

CONSULTATION RESPONSE



**Allied Health
Professions
Australia**

Productivity Commission Inquiry into the National Disability Agreement

August 2018

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to the Productivity Commission's Inquiry into the National Disability Agreement (NDA). We represent 20 national allied health associations and collectively work on behalf of their 100,000 allied health profession members. 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 and its member associations are committed to ensuring that all Australians, regardless of disability, can access safe, evidence-based services to support them to realise their potential for physical, social, emotional and intellectual development to participate in life fully.

This submission has been developed in consultation with AHPA's allied health association members.

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Introduction

Allied Health Professions Australia (AHPA) and its member associations represent a significant proportion of the workforce involved in providing support to people with disability in Australia. That workforce is uniquely placed to identify many of the current issues related to the interaction of different funding programs, divisions between health, disability and other sectors, and changes to the delivery of services due to their role in working across sectors. Through close engagement with this workforce and through our ongoing engagement with the National Disability Insurance Agency (NDIA), the NDIS Quality and Safeguards Commission, the Departments of Health and Social Services, AHPA is in a strong position to provide expert commentary on some of the issues raised in the discussion paper and on the challenges currently experienced by participants and the allied health providers that support them.

AHPA strongly supports the need for an updated National Disability Agreement that takes into account the issues that are impacting on access to services for participants. While AHPA recognises the transitional state of disability services in Australia, and the role this is having in exacerbating many of the issues outlined in this submission, we note the urgent need for genuine cross-jurisdictional and cross-department dialogue to ensure these issues are dealt with and do not have a detrimental impact on people with disability. We believe that there people are unnecessarily experiencing hardship due to uncertainty around service delivery and the transition to the National Disability Insurance Scheme (NDIS). We contend that the review of the National Disability Agreement provides an important opportunity to provide a more coherent plan for the Australians that need services, regardless of whether they fall within the eligibility criteria of the NDIS or not.

We also note the impact on providers who may be spending significant time submitting and re-submitting plans and being re-directed to other funding sources on behalf of participants and their families. The current lack of clarity around responsibility for services is impacting workloads and certainty about service planning. In addition, changes to the structure and funding of services is impacting the ongoing and future development of the disability workforce by reducing opportunities for training and supervision.

We have kept our response to this round of consultation short but encourage the Commission to engage with AHPA and our member associations further on any of the issues outlined in our submission or those provided individually by our member associations.

Commentary to the discussion paper

AHPA has structured its feedback in response to the questions outlined in the discussion paper. Question responses have only been provided where AHPA has determined that we can provide meaningful feedback.

The AHPA response covers the following questions from the discussion paper:

1. In light of developments in the disability policy landscape and intergovernmental funding arrangements, is an NDA still required? If so, how can the NDA remain policy relevant in an evolving policy environment?
2. What should be the purpose of the NDA? Is it an effective accountability mechanism for government actions relating to disability? If not, what are the more effective mechanisms that could be used?
3. What should be the scope of the NDA? Should it continue to cover all people with disability? What services should it cover (such as specialist disability services and/or mainstream services, including mental health, healthcare, aged care, education, transport, housing and justice)?
4. Are the objectives, outcomes and outputs of the NDA relevant in the context of contemporary policy settings? Are they clear and consistent? How do they, or should they, relate to the six outcomes articulated in the NDS and the outcomes of the NDIS?
5. To what extent should the outcomes be aspirational (worked towards but not necessarily achieved within a specified time period), versus achievable within a defined period? Should there be specific performance measures linked to the outputs and if so, what should they be?
6. How have the roles and responsibilities of Governments changed since the NDA was updated in 2012? Are roles and responsibilities clear?
7. What criteria should be used to assess roles and responsibilities of Governments under the NDA? What role should the NDA play in assigning responsibilities for all disability services between governments? How should this relate to the responsibilities set out in the NDIS bilateral agreements?
8. Should the roles and responsibilities of mainstream services to people with a disability be more clearly outlined in a national agreement?
9. How has the introduction of the NDIS impacted on access to services for people not eligible for the NDIS?
10. Does it make sense to separate them, or should the NDA and the National Disability Strategy (NDS) be merged into a single agreement?

