

Review of NDIS Costs Productivity Commission

Submission by the
Australian Physiotherapy Association

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Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Review of National Disability Insurance Scheme (NDIS) Costs by the Productivity Commission.

We support a national disability insurance scheme that adopts a person-centred model of care and support.

Our view is that a major cost driver for the NDIS is likely to be the provision of low/poor value services – funding services that do not optimise the (health) outcomes achieved per dollar spent. We are concerned that when the NDIA groups cost drivers into high-level categories, the focus is on *price*, not *value*.

We argue that the delivery of sustainably high value from the investment everyone makes in the Scheme requires the NDIA and NDIS to provide information to the stakeholders in a way that is relevant, timely and transparent.

We argue that it is difficult to know whether the current costs of the Scheme and the current utilisation rates reflect the situation that might be expected as the Scheme ‘settles’, or whether they reflect problems with:

- the planning process (especially delays and disagreements about entitlement)
- the availability of an appropriate workforce
- the previous arrangements that have resulted in unmet demand for some services and equipment, or
- a new market (especially information asymmetry and the need for participants in the Scheme, the families and friends to further improve their literacy on how the Scheme works, and which services and equipment provide the best value in meeting their needs).

We are concerned about a number of issues associated with the boundaries of the Scheme, including the degree to which the current approach of the Scheme to Early Child Early Intervention reflects contemporary best practice in this area.

Although this Review is occurring in the midst of a national roll-out, our members are concerned that the problems in ‘hand-over’ between funding programs represent key problems with the design of the Scheme as a whole. In our view the point of ‘hand-over’ represents a substantial safety risk for participants and issues of the funding boundaries must be addressed in a way that ensures safety and continuity of care as a primary goal.

We are also concerned the ‘boundary-riding’ will result in material disadvantage to people who are not eligible to access the NDIS, especially as programs are folded into the NDIS during the transition.

We argue that it is essential to review the purpose of the ‘planner’ function, and ensure that the role does not compromise decisions by participants and service providers about the provision of services of high value in meeting participant needs.

We argue that the degree to which the ‘market’ for the NDIS is ready depends on the readiness of the consumers (potential and existing participants in the NDIS, their families and friends) the providers, and the NDIA and NDIS.

We are concerned by the focus on 'efficiency', rather than 'value' and argue that it is important, in the first instance, to explore what is really meant by 'efficient'. Our members are concerned that this means only technical efficiency and has no focus on allocative efficiency. Additionally, our members are concerned that 'efficiency' suggests a focus on a very short horizon, not on the sustainability of high quality services over the long term. We believe that it would be prudent for the Productivity Commission to overtly consider long term sustainability, not only short term viability, when looking at whether prices are 'efficient'.

We support a disciplined consideration of the potential for technology, especially as a means of enhancing communication. However, we suggest that care will need to be taken when considering new technologies as innovation may need to be balanced against equity and overall costs to the Scheme.

We believe that it is prudent for the Productivity Commission to consider the costs of remediating the problems that have resulted from the roll-out to date, especially the costs of regaining the trust of many participants, providers and community members. Our members suggest that many people are concerned about the delays in access, the potential that the issues with the payment gateway are symptomatic of long term governance, managerial and administrative problems. More, they suggest that the current culture within the NDIA needs to change, and that it is prudent for the Productivity Commission to consider what this organisational transformation will cost.

1. Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to make a submission to the Review of NDIS (National Disability Insurance Scheme / the Scheme) Costs by the Productivity Commission.

Our Association recognises that this Review occurs during a period of substantial change – as the Scheme is rolled out nationally.

We support the Scheme taking a person-centred approach to care and support. Taking this approach requires the Scheme to find and fund ways that assure the participation of people with enduring and complex disability in planning and managing their own care, with the support of family and friends, or formal systems where appropriate.

A number of the recommendations we make in our submission aim to ensure that the centrality of personal decision-making is enshrined, and appropriately balanced a number of other legitimate issues, including the overall costs to the community.

At a whole-of-Scheme level, many of the issues that this Review addresses are influenced by the model of 'regulation' that is adopted. Our profession is committed to active self-regulation. In the context of the NDIS, we believe that this role will be aided by the provision of transparent, timely, relevant information by the NDIA and NDIS to consumers, their families and friends and service providers. The provision of tailored and timely information to peak bodies such as ours will assist us to support our members through education, the provision of clinical guidelines and other tools.

