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City of **West Torrens**

Between the **City and the Sea**

8 April 2011

Draft Inquiry Report
Disability Care and Support
Productivity Commission
GPO Box 1428
Canberra City
ACT 2601

Dear Commissioners

Comments on the Productivity Commission's Draft Report

Thank you for the opportunity to respond to your draft report.

The City of West Torrens is a midsized local authority in metropolitan Adelaide, ideally placed between the City and the sea. We have a very diverse population of some 55,000 and a higher than average number of residents aged 65 plus.

Council operates a 115 bed residential aged care facility (St Martins), coordinates 30 CACPs and provides a range of HACC services, which have been extended recently by Council's direct financial support.

Our comments, which follow, are generally restricted to the Key Points, Overview and the Recommendations, so as to focus our response.

We therefore acknowledge the likelihood that our comments/suggestions have been more than adequately addressed within the Draft Report.

We also acknowledge the amount of work that the Commission and its staff have done in this area and commend you on your efforts.

Finally, by way of explanation of the source/background to some of the following comments, I 'declare' my previous experience as a registered nurse working in disabilities, speech pathologist in education, community and allied health manager in country SA and as a consultant who contributed to the development of the assessment tools and eligibility requirements used for the child and adult disability and carer payments.

Yours sincerely

Declan Moore
Deputy Chief Executive Officer
City of West Torrens

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Overview

1. We understand that the Government's Terms of Reference specify that the Productivity Commission must examine a social insurance model, consider a range of design issues, governance models and the financing and implementation issues for '*any proposed scheme*', so we express some trepidation about the Report and Findings if those criteria were also the *prism* through which the Commission viewed the broader issues and the submissions it received.

2. Care must be taken by the NDIS in the selection, training and appointment of assessors, if it wishes to have **consistent** and rigorous assessments of eligibility and needs. After many years of operation, the quality, accuracy and consistency of reports from Aged Care Assessment Teams continue to deviate substantially from our own pre and post admission assessments of CACP and Residential clients.

   Whether it's the assessment tools, the reliance on self or carer reporting rather than direct observation or independent reports from community and health service providers, training or the professional background of the assessors, is difficult to establish, but the NDIS will be subjected to the same assessment vagaries unless it proscribes and continuously monitors compliance with the qualifications, skills and experiences of the assessors, the source of information relied upon, the assessment tool, training and validation of the process for accuracy and repeatability.

   i.e. the validity of the process is just as important as the validity of the assessment tools used.

3. The cashing out of funding allocations is problematic and at odds with the basic approach which relies on funding a package of support services, rather than cash.

   Given that the source of funding is the taxpayer, it is not unreasonable for them to expect that funding will be provided on the basis of an independent assessment of needs, which leads to the provision of services that address those needs, and that across Australia the same level of need will entitle individuals to receive the same type and level of services.

   How that package of services is delivered and by which service provider, should certainly be based on client choice, and they should be able to decline particular services.

   But the principle of switching services within a package or cashing out services to purchase something else, is not supported, for the very rationale expressed in dot point one of the Commission's own *key points*.

4. The Commission notes (last dot point page 2) the amount of funding allocated by Australian Governments to the disability sector, in much the same way that the Inquiry into Aged Care commented on funding in that sector.

   Council notes, as it did in its Aged Care response, that the contributions made by individuals, families, friends, charitable and not for profit organisations and local government would boost this figure substantially, but no attempt has been made to quantify other sources of funding to the sector.

   Naturally the NDIS could only 'control' government funding, but additional sources should be recognised, especially those of the charitable and not for profit sectors which use or contribute hard earned cash from community fundraising activities, not government grants, to provide much needed and highly valued supports and services.

5. Dot point one on page 3 appears ambiguous in terms of the cost of the NDIS.

   Given the preceding point, it reads that an **additional** amount of $6.3 billion, **over** the current $6.2 billion is required to fund the NDIS. Does that not equal $12.5 billion of funding?

   The statement *'Accordingly the real cost of the NDIS would be around $6.3 billion per annum'* seems at odds with the basic maths?

   Given that many people (Council included) will rely on the Key Points, Overview (executive summary) and the Recommendations to determine where funding of the sector may be heading, perhaps the wording of this dot point could be reviewed?

6. We agree that the Disability and Aged Care systems should remain separate, but each should work with a common principle of equivalent services for equivalent needs.

   This is not the case with the Aged Care system which is based on funding services using an Administrative Ratio of 113 people per 1,000 aged 70 yrs and over, to determine the number of people 'requiring' support.

   The Draft Report into Disability Care and Support seems to be focused on assessed needs, not a ratio, although estimates of the numbers in various tiers have been provided.