1. In light of developments in the disability policy landscape and intergovernmental funding arrangements, is an NDA still required? If so, how can the NDA remain policy relevant in an evolving policy environment?

AHPA strongly supports the continued need for a National Disability Agreement (NDA). We contend that it provides an important means of providing an overarching national approach to the needs of people with disability, one that is sorely needed to ensure consistency and coordination across different jurisdictions and patient cohorts. We note that while the NDIS may transform the lives of many Australians and will be the primary funder of services for a cohort of people, many more people experience disability and are likely to require support than will be eligible for the NDIS.

The AHPA position is that one of the original purposes of the previous Agreement, to “affirm the commitment of all governments to work in partnership, and with stakeholders including people with disability their families and carers, to improve outcomes for people with disability and *to clarify roles and responsibilities*”ⁱ, remains a significant area of need.

Allied health practitioners based in a range of locations report ongoing issues in the interface between different sectors such as health and disability and in the interface between the NDIS and the services provided by each jurisdiction. This latter issue is of particular concern to AHPA and its member associations as there are examples of significantly differing views between the NDIA and Australian governments in terms of responsibility for the provision of some types of supports. For example feedback from practitioners suggests that NDIS participants are currently being denied Accredited Practising Dietitian services in their plans as well as access to nutrition support products, both of which were previously provided by disability services such as ADHC in NSW. Exacerbating this issue is that when service providers approach local hospitals for access to support, they are told that NDIS participants are eligible to receive products.

A further area of ongoing concern to two AHPA member associations—the Dietitians Association of Australia (DAA) and Speech Pathology Australia (SPA)—is the current NDIA determination that mealtime supports for people with swallowing difficulties are deemed to be a health issue and not funded through a plan. This is significantly limiting access to services and causing significant anxiety. Both professional associations have undertaken significant engagement with jurisdictional governments who have stated that they see this as a disability issue and not to be provided through mainstream, health services and funding.

While the bilateral agreements supporting the NDIS have attempted to address this issue and state that those found eligible for the NDIS are to be supported by a combination of the Scheme and mainstream services, there is still significant disagreement and disparity about whether a service is ‘within Scheme’ or mainstream and significant risk that there is no mainstream service able to provide services. This risk is even greater for those people currently receiving specialist disability services who are not eligible for the NDIS.ⁱⁱ A key area of concern for AHPA and its member associations is the lack of coordination between state health services, state disability services, federally funded disability services (such as Medicare funded Autism Spectrum Disorder supports) and federally funded health services (such as Chronic Disease Management or Better Access to Psychological Services Medicare items).

AHPA contends that significant work is required to identify gaps in service delivery in each jurisdiction and to assign responsibility for those to governments or the NDIA as part of an NDA. We note that there are significant issues already arising in areas such as Barwon in regards to so-called providers of last resort. Our experience suggests that providers are experiencing demand for less complex services at a level that means they have no motivation to provide services to more complex clients, particularly those with challenging behaviours. While the NDIA is attempting to address this issue through pricing measures, AHPA remains concerned that providing some services may be financially unfavourable to private providers making purely economic decisions and may continue to leave some participants unable to access services. AHPA contends that if this is allowed to happen and participants with complex intellectual, physical and mental impairments cannot access services they may not only be at risk to harm themselves, but may also present a risk of harm to the public.

AHPA contends that for the NDA to remain relevant in an evolving policy environment, it must be carefully aligned with the next National Disability Strategy and include review mechanisms aligned with key transition stages in the Scheme. This should include not only NDIS milestones but also those related to the transition of responsibility for registration to the Quality and Safeguarding Commission. These review mechanisms should be designed to allow the effectiveness of the agreement to be tested with a particular view to identifying where ongoing gaps are resulting in lack of access to services and funding for differing patient cohorts (i.e. those within the Scheme and those outside it, those with more complex behaviours) in different regions.

