dealing with disputes with the NDIA?

Families report finding the process to be adversarial, intimidating and time-consuming. Is there a role for a skilled intermediary to work with participants and families to seek resolution of their complaints or concerns? Or alternatively as suggested under Section 4.7 in response to avenues for resolving participant disagreements, an independent review panel, could be another mechanism.

Is the NDIA's target for operating costs (as a percentage of total costs) achievable? Is it practical? Should it vary over the life of the Scheme?

The desire to constrain expenditure is understandable but in commercial terms is perhaps limiting. In essence the NDIS is a business start-up requiring early investment to achieve scale rapidly.

How appropriate, effective and efficient are the market stewardship initiatives?

The role of market stewardship for the NDIA has been defined in terms of high level principles and options that the Agency may consider for targeted intervention. What is needed is the establishment of a well defined risk appetite in regard to supplier failure and scenario based modelling to build a detailed understanding of the impact of widespread and geographic market failure. Mitigation strategies can then be developed ready for rapid implementation when market signals show an imminent risk to the provision of services.

Is there likely to be a need for a provider of last resort? If so, should it be the NDIA? How would this work?

During transition this role is likely to be borne by the state and territory governments. Post transition, the obligation will rest with the Agency. In practical terms, the Agency is not a provider but bears a duty of care to source timely supports for participants in the event of provider failure. This could be achieved by establishing a provider panel that have the scale and capacity to respond to crisis-driven support requirements in the short-terms whilst a longer terms solution is found, based on participant preference.

¹⁹ Dodd, D & Favaro K. (2006). Managing the Right Tension. Harvard Business Review.

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Does the current funding split between the Commonwealth and the States and Territories have implications for the scheme's sustainability? Does it affect the NDIA's capacity to deliver disability care to scheme participants at the lowest cost? Are there any changes that could be made to the funding split that would either improve the financial sustainability or the efficiency of the scheme?

The current arrangement has enabled the transfer of state and territory services to the NDIA in a controlled manner that meets the requirements of each jurisdiction as agreed under the bilateral agreements. Post transition, this may not be the most effective means of funding the Scheme. Refer to comments regarding Government Business Enterprises.

What proportion of a state or territory's contribution to the NDIS are in-kind services? Are there risks associated with in-kind service contributions?

State and territory governments are, in many cases, the largest provider of supported independent living services. Refer to comments regarding in-kind arrangements.

What are the implications of the current risk sharing arrangements? Do they encourage either cost shifting or overruns? What, if any, improvements could be made to the current risk sharing arrangements?

There is an inherent risk of cost shifting where state and territory governments have committed all funds currently committed to the provision of jurisdictional disability services and agreed to double these funds.

In Victoria, the \$2.516 billion state government funds will combine with a proportion of the Commonwealth's overall \$22 billion a year cost to fund approximately 105,000 Victorians eligible for the Scheme.

There are another 900,000 Victorians with an identified disability whose needs must be met within the universal service systems. This may prove a challenge, particularly when expectations have been raised by the promise of the NDIS and the ILC.

Is there a better way of paying for the NDIS? For example, would it be better to fully fund the NDIS out of general revenue?

Refer to comments regarding Government Business Enterprises.

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5. Summary

As identified in Section 1, Scope's submission outlines messages across five key areas. Following are suggestions to address each of these areas.

a. Pricing

- That pricing should incorporate the additional costs of supporting people with complex support needs including:
 - Additional staff required due to additional hours of support required
 - Additional staff required due to higher support ratios required
 - Higher cost of staff with the skills required to support people with complex needs
 - Cost of providing the required systems and safeguards
 - Cost of providing crises support
 - Cost of facilities/transport required to support people with complex needs in group activities.

b. Complex Support Requirements

- That a mechanism is needed to identify the range of factors which contribute to a person with complex support requirements living an ordinary life. The combination of these factors should result in a weighting that informs decisions about pricing and package sizes.
- That an additional allowance is allocated for the cost of supporting people with complex needs. An additional allowance would more accurately reflect the costs associated with supporting people with complex needs. This allowance could be used to increase support on an as needed basis, including crisis support that would be consistent with organisations' duty of care obligation.

c. Supported Independent Living

- That the criteria to qualify for higher support needs funding should be reassessed and broadened to include a range of factors. 92% of Scope's Supported Independent Living residents have needs not currently considered as cost drivers under NDIS pricing but which can act as cost drivers.
- That people with complex support requirements are engaged in decision making on price setting.
- That pricing factors in the cost of interdependencies between residences in a household which increase costs beyond assessed on an individual client basis.

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d. Assets

- That there is specific funding for people with complex support requirements to attend group programs in-community.
- That pricing incorporates the cost of premises, specialised facilities, transport within an activity session and the cost of client cancellations.

e. Workforce

- That the NDIS pricing is increased to make an allowance for a qualified and trained workforce e.g. cost of compliance training which is mandatory and currently unfunded.

6. Closing Statement

Scope is fully committed to the implementation of the National Disability Insurance Scheme. The Scheme creates a paradigm shift in social policy and recognises the rights of all Australians to live an ordinary life. It has enhanced the lives of more than 60,000 participants and their families and for the first time fully recognises the rights of people with a disability to live their lives as empowered and equal citizens.