We are concerned by the absence of this interchange of information with our profession, to date, as it provides one of the most useful means of improving the value that the NDIS provides to its participants and the broader community.

We are keen to continue to participate in the discussion that surrounds the long term sustainability of the NDIS.

2. Scheme costs

The NDIS started in July 2013 as a trial in a four locations, has trial sites in all states and territories, and began a roll out of the full Scheme in all states and territories (except Western Australia) in July 2016. Despite this, our members are yet to see reports on the activities since 2013 which provide an overview of the sustainability of Scheme costs, cost pressures and efficiencies gained within the Scheme.

We understand that it may be difficult to discern whether issues with the Scheme's costs are associated with:

- its design and/or
- its implementation in sites and/or
- transitional issues / roll-out issues.

However, our members are concerned that many of the problems associated with the implementation and its roll-out reflect fundamental problems with the design of the Scheme.

Integration costs before it pays.¹

Our members are keen to see that the work of the Productivity Commission is informed by detailed reports on the cost structures of the trial sites. They are also keen for the Productivity Commission to distinguish 'upfront' costs from those which will be incurred over time, and to ensure that the real costs of key cost drivers such as capital and innovation are included in the overall approach.

2.1 Are there any cost drivers not identified above that should be considered in this study?

As we understand it, the NDIA groups cost drivers into five high-level categories:

- access — the number of participants in the Scheme
- scope — the scope of supports provided to participants in the Scheme
- volume — the quantity of supports received by Scheme participants
- price — the price paid for supports under the Scheme
- delivery — the costs associated with operating the Scheme.

Amongst the questions identified as relevant in the Issues Paper, 'quality' is mentioned twice, 'value' is mentioned once and 'outcome' is mentioned once.

Our view is that a major cost driver – either not identified above or not well articulated in the Issues Paper is the cost of providing low/poor value services – funding services that do not optimise the (health) outcomes achieved per dollar spent.²

We are concerned that the current settings, echoed by the way in which costs are characterised above, encourages a focus on price, not on value. Our members have raised concerns that the metrics being given most attention relate to money and not to person-focused outcomes.

Facilitating a Scheme that funds high-value services, and monitoring their provision requires different forms of action, reporting and surveillance.

2.2 Why are utilisation rates for plans so low?

Our members have suggested that utilisation may also be low because some participants their families and friends need support to move from plan completion to plan implementation. Plans are set and become active, but participants (and their families) can be unaware of how to engage a service provider.

Our members have advised us that one of the reasons for low utilisation in regional areas is that there can be a long delay before some service providers sign off on the proposed plan. This is because some organisations need to decide which elements of the plan are a part of their existing mandate to provide services and which are to be funded under the NDIS. Our members suggest that this is a particular problem for providers which are state-government operated.

It is possible that this challenge is specific to the roll-out period, however, it does suggest that the 'demarcation' between the expectations of 'universal' service obligations and those which are appropriately funded by the NDIS will need ongoing attention.

Utilisation rates may also be low because of perverse impacts of shifting the obligation of support onto universal services for short periods.

Our members have advised us of situations in which participants in the NDIS have been hospitalised. In the case studies they have brought to our attention, the role of the hospital staff and other carers is unclear. It appears that the NDIS precludes funding of support workers to assist the participant during the hospital stay (presumably on the basis that this is an obligation of the hospital). However, the hospital's 'usual' level of support for patients is reportedly inadequate for the participant (e.g. the degree to which the hospital can routinely support the patient with routine activities of daily living); and thus our members have reported substantial disruption to the family.

Taking a 'whole of system' approach, it may be important for the jurisdictions to determine the most effective manner to address these circumstances – whether hospital funding and

staffing models need to be adjusted to better facilitate the hospitalisation of people with ongoing and substantial disability or whether it is better to allow the NDIS funding to 'cross the border' and be available to a participant during hospitalisation.

Even where a participant in the NDIS has a 'smooth run' involving eligibility for the Scheme, and getting a plan, our members tell us that there can be limited capacity of providers to 'pick up' new clients.

2.3 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?