2. What should be the purpose of the NDA? Is it an effective accountability mechanism for government actions relating to disability? If not, what are the more effective mechanisms that could be used?

AHPA contends that the NDA must provide a clear definition of roles and responsibilities for all levels of government, including funding responsibility and so-called 'provider of last resort' responsibility, in all jurisdictions. It must provide certainty for any person with disability that there is a service available to provide for the needs that they have and a mechanism for determining accountability if that service is refused or unavailable. AHPA is not certain that the NDA itself is able to provide an effective mechanism for accountability but AHPA does contend that the NDA must identify and specify where accountability lies for different cohorts and identify the mechanisms that allow people to have decisions about access reviewed. It may be appropriate to provide some responsibility for oversight to the Quality and Safeguarding Commission. This would support participants, families, and the providers that are working to support them to understand where final accountability on different issues, particularly of access and funding lie and what mechanisms are available to challenge the decisions made by those with accountability.

AHPA recognises the complexity of mapping the different cohorts and the different approaches being taken in each jurisdictions, and as a result of the independent nature of the NDIA. However, we contend that if the NDA is to be effective and if it is to meet the needs of potentially vulnerable Australians, it must be designed such that it is based on a solid understanding of the current and

future directions of disability policy in each region and the capacity of disability services, specialised or mainstream, in each region.

3. What should be the scope of the NDA? Should it continue to cover all people with disability? What services should it cover (such as specialist disability services and/or mainstream services, including mental health, healthcare, aged care, education, transport, housing and justice)?

AHPA contends that scope of the NDA should continue to cover all people with disability. We note that there is still significant work underway to determine eligibility with some eligibility for people experiencing conditions such as Autism Spectrum Disorder and psychosocial illness still very uncertain. We also note that different governments appear to be differently interpreting their own responsibilities within the context of the NDIS. As such a broad NDA is essential.

AHPA notes that to be effective, the NDA must cover specialist disability services provided by the states and territories as well as mainstream services with the intention of providing a unifying agreement that has responsibility for all people with disability. AHPA believes significant efficiencies could be gained and major improvements made to the experiences of people with disability through a more holistic view of the needs of a person with disability, and the interaction with other services particularly with regards to mental health, healthcare, aged care and education. The current artificial walls that largely exist between these services and the lack of unifying policy across these different areas of service delivery continue to result in gaps for consumers, additional complexity for providers, and inefficient use of public funds.

4. Are the objectives, outcomes and outputs of the NDA relevant in the context of contemporary policy settings? Are they clear and consistent? How do they, or should they, relate to the six outcomes articulated in the NDS and the outcomes of the NDIS?

AHPA believes that the current objectives, outcomes and outputs of the NDA remain relevant and should be carried forward into an updated agreement. However, we note the potential to more closely align these with the outcomes outlined in the National Disability Strategy and the outcome domains identified within the NDIS Outcomes Framework. In particular we note that both the NDS and the NDIS Outcomes Framework specifically highlight health and wellbeing whereas the NDA makes no mention of the health of the participant. Aligning the objectives and outcomes articulated across different policy setting would more appropriately reflect the move to greater standardisation across Australia in disability policy and in the way that services are designed and evaluated.

5. To what extent should the outcomes be aspirational (worked towards but not necessarily achieved within a specified time period), versus achievable within a defined period? Should there be specific performance measures linked to the outputs and if so, what should they be?

AHPA recognises the benefit of setting aspirational goals in order to acknowledge the potential for outcomes that may not be achievable in the short term and to support a vision for an improved disability services. However, our experience with intergovernmental agreements is that aspirational agreements can result in a lack of tangible progress, particularly in the short term and with regards to funding decisions.

