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Allied Health Professions Australia

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Dear Mr De Luca,

I am writing on behalf of Allied Health Professions Australia (AHPA) and our allied health association members, who collectively represent some 100,000 allied health practitioners, to seek an urgent meeting in regards to the National Disability Insurance Agency (NDIA) adoption of the recommendations of the Independent Pricing Review. We request an immediate halt to the implementation of tiered pricing for therapeutic supports to allow time to review the assumptions that underpin this recommendation and consultation to consider the impact it will have on the marketplace.

AHPA and its members have the gravest of concerns about the impact of this change on the therapeutic supports marketplace and the availability of essential services for participants. Thousands of practitioners across a range of allied health professions, each of whom currently deliver services to participants, have already contacted our peak body members to voice their concern about this announcement. Those concerns are also being voiced across provider forums, on social media and in conversations with participants and their families. Our practitioners are genuinely anxious, many expressing concern about the immediate and lasting impact this will have on the participants they support, the ongoing viability of their businesses and their ability to continue employing staff.

While AHPA and its members support the intention of the Independent Pricing Review and understand the importance of a sustainable Scheme, it is our firm contention that the findings of McKinsey and Company with regard to the tiering of prices have been made without appropriate consultation and without sufficient understanding of allied health service delivery across different schemes. We note that no allied health professional peak bodies were engaged in direct consultation by McKinsey. We contend that McKinsey lacked sufficient understanding of the pricing of the different funding schemes, and the needs of people accessing services through those schemes, when they used these as the basis for their recommendations. We also believe they lacked understanding of the inconsistencies in the information to, and application of, the pricing guidelines across different NDIS providers. We contend that this lack of understanding led McKinsey to make significant procedural errors in comparing service funding and have included detailed reasoning in the attached documents.

Given these issues, AHPA and its members believe an immediate halt to the implementation process is required. We believe it will be essential to re-consider not only the pricing level of the tiers but whether there is sufficient basis to justify the introduction of tiers.

In addition to those concerns, AHPA and its members contend:

1. There is no foundation for the split between physical and psychological therapeutic supports or for the introduction of payment tiers.

A lack of understanding of the competencies of allied health professionals has resulted in tiers that do not reflect the skill-base of the professions.

2. The proposed basis for determining the level of complexity of a person's needs is inappropriate. Basing complexity on the number of physical conditions, the interaction of symptoms they may experience and/or the level of risk in the environment is not sufficient and not likely to address the impact these factors will have across domains. For example, the suggested use of the Gross Motor Function Classification System (GMFCS) is not able to address complexity across a broad range of functional domains such as communication, cognitive and intellectual disabilities.
3. There is no clear or consistent relationship between the complexity of an individual's body structure and functional difficulties, and the intensity or level of competencies required, for provision of allied health supports.
4. Even if complexity could usefully inform the level of pricing, determining complexity would require specialised assessment and slow the planning process without improving patient outcomes or support.
5. Tiered pricing will add additional complexity to the planning process and will encourage a deficit-focused model rather than focusing on outcome achievements.
6. Tiered pricing is likely to put the availability of services at risk for those participants classified in the lower tiers.
7. Participant feedback in relation to pricing levels reflects the NDIA's continuation of the rationing approach that was supposed to end with the NDIS but is now being driven by planners and a Scheme that is focused more on driving lower costs than the quality of supports.

In closing, we note the NDIA has come under heavy fire in recent times for implementing changes that impact dramatically on consumers and providers without sufficient consultation, or first testing the impact of changes. That has led your organisation to introduce processes that ensure better consultation, and to first pilot significant changes in a particular region before implementing these changes nationally. We question why this change, given its significance, has not been addressed in a similar way. This is particularly questionable considering the fact that the Scheme has been plagued by payment issues, which continue to impact heavily on many providers.

We hope to hear from you urgently in regard to our concerns. It is our belief that the goals of both the NDIA and the allied health professions should be aligned and focused on ensuring allied health professionals can deliver appropriate, high quality supports that improve the lives of people experiencing disability. It is therefore unfortunate that the sector continues to feel that the NDIA is taking an adversarial approach in its engagement with us. This cannot lead to the outcomes participants and their families need.