Our members have indicated that specialty services are not broadly available in the private market. In effect, the more specialised the service, the more likely it is to be available only through specialist (often hospital-based) services and funded by the state government.

Our members suggest that this presents a substantial risk that specialist services needed in multidisciplinary teams could be disbanded, despite their importance, or 'cannibalised' by private sector organisations – neither of which is necessarily a better outcome for the system as a whole.

Members of the APA have expressed concern about the perceived difficulty in modifying / reviewing plans once they have been 'set'. Our members suggest that this difficulty encourages a contingency mentality – that everything which *might* be needed in the next twelve months must be included because, if it is not in the plan when first 'set', the participant may not be able to request an amendment if the need arises.

A lack of available service providers has made it difficult for some clients to fully utilise their plan hours according to our members. Additionally, our members have suggested that it can be challenging to match the timing of availability of the participants with that our providers. For example, when school participation is a key goal, some children and families then need to coordinate contact with physiotherapists (and other providers) in narrow windows of opportunity (e.g. after school or before school). These can be periods of peak demand from other physiotherapy clientele.

Our members have advised us that some of their clients are experiencing difficulty with such things as equipment adjustment (e.g. wheelchairs adjustments as children grow).

It is possible that the issues with equipment signal a broader matter. If one of likely the outcomes of the NDIS is a higher level of access to equipment, then it is possible that there will need to be a specific effort to build the workforce needed to adjust and maintain this equipment. Additionally, it is possible that there will need to be specific strategies to allow the equipment to be transferred to other users (e.g. when a child 'grows out of it').

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

Amongst the reasons that our members cite for higher numbers of participants entering the Scheme is the number of clients who were not accessing funded supports prior to the introduction of the NDIS (e.g. those reliant solely on family and friends). Additionally our members believe that the number of children with disabilities who could not access services under the existing systems has been higher than modelled and reported. This includes

children and young people outside of Early Childhood intervention who did not receive funding for ongoing therapy. Our members have examples of children aged 8-12 years who have ongoing and significant disabilities who were not able to access therapy under the existing systems, but now can.

Our members have suggested to us that members of the community are seeing entry to the NDIS as 'insurance'.

In this context, we believe that members of the community may want to test their access and continue to participate in the NDIS 'in case'. This rationale for enrolment may be exacerbated by the challenges involved in gaining entry and the resulting fear that gaining re-entry at some later point would be time consuming or problematic in other ways. Such a concern about the uncertainty of both the Scheme and an individual's needs for it may weigh heavily on the minds of parents.

One of the reasons for taking this prudent view is the perceived lack of material support in other systems, such as the education system. Our members suggest that the NDIA is probably having to 'pick up some of the slack'.

2.5 What factors are contributing to increasing package costs?

Our members advise us that one of the reasons that costs may be higher than anticipated is that priority may be being given to participants who, historically, needed high cost services but had no effective 'insurance'; and are now having their needs met effectively for the first time. This includes substantial equipment costs which might be thought of as being amortised over the useful life of the equipment.

Our members have suggested that waiting lists for services funded by other schemes (e.g. through the state government) are being overcome by the way in which the NDIS funds packages. This means, in effect, that there is a concurrent resolution of issues that would, otherwise, be addressed sequentially.

It is likely that one of the factors contributing to increasing package costs is the inability of participants to discern the difference between low-value care and high-value care. A recently published study suggests that the public's awareness of low-value care is incomplete, with substantial disparities in the ability to discern low-value care related to such factors as socio-economic status.³

Choosing a 'market' model brings the complexity of equipment providers, for example, entering the market with information that their (more expensive) product is superior, when in terms of the individual need of a person, other supports may provide more value.

It is possible that this is part of a 'maturing' market. Our members have suggested that in some situations there are active 'communities of interest' (sometimes online and sometimes geographic) which participate in discussions about the 'best' service models and equipment.

This is an important discourse which is likely to mature. However, our members suggest that it can currently result in substantial time-costs being incurred in discussion about the advantages and disadvantages of different equipment and activities. They also suggest that it may also be a driver to increasing package costs as people seek the newest and not necessarily the best value.

It is also possible that there will be a significant cost overrun until the health and purchasing literacy of consumers and providers matures further.