We have strong concerns that given the complexity of the interaction between different levels of government and within governments with regards to the delivery of disability services, and the vulnerable nature of people with disability, any outcomes must be specific and achievable goals that provide the foundation for assigning specific responsibility to the different parties to the NDA. We reiterate our concern that any outcomes that are not achievable and linked to timeframes and outcomes will not be prioritised and funded by governments given the competing priorities that inform government budgets.

6. How have the roles and responsibilities of Governments changed since the NDA was updated in 2012? Are roles and responsibilities clear?

AHPA notes that the shift to the NDIS in each region has been accompanied by a rapid shift in responsibility for disability service delivery away from the jurisdictions. This is having a significant impact on participants and providers and leaving significant gaps. AHPA's experience strongly supports the finding of the Commission's 2017 NDIS Costs Inquiry, which indicated confusion about responsibility for the delivery of services for people with disabilities resulting from the establishment of the NDIS. Our own engagement with various levels of government bears out this finding and suggests that there is a strong need to develop greater clarity about where responsibility lies for funding and service delivery and to address the gaps that are emerging.

While our greatest concern is the lack of availability of necessary and appropriate services, AHPA also has particular concerns around workforce development and the closely related role of market stewardship. Our engagement with providers of different sizes shows a real gap in the provision of training, both in terms of opportunities for new graduates and in terms of ongoing mentoring and supervision. With a significant shift to smaller, private providers, and NDIS funding provided on the basis of face-to-face contact with a participant many providers are expressing significant concern about their ability to find appropriately skilled staff or to provide the support for those staff to develop the necessary expertise. This applies also to clinical placements where opportunities are increasingly limited through the closure of specialised disability services in many jurisdictions.

AHPA contends that there is significant capacity to identify and address workforce issues as part of a NDA, particularly if as recommended below, the Agreement seeks to take a wider view that encompasses education.

AHPA does not believe that there are clear roles and responsibilities defined for the parties to the NDA in terms of final responsibility for providing support. We note the previous Productivity Commission's finding about different intentions by the states and territories with regards to the provision of specialist disability services and note our own experience with many jurisdictions appearing to withdraw entirely from engagement with the needs of people with disabilities, even those without access to NDIS funding.

We also note the key philosophical difference between an insurance scheme that covers only those it considers eligible and the role of a government with the responsibility of ensuring that people with disability can't fall into a gap where they are unable to access the services they need. It is our

contention that the NDIS will never take on the final responsibility for those in need and this needs to be recognised and addressed in the NDA.

7. What criteria should be used to assess roles and responsibilities of Governments under the NDA? What role should the NDA play in assigning responsibilities for all disability services between governments? How should this relate to the responsibilities set out in the NDIS bilateral agreements?

AHPA contends that the primary criteria used to assess the roles and responsibilities of Governments under the NDA should be the availability of accessible and appropriate services for all people with disability, whether they are NDIS participants or reliant on state- and territory-based services. This should cover both the availability of appropriate and safe services, and the funding to cover these. The NDA should seek to review performance against these criteria and evaluate if people with disability are experiencing inappropriate wait times or lack of access to services and should outline mechanisms to address poor performance.

AHPA believes the NDA should seek to define categories of participant including those outside the NDIS with the intention of clearly defining responsibility for each category of participant to either the NDIS or to governments. The NDA should also seek to address the fundamental challenge of a market-driven system, within which providers can choose not to provide services to more complex participants, particularly those with behavioural support needs.

8. Should the roles and responsibilities of mainstream services to people with a disability be more clearly outlined in a national agreement?

AHPA believes it is essential that the roles and responsibilities of mainstream services to people with a disability are clearly defined in a NDA. We further contend that it is necessary to map not only the roles and responsibilities of mainstream services but also to identify the limitations of these mainstream services in terms of capacity and funding and to consider these in the context of the NDIS and services delivered both through the Scheme and outside of it.

