Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into Current Scheme Implementation and Forecasting for the NDIS

Allied Health Professions Australia

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

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About AHPA and the allied health sector

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 140,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, providing services including diagnostic and first-contact services, preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

Introduction

AHPA makes this submission for consideration in the Joint Standing Committee's forthcoming interim report. Due to time pressure and numerous recent NDIA consultations, the submission is necessarily brief and at a high-level of generality. We anticipate elaborating upon the points below and additional themes in a more fulsome submission in February 2022, for consideration in the Joint Standing Committee's final report.

Responses to Terms of Reference

a. The impact of boundaries of NDIS and non-NDIS service provision on the demand for NDIS funding

To be addressed in the February 2022 submission.

b. The interfaces of NDIS service provision with other non-NDIS services provided by the States, Territories and the Commonwealth, particularly aged care, health, education and justice services

The allied health sector welcomed many of the changes resulting from the rollout of the NDIS across Australia, and supports a strong, effective NDIS. However, the Scheme's introduction was accompanied by a range of issues that continue to affect the experiences of providers and participants.

Some of the most significant difficulties are the result of a shift from state-based services to a largely fee-for-service, market-based system, and reliance on shared responsibility across multiple governments, departments and agencies for policy, workforce development, regulation and

pricing. Overlapping and at times uncertain responsibility for different aspects of the Scheme also makes it much more difficult to address issues that hamper the effectiveness of the NDIS.

c. The reasons for variations in plan funding between NDIS participants with similar needs, including:

i. the drivers of inequity between NDIS participants living in different parts of Australia,

ii. whether inconsistent decision-making by the NDIA is leading to inequitable variations in plan funding, and

iii. measures that could address any inequitable variation in plan funding

Plan funding and its translation into provision of supports continues to be inequitable for participants who are otherwise similar in terms of the costs of supports needed to be funded by the Scheme to enable them to meet their goals.

As AHPA has previously advocated, some of this inequity is due to the reliance of the NDIS on a market model to overcome lack of access to relevant support services for participants disadvantaged by postcode, particularly those who are rurally or remotely located. [1] The problem is compounded by a continuing failure of the NDIA to address allied health NDIS workforce issues, including registration and administration costs incurred to provide services under the Scheme.[2]

The planning process itself is the greatest contributor to both participants' and providers' negative views of the Scheme. Individual allied health providers and allied health peak associations have consistently sought to engage with the planning process in a constructive and collaborative manner. However, these efforts have been hampered by a lack of transparency about the planning process and concerning the training and guidance provided to planners, together with a general unwillingness to formally engage with our sector concerning planning issues.

Both NDIA planning and support coordination roles require not only a sophisticated understanding of the needs of the person with disability, but also a strong understanding of the broader disability sector. This must include an appreciation of the roles and potential contributions of a broad range of supports, the impact of different types of intervention, and the value of assistive technology.[3]

However, allied health providers regularly experience a failure of such understanding. This is particularly evident with regard to planning and coordinating supports for participants with complex needs. AHPA's Disability Working Group is currently compiling a dossier of examples where planners and coordinators have failed to approve or have underfunded allied health supports, because they are seemingly not aware of their value and do not appreciate important

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[1] See eg AHPA, Consultation Response to Queensland Productivity Commission Inquiry into the National Disability Insurance Scheme (August 2020); AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into the NDIS Workforce – National Workforce Plan (August 2021).

[2] AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into the NDIS Workforce (May 2020); AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into the NDIS Workforce – National Workforce Plan (August 2021).

[3] For more detail, see AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into NDIS Planning (September 2019).

distinctions among different types of allied health services. AHPA plans to make this dossier available to the Joint Standing Committee as part of our submission in February 2022.

We are also familiar with examples where planners have substituted a lower-priced service for a higher priced one, on the mistaken assumption that they are equivalent in quality and value. For example, a decision may be made to fund personal training services rather than exercise physiology. Personal training is not an allied health profession and its personnel do not have the training, credentials and competencies required of any NDIS exercise therapist. A similar process may occur with regard to selection of assistive technology.

Another example of false economising concerns approving funding for allied health assistance on the basis that this is cheaper than paying for an allied health professional. This practice can also be dangerous, as although allied health assistants are a valuable part of the allied health workforce, they are not trained for many of the activities that allied health professionals undertake, and should only perform certain other tasks under supervision or via an appropriate delegation arrangement.

AHPA is particularly concerned that if the NDIA and Government response to the claimed cost 'blowout' of the Scheme is to try to cut the average cost of supports, these examples will proliferate and thereby risk further compromising the ethos of the NDIS legislation.

d. How the NDIS is funded

To be addressed in the February 2022 submission.

e. Financial and actuarial modelling and forecasting of the scheme, including:

i. the role of insurance-based principles in scheme modelling, and

ii. assumptions, measures, and methodologies used to forecast and make projections about the scheme, participants, and long-term financial modelling

When the 2020-21 Annual Financial Sustainability Report ('AFSR') is read against the Insurance Principles and Financial Sustainability Manual (v5, November 2016) ['IPFSM'], it is clear that the modelling and forecasting of the Scheme rely on a narrow market approach that also fails to adequately appreciate the important differences between the NDIS and a profit-making insurance scheme.