The comparative value of engaging a physiotherapist, or engaging a physiotherapist who delegates some tasks to their physiotherapy assistant, or engaging a person with no physiotherapy supervision will depend on the circumstance. However, our members are

concerned that there is no structural mechanism to monitor the comparative value, and no existing presentation of data about these issues to the consumers or providers.

We discuss this issue with specific reference to the support of people with ongoing and complex pain states, later in our submission.

Structurally, this argues for more rapid and more transparent sharing of information held by the NDIS with the population of participants and with national professional peak bodies. This information sharing would allow both sides in the decision-making process to discuss ways to inform participants about the relative benefits of equipment and activities, to understand the cost implications. This also argues for a sophisticated national strategy to address the costs of equipment – an issue we address in at 5.7.

Our members are concerned that the way in which the NDIS is structured allows for the purchase of services for which there is little evidence of benefit. The Australian Government has explored this issue previously.⁴

It would be prudent for the Productivity Commission to explore the impact on the sustainability of the NDIS caused by allowing government funding to be spent on services with low evidence of benefit, and to explore ways which the market can be shaped to ensure that such purchases are minimised.

Our members have provided consistent feedback that the levels of subsidy from other schemes is systematically inadequate, leading to a series of mechanisms such as cross-subsidisation and queuing. Depending on the way in which the benchmark was devised, it is possible that the low benchmark reflects a misunderstanding of the real cost of providing reliably high quality care.

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

Our members have expressed concern that the benchmarks for package costs and figures on the actual spend are inaccessible. Our members would prefer that this information is accessible to both consumers and providers. We understand that there is a benchmarking project underway, however, our members are concerned about the lack of transparency that will exist unless benchmark package costs and actual spend is provided to consumers and providers in the interim. Our members have expressed concern at apparently wide variation in actual spend, together with what appear to be anomalies in the nature of the spend in similar circumstances. They are concerned that the absence of transparent and timely information is undermining the credibility of the program parameters, decision-making and review structures within the NDIS.

Our members suggest that there may be a number of reasons for the mismatch between benchmark package costs and actual package costs.

It is possible that the benchmark costs, especially for first plans, under-estimate the ‘catch up’ that participants need in order to achieve an environment that optimises their ability to function effectively – issues like equipment, renovations, and other support.

It is possible that this issue relates to limited availability of appropriate, but ‘second hand’ equipment; and that over time, an effective ‘market’ for second hand equipment may reduce the gap.

It is possible that the expectation of consumers and the capacity of the NDIS to fund services is at odds. Our members report some similarities between this and other schemes in which there is a strong sense of entitlement.

3. Scheme boundaries

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

Our members have consistently advised us that the capacity of the NDIA to manage the number of people seeking to test their eligibility is too low.

Members of the APA are concerned that the balance between the speed of the roll-out and its effectiveness needs to be changed, and the roll-out slowed so that the NDIS can properly train its team, manage its workload and provide consistent support to the regions in which the roll-out is occurring.

Alternatively, the financing of the Scheme needs to be adjusted to address the substantial implementation costs.

Our members have expressed the view that the NDIS has misunderstood the critical value of face-to-face contact, and an unanticipated outcome of the current model is a reliance on comparatively de-personalised phone contact. Our members believe that the absence of personal contact will drive up costs for assessment of eligibility and for introduction into planning. They have expressed the view that participants, their families and friends feel 'lost' as they may unwittingly deal with a number of people at a number of levels and at a number of critical milestones.

3.2 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?

We support the role of early childhood early intervention (ECEI).

Our members have suggested that it is important for the Productivity Commission to consider the mechanisms at play for newborns. There may be some benefit to have immediate access to supports to provide preventative interventions such as with babies born pre-term. There is good evidence that support in the first few months of life will reduce the long-term impacts of the child, but the support needs to be intensive and immediate.

We are concerned that the roll-out of the ECEI within the NDIS may result in the reduction of access to ECEI services for children who need these services and are outside the NDIS. It has been suggested that the result of this sort of health and social service program reallocation results in cost-shifting between sectors and that reducing access to one part of the system may simply increase use in other parts that are not necessarily less costly.⁵

There is a symbiotic relationship between the health and social service systems. If people do not find answers to their difficulties in one system, they search in another for assistance. Health services are often substituted for other social or nonmedical services in a system that insures only health care.