AHPA notes that NDIS and non-NDIS participants are frequently reporting being directed to the Federally-funded health system by planners, with little apparent understanding of the significant limitations of Medicare funding for therapy services. A key example is enteral tube feeding as noted in the Dietitians Association of Australia submission. Currently there is a strong risk of cost- and responsibility-shifting between disability and mainstream services and different funding schemes. With no clearly defined responsibility for providing services people with disability are likely to suffer adverse consequences.

If the funding and availability of mainstream services is likely to result in limited access to support and with consequences for outcomes for participants, then AHPA contends that the NDA must seek to identify and address this and negotiate solutions.

9. How has the introduction of the NDIS impacted on access to services for people not eligible for the NDIS?

It is AHPA's understanding that the introduction of the NDIS is negatively impacting the availability of services for non-NDIS participants in several different ways. AHPA understands that there has been a significant and rapid reduction in the services provided by the jurisdictions. In addition, AHPA is also aware that in some cases community health centres and other mainstream, state-funded providers such as specialised progressive neurological clinics have registered as NDIS providers. This is resulting in services being utilised by those people receiving NDIS funding and this is resulting in a reduction in the accessibility of services and increasing wait times for those not in receipt of NDIS funding.

AHPA suggests that one reason for this may be a reduction in funding levels from the jurisdictions. For example, AHPA understands that Community Health centres in Victoria are seeing a proportion of their Home and Community Care (HACC) state level funding cut as a result of the introduction of the NDIS. HACC funding is a type of block funding which allows community health centres to provide appropriate health services to people under the age of 65. Traditionally in Victoria, a community health centre receiving HACC funding would be working under a framework, set out by the Department of Health or State Government, which allowed flexibility in decision making with regards to what health services an individual could access. For example, if someone with an intellectual disability was to be referred to an occupational therapist in a community health centre, then the therapist had the ability (under the HACC framework) to refer directly to other Allied Health services (i.e. Exercise Physiology, Dietetics).

This means that allied health professionals are able to make clinical judgements based on their assessment findings, and they are able to promptly link the individual into the appropriate health services that they require. Under the NDIS framework, the client journey to access the appropriate health services requires multiple additional steps. Using the same example above, the occupational therapist may not be able to refer to an exercise physiologist or dietitian, even if this is clinically indicated. This is dependent on the initial outcome of the individuals planning meeting, and which categories the individual has been allocated funding for.

AHPA is also aware of significant uncertainty about pricing levels across different schemes that may support people with disability. We understand that the introduction of the NDIS is highlighting issues in the funding levels of other funding schemes including accident and other compensation schemes where professional associations have lobbied for some time for more sustainable remuneration rates. Current NDIS rates for therapy services have been set at what AHPA and its member associations consider sustainable levels that are higher than other comparable schemes and this is leading to a shift or prioritisation of clients/participants from the NDIS over other schemes. This difference is even more significant for consumers who may be dependent on a limited number of Medicare items, such as those that provide access to some limited support for younger people with Autism Spectrum Disorder or Pervasive Development Disorder.

10. Does it make sense to separate them, or should the NDA and the National Disability Strategy (NDS) be merged into a single agreement?

AHPA takes the position that the NDA and NDS could be merged into a single agreement as we contend that both are intrinsically linked—any disability strategy must have consideration of the limits and constraints of a NDA while any national agreement should be developed to encompass the strategies identified for the longer term development of the disability and related sectors in Australia and any related policy implementation undertaken in the jurisdictions.

Should the two not be merged into a single agreement, we strongly recommend that the two are developed in close conjunction with one another, ideally in a single process to ensure that the two fully inform one another and encompass not only existing issues but also build in capacity to map out and plan for future policy directions. By combining the consultation and implementation processes for both, there is significant potential to take a more effective and broad ranging view of the immediate and future needs of people with disability in Australia.

ⁱ Council of Australian Governments 2009, *National Disability Agreement*, Canberra. p. 2

ⁱⁱ Productivity Commission 2017, *National Disability Insurance Scheme (NDIS) Costs*, Study Report, Canberra.