Sincerely,

Cris Massis
Deputy Chair, Allied Health Professions Australia

Attachment A – Analysis of pricing in other schemes used as benchmark data sources

The Independent Pricing Review (IPR) references as benchmarks a range of pricing rates that are structured as fee for service and not hourly rates. Some of these are graded by complexity because the length of the consultation is assumed to be greater. Many of the referenced rates assume a clinic-based model of service in which the consultation time may be as little as 20 minutes. This service delivery model would not be clinically appropriate to achieve good therapy outcomes for the vast majority of NDIS participants.

The levels of complexity referenced in the referenced data sources are all based on lower fee-for-service rates, rather than hourly rate. This is significant because the rate is based on a shorter service duration and comparing rates results in a significant procedural error. Despite careful analysis, we have not found or readily extrapolated the suggested levels and hourly rates claimed in the benchmarking of the pricing review.

Our analysis laid out further below also suggests that the current NDIS rate is broadly similar to rates paid across Schemes when these are calculated appropriately. DVA is a notable exception and out of line with current rates in other schemes. Evidence from AHPA's allied health members suggests that allied health providers are struggling to continue to deliver services to DVA-funded consumers as a result. Additional attachments detail the DVA Scheme rates.

In addition to the errors of comparison identified above, AHPA and its members are extremely concerned about the lack of foundation for the comparisons made. We are not aware of any analysis that shows that the services referenced in other schemes can be applied to those required by NDIS participants. AHPA's members also consistently report that the level of 'complexity' of providing allied health services to support a child or adult with a disability is aligned only very loosely with measures of their physical disability and in many cases there is no correlation between the two. Every participant who needs therapy services deserves good quality, evidence-based care from a suitably qualified, skilled and, where appropriate supervised allied health professional who is actively engaged in professional development.

AHPA and its members believe that the outcome of this change will be a significant reduction in participant access to ethical, skilled, experienced and evidence-based practitioners right when NDIS participants most need them. We are strongly concerned that these changes would mean the disability therapy services marketplace will primarily consist of two distinct groups in future:

1. Independent private practices that set their own fees and don't deal directly with the NDIS in order to deliver high quality care (thereby reducing access to participants that don't or can't self-manage or plan-manage).
2. Unethical, low quality or financially unsustainable allied health services as "NDIS registered providers" who depend on new graduates who operate without supervision or training and degrade the workforce base of all allied health professions.

Detailed analysis by scheme

Department of Veteran Affairs: Occupational Therapist Schedule of Fees (Effective 1 November 2013), p. 5. See also https://www.dva.gov.au/providers/fee-schedules/dental-and-allied-health-fee-schedules

- The DVA fee schedule has not been updated since 2013 and was already below the industry averages when it was released 5 years ago. Industry bodies have provided submissions to DVA advocating for changes to their allied health pricing. For example, a submission made to DVA in 2011 stated, "Occupational Therapy Australia believes the existing assumed hourly rate that underlies the current Fee Schedule is inadequate and out of line with other statutory systems who engage the services of occupational therapists." It further recommended "that the DVA assumed hourly rate be increased consistently across all occupational therapy codes, and based on an hourly rate of $150/hr."
- see: https://www.otaus.com.au/sitebuilder/advocacy/knowledge/asset/files/8/2012-10dvasubmission.pdf).
- See also Physiotherapy Australia's submission in 2016: https://www.physiotherapy.asn.au/DocumentsFolder/APAWCM/Advocacy/DVA%20Review_APA%20submission_FINAL.pdf
- The current DVA reimbursement rate in 2018 of $105.80/hr is clearly completely inappropriate in relation to the recommended (and now outdated) market rates from 2011 and 2016.
- The IPR appears to have taken the lowest market rate of any in our industry and used it as a "benchmark" which is clearly inappropriate.