   We support the provision of services based on needs, not ratios designed to limit the number of people receiving support.

7. We agree that a co-contribution, from those who can afford to do so, is appropriate in Aged Care, and that for people who acquire a severe Disability later in life the same requirement should apply.

8. While fully understanding an individual's preference to remain within familiar services as they age, there is a risk of creating a third system of support when it is not required i.e. Disability support services, Aged Care support services, and Disability & Aged Care support services.

If equity is the standard to be applied, and it should be, then people should 'transfer' to the Aged Care system on attaining 70 years of age, BUT, the NDIS should continue to directly fund their care so that people 'transitioning to aged care do not 'take up' places from the inadequate Administrative Ratio that currently dictates the extent of aged care funding.

Change to aged care services may well be required to more appropriately address more complex needs, but that should be embraced and supported because the entire aged care sector will benefit from improved services.

9. Page 20 – last paragraph.

Who would determine the appropriate number of therapy services and who would provide them?

The potential for creating perverse incentives is high if the source of the advice (never mind the decision maker) is the provider, whether employed in a government agency, not for profit agency or in private practice (business, group or individual).

NDIS should fund the initial assessment, diagnosis, recommendations for treatment, prognosis and indicators of suitable and independently assessable treatment progress indicators (milestones) at 3, 6, 9 and 12 months if receiving the recommended treatment.

NDIS should review reported progress made against the specified milestones and modify or withdraw therapy funding conditional on that comparison.

Panels of experienced clinicians may be required to set parameters for the reporting of assessment, treatment and progress data, and moderate the responses to fine tune those parameters.

Many disabilities, almost by definition, cannot be fully remediated and progress may be so slow with others that any progress/changes, no matter their importance to the life of the individual or carers, would not show up in repeat assessments for months or years to come i.e. test /retest sensitivities for most 'age appropriate' based assessments will detect only substantial or gross improvements.

In other words, *clinically significant* progress does not equate to *statistically significant* progress. Individuals, carers and clinicians are concerned about the former, while researchers and funders are more concerned with the latter.

10. Page 21 – Box 2

The range of supports/services included within the proposed NDIS is supported, provided that the provision of those services is based on NDIS set *fee for service* amounts, not in response to tenders from providers (whether public, not for profit or private) i.e. develop a funding system for the supports.

11. Page 24

Retention of the *other payments* (Carer payment, Child Disability etc) mentioned in the last paragraph is supported, as is their exclusion from the $s assigned to provide a package of care for individuals.

By all means review the eligibility requirements and perhaps even the amounts, but these payments recognise the role and responsibilities of carers who generally provide support well above and beyond the norm, so the payments should not be rolled into a package to fund direct services for the person with the disability.

12. Page 25

    Self directed funding remains a problematic concept in the context of the NDIS (refer our point 3 above), perhaps the element of choice (as described in b)) could be deferred until the NDIS packages have been in place for 3-5 years?

    During that that time, and based on real cases, the NDIS could develop alternate options for providing/improving choice.

13. Page 32/33 – figures 2 and 3

    Good *figures* to help conceptualise the narrative.

    Thank you.

NB unless otherwise stated in the following table, we express our support for the Commission's recommendations.

<u>Comments on the Draft Recommendations</u>

#	Comment
3.2	Supported We note that the last dot point will prove to be a major exercise in and of itself.
3.5	Mixed support In time there will be a *three class* aged care system: • those in and funded by the NDIS, • those in community or residential aged care, funded by the Commonwealth and themselves; and then the largest group • those requiring aged care but receiving none, because they don't fit within the capped system – i.e. excess to the administrative ratio funding limits. Agree with co contributions and a younger age threshold for indigenous people.
3.7	Supported, subject to earlier comments on the assessors, tools used etc

#	Comment
4.3	Not supported. Inconsistent with the principle articulated in 4.2 and would involve additional resources to be tied up in reviewing records to determine what if anything should be recognised, allowing for appeals etc.
4.4	Supported The onus will be on the NDIS to develop a consistent assessment and reporting system with the 'therapists' so that decisions on treatment efficacy and prognoses are as 'scientific' as possible. Perhaps families could claim the costs of therapy from the NDIS should independently verifiable and equivalent clinical benefits be demonstrated over an equivalent timeframe?
4.6	Supported, provided the 'work test' is reasonable and based on an individual's capacity to work, not on an administrative process that has already predetermined 'all people can work *x* hours per week'.
5.3	Supported The tools need to be sensitive to small incremental changes of clinical significance i.e. test/retest validity needs to be (and be seen to be) high.
5.4	Supported, provided the assessors have an undergraduate qualification in a recognised health, community or disability field which featured evaluation, assessment and measures of significance in the course. i.e. potential assessors should be experienced users of assessment tools, not administrative staff 'trained' for this one purpose.
5.5	Supported – refer 5.3 above
5.7	Supported Subject to earlier comments about the tools and assessors.
5.8	Supported Subject to the comments at 5.3