As the IPFSM states:

> '. . . a one-dimensional financial focus appears unlikely to provide the only metric to indicate financial sustainability for the NDIS.' (p15)
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> '. . . it is suggested that the management of financial sustainability is likely to involve the support and management of perceptions and attitudes. That is, in seeking to manage financial sustainability, the Agency should be seeking to influence the perceptions of both participants and contributors (including broader community attitudes), through evidence of independence, outcomes and social participation, and both the immediate and longer term financial outlook of the scheme. (p18)

And yet, while the costs of supports are enumerated, measurement of 'independence, outcomes and social participation' is the thinnest part of the AFSR.

Similarly, the AFSR fails to enumerate the social and economic costs of not funding supports, and to factor these in when assessing the costs of the NDIS and any 'blowout'. But by not doing so, the NDIS risks becoming the State/Territory 'welfare' model it was meant to avoid and improve upon.

Due to time constraints, AHPA plans to submit a more detailed critique in our February 2022 submission.

f. The measures intended to ensure the financial sustainability of the NDIS (e.g. governance, oversight and administrative measures), including:

i. the role of state and territory governments, and the Disability Reform Ministers Meetings

To be addressed in the February 2022 submission.

ii. the arrangements for providing actuarial and prudential advice about the scheme

To be addressed in the February 2022 submission.

iii. the way data, modelling, and forecasting is presented in public documents about the NDIS, (e.g. NDIS Quarterly Reports and Reports by the Scheme Actuary)

iv. measures to ensure transparency of data and information about the NDIS

It is pleasing to see that due to public pressure, the AFSR has recently been released, apparently in full. However, as outlined above, the 2020-21 AFSR is based on assumptions that are not elaborated upon, and data summaries are not unpacked sufficiently to be able to answer many queries about what is claimed about the Scheme.

AHPA is also aware that although private consultancy continues to be a significant form of expenditure for the NDIA, the actual figures and contracting agencies are not evident.

g. The ongoing measures to reform the scheme

To be addressed in the February 2022 submission.

h. Any other related matters

NDIA consultation and engagement

Despite the NDIA website promotion of 'Have your say' and 'We listened', there are significant flaws in the NDIA's current consultation and engagement process.

At times, allied health professions continue to experience a complete failure to consult with us about significant policy and administrative changes, as with the development of the now discredited and abandoned independent assessment model.[4] More frequently, we receive only a late invitation to comment, with an associated very tight deadline.

[4] AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into the NDIS Workforce – National Workforce Plan (August 2021).

Even when allied health is invited to comment within a timely framework, the consultation paper or questions is often framed as a one-size-fits-all document or consultation that claims to encompass all of the interests and understanding of providers, participants and the general public. It consequently fails to satisfy most stakeholders. This state of affairs is exacerbated when another Government department, such as the Department of Social Services, takes on the coordinating role.

As a consequence, AHPA and our members spend inordinate amounts of time trying to respond to issues that are framed at too high a level of generality, or that appear to be 'reinventing the wheel'.[5] The impact of this process on the capacity of modestly funded peak bodies is made more severe by the sheer volume of consultations issuing from the NDIA.

We continue to engage with these processes because they are one of the few conduits through which to try to make allied health perspectives heard. It is therefore especially discouraging when the NDIA responds to our and others' efforts by claiming to have incorporated submitters' views but provides no clear rationale for the policy or model selected – making it difficult not to conclude that the decision was already made.

It is essential that allied health providers be meaningfully engaged at all stages of relevant policy and practice development, implementation and evaluation, in a manner which acknowledges our various roles in the Scheme and our specialist knowledge. To date there has been no regular mechanism to facilitate such engagement.

The Scheme's human rights framework

Considerable work remains to be done to ensure that NDIS policy and practice expressly adopts the human rights approach embedded in the enabling legislation.[6] In particular, as epitomised by much of the recent discourse around the 'unsustainability' of the Scheme, there is an unresolved tension between the current market forces approach and the human rights framework.[7]

[5] AHPA, Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the NDIS Workforce – National Workforce Plan (August 2021) and AHPA, Submission to the NDIA Consultation on Supported Decision Making (September 2021).

[6] AHPA, Submission in response to NDIA Consultation Paper: National Disability Insurance Scheme Psychosocial Disability Recovery-Oriented Framework (June 2021).

[7] *National Disability Insurance Scheme Act 2013* (Cth), s 3(1).