Transport Accident Commission: Fee Schedules (2017), Government of Victoria, available at http://www.tac.vic.gov.au/providers/invoicing-and-fees/fee-schedules

- The service fees here appear to have been treated as "hourly rate" when the majority are fixed fee for service irrespective of duration. The only hourly rates actually stated here are in relation to report writing and have been shown to be well below market rates.
- Again, the fees set by TAC were well below market rates back in 2013, have not kept track with market changes or even CPI and this was stated by the APA in the following statements quoted directly from their submission to TAC:
    - *The current TAC fee schedule is significantly below market rates when compared to the treatment of private patients in Victoria.*
    - *The current TAC fee schedule has failed to increase in accordance with CPI Health Index over a significant period.*
    - *The current TAC fee schedule pays significantly below fees in other states and therefore national average fees for treating injured road users.*
    - *The TAC is failing to meet its legislated obligation to pay reasonable costs as required by s60(2)(a) 'Medical and like benefits' of the Transport Accident Act 1986*
      See: https://www.physiotherapy.asn.au/DocumentsFolder/News/05%20TAC%20Fee%20Submission%20(3).pdf

Worksafe: Fees and Policies (2017), Government of Victoria, available at https://www.worksafe.vic.gov.au/health-professionals/fees-and-policies

- Worksafe Vic work on a fee-for-service base that is fixed by service units rather than time-based billing. Therefore their rates are not appropriate in directly calculating an hourly rate.
- A "standard consultation" which is described in the fee schedule as less than 30 minutes should not be treated as though it was a per 30 minute billing rate because it states "less than" and additional information indicates this is estimated based on 20 minutes. In this case the hourly rate would be above $150/hr rather than the $110 calculated in the IPR.
- Other states have higher rates than Worksafe Victoria for example Worksafe QLD's speech pathology and occupational therapy service rates for hourly units

are set at $176 and $222/hr.
See: https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0013/140260/2017-Speech-Pathology-table-of-costs.pdf

State Insurance Regulatory Authority: Physiotherapy, Chiropractic, Osteopathy Fees Order (2017), Government of New South Wales, available at https://www.sira.nsw.gov.au/__data/assets/pdf_file/0019/112870/Physiotherapy,-chiropractic-andosteopathy_Fees-Order-2017.pdf 27

- The rates set here are also typically fee for service rather than hourly rates. The only fee that could be readily translated into an hourly rate is the case conferencing fee which is $15.40 per 5 minutes which returns an hourly rate of $184.80/hr.

Comcare: Allied Health Rates (2017), Government of Australia, available at https://www.comcare.gov.au/claims_and_benefits/benefits_and_entitlements/fees,_rates_and_reimbursements/allied_health_rates

- Current Comcare rates are considered below the market standard as well as also being typically structured as fee for service and not hourly rates.
- Analysis suggests that to arrive at the recommendation, only the lowest of these highly variable rates were considered.
- The only fees that are directly stated as hourly rates are for Occupational Therapy SA at an hourly rate of $181.60.

Please also refer to the following documents, both attached separately:

1. *2017 DVA payments in relation to fees in private practice physiotherapy (National average data)*
2. *ReturnToWorkSA case study*

We understand additional information has been provided by a range of associations directly to the NDIA and further information is currently being compiled by others. We encourage you to contact us if you would like more information to help you understand the impact this is having on allied health NDIS providers and the participants they support.

We further recommend the following submissions by allied health professional bodies to the NDIS for additional information:

- https://www.physiotherapy.asn.au/APAWCM/Advocacy/Submissions.aspx
- https://www.speechpathologyaustralia.org.au/SPAweb/Document_Management/Public/Submissions.aspx#anchor_n2017
- https://www.otaus.com.au/advocacy/our-submissions

About Allied Health Professions Australia

Allied Health Professions Australia (AHPA) is a collegiate body consisting of 20 national allied health associations members and a further 6 organisational friends with close links to the allied health sector. AHPA's members collectively represent over 100,000 allied health professionals who provide services across a broad range of settings and to people experiencing a wide range of health conditions. Many of those allied health professionals are involved in providing services to people experiencing disability, people who may or may not be participants in the National Disability Insurance Scheme (NDIS).

AHPA believes that it is vital that people with disabilities have access to the allied health services they need to achieve the outcomes and goals they have identified.
Allied health professions provide crucial support for people experiencing disability, chronic illness and a wide range of other health issues and it is only by ensuring that allied health services are fully accessible across the country will we ensure that Australia has an integrated, comprehensive health care system which delivers world class health care to those with the greatest need.

Please visit www.ahpa.com.au *for further information about our organisation and the important work of Australia's allied health community.*