#	Comment
6.1	Supported, subject to earlier comments on the deferring 'cashing out' options for 3-5 years to allow the NDIS to develop better monitoring and evaluation systems. There is a high risk of creating inequity across the system with cashing out of approved/funded services. If the assessment protocols are designed to determine what needs are and the funding provided determines the amount of those services (for all individuals), NDIS allocated funds should not be spent on services not contemplated by the assessment. It would be inequitable to create a system that allows one client to purchase services different to those assessed by the NDIS as being required (because the individual *prefers* an alternative), but at the same time deny an individual funding for a therapy that the assessment doesn't indicate is required, even if the individual strongly feels that the service would be valuable to them.
6.2 and 6.3	As above. If the NDIA is to consider a detailed service plan before cashing out approved services, it must closely monitor and regularly evaluate the efficacy of the new arrangements to ensure that the envisaged benefits are actually delivered. If not, then the arrangements need to be modified or cancelled.
6.5	Supported, provided that the review of individual arrangements focus on the advantages and disadvantages (for the individual), not just on program risk.
6.6	Supported, subject to earlier comments (e.g. 6.1)
6.7	Supported, subject to earlier comments (e.g. 6.1) and the development of appropriate assessment tools to guide the NDIA person making the assessment of competency.
6.8	Supported, subject to earlier comments.
6.9	Supported, but perhaps consideration could be given to a clearly explained and well publicised 'sunset clause' on self directed funding? It would then require a conscious evidence based decision to continue the program, rather than the alternate which would be to cancel a program and suffer the inevitable negative consequences and claims of broken promises etc. i.e. politically easier to let a program finish up as advertised, or even extend it, rather than have to cancel it – no matter how poorly it's been performing.

#	Comment
7.3	Supported Perhaps individual state and territory bodies could be considered, with the national council drawn from their membership? It would increase the level of representation at the advisory level and provide the *national members* with 'advice' from a much broader constituency than their usual one.
7.6	Supported, though perhaps annual actuarial reports would be sufficient.
7.7	Supported, provided the performance indicators include satisfaction with the scheme as rated by individuals, families, providers etc, and not merely a financial review. Similarly, the specialist unit should include people with skills sets reflective of the broader program intents, not just financial performance i.e. it needs more than accountants and financial consultants etc.
7.8	Supported. Perhaps the first review (at 3 years) could determine the maturity and readiness of the system to implement self directed funding, in line with our previous comments.
7.9	Supported – subject to comments under 7.7
7.11	Supported, with a rider *that* the NDIA has an equivalent obligation to make reasonable attempts to accommodate requests that fall substantially, if not completely, within eligibility and entitlement guidelines. i.e. there should be some mechanism to make reasonable decisions when the lines are blurred, rather than stick rigidly to an administrative border, traditionally a source of much 'disquiet'.
7.12	Not Supported There are a number of existing complaint mechanisms that should be used, rather than creating another one. Naturally the NDIS and NDIA should deal with complaints as a first step, if the matter is not resolved then individuals, carers, service providers etc should use the more generic Commonwealth complaint mechanisms.
7.13	Supported Given the comments at 7.12 and the inevitable interaction between the NDIs, NDIA, CentreLink etc a better resourced Administrative Appeals Tribunal seems the most appropriate option.

#	Comment
8.2	Supported, provided individuals can 'opt out' without loss of or interference with their entitlements and, if they remain in, that they have unfettered access to the data held about them etc.
10.2	Supported, though the Australian Institute of Health and Welfare (AIHW) seems a more appropriate and already skilled body to manage and/or conduct such research on behalf of the NDIA.
11.2	Supported, if in conjunction with AIHW or similar.
12.2	Supported, both the recommendation and the alternate
12.3	Supported Agree with option a) and that states and territories should not be rewarded for cost shifting.
13.1	Supported But noting that the largest barrier to attracting and retaining disability (and aged) care workers is the poor pay and conditions, not a disinterest in employment as a personal carer.
16.2	Supported, but not from municipal rates. Local government is not an agency of state or territory governments for the collection of taxes, no matter that some states (including SA) have tentatively ventured down this path. There is no logic in the level of government least involved in the provision of disability services and with just the one basic tax (rates) participating in the collection of such a specific revenue on behalf of the Commonwealth. No rationale has been offered by the Commission for the inclusion of 'rates' in the recommendation?