It is possible that the children who do not meet the threshold for entry into the ECEI will subsequently need higher levels of support because funding that might have assisted them is re-directed to the ECEI.

Thus, it may be prudent for the Productivity Commission to consider where the flow-on costs of reduced access to ECEI services would be found, especially in the longer term.

The limited availability of experts in the paediatric field has led some of our members to express the view that children are being over-therapised; and that this approach is leading

to over-dependency on therapy rather than capacity building. Such an approach will lead to ongoing increased costs rather than reducing costs. Our members suggest that there needs to be specific focus on assessing a family's ability to build capacity and taking a strategic approach to maximising this capacity. Additionally, discussion about 'better' models of care occur at individual, familial and peer-group levels.

We believe it would be useful to confirm that this capacity-building for persons who are not the participant/client is to be funded from the participant's 'envelope'. Other insurers have caveats that prevent such capacity building, and this capacity building is also at the opportunity cost of other supports potentially funded by the NDIS.

This sort of challenge – of working with a group of people in addition to the client themselves is amongst the reasons that some of our members have asked whether the ECEI model is one which can be effectively funded on a fee-for-service model. It often requires the coordinated input of multiple stakeholders. Models such as this can require substantial catchments in order to make the employment of these experts viable. This can also mean that the assessment and professional supervision and support aspects of the model are difficult to maintain unless the service has sufficient scale.

The capacity-building may be better supported as an overt strategic alignment with ILC initiatives.

Our members have also expressed concern that some employers misunderstand the key worker model that underpins the ECEI and provide access to a limited range of therapy disciplines, or inadequate input to the key worker from specialist disciplines such as physiotherapy. The way in which the ECEI approach is actually delivered will have an impact on its effectiveness, and it would be prudent for the Productivity Commission to consider whether the appropriate levels of professional input (including input to key workers) is occurring. It may also be useful for the Productivity Commission to consider whether the model is sustainable in a fee-for-service setting.

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

We need a smooth transition into ECEI with adequate funding to prevent waitlists occurring and a place where families can understand what inclusive and family-centred services really look like.

Our members have suggested to us that the NDIA may be overestimating the number of children who will subsequently leave the NDIS. Our members have also suggested that the NDIA may be under-estimating the long-term costs that these participants will incur.

Additionally, our members are concerned that little focus is being given to the time lost to early intervention through the current delays in activating plans.

We believe that it would be prudent for the Productivity Commission to re-appraise the benefit proposition of ECEI. We would suggest that the benefits that accrue from the model will be seen in other areas of the economy and human services sector; and that some of the benefits are unlikely to be accrued for some years.

3.4 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?

We have provided comment about this issue at 2.2.

3.5 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?

Our members have suggested that there are increasing incentives for 'early discharge' from public and private hospitals resulting from the introduction of the NDIS; and that these shifts in procedures need to be carefully monitored for their clinical appropriateness and risk of cost-shifting. There is little incentive, for example, for hospitals to ensure optimal pre-discharge functioning of a participant, compared with early hand-off and the transfer of the responsibility for achieving optimal functioning into the hands of the participant, their NDIS budget and community-based providers. There is little incentive for any delay in discharge should equipment necessary for home-based care not be available (apart from the professional/ethical incentives of individual practitioners). Our members have advised us that premature discharge runs the risk of two unnecessary costs – short term readmission costs, but more important and larger long term costs associated with inadequate pre-discharge preparation.

Our members have reported instances where local state-funded rehabilitation services have 'closed their books' to NDIS package holders in circumstances where our members believe that these services are being funded to support the NDIS package holders.

Our members have advised us that one of the main mechanisms being used to resolve these situations is the advocacy by consumers themselves, their family and friends, or physiotherapists engaged in providing services.

The direct and indirect costs of this negotiation need to be directed to other activities.

It will assist if the NDIS and mainstream services develop clearer delineation of their responsibilities and if they promote this delineation effectively.

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

Our members have raised serious concerns about the interface between the NDIS and mainstream (and other) services that have been supporting participants prior to their entry into the Scheme.

Effective hand-over between services is a critical safety issue.

Our members report to us a number of occasions when the communication between the public system and the chosen NDIS provider is substantially interrupted. This results in inadequate preparation of the NDIS-funded service provider. It can also result in simple problems like the provision of duplicates of equipment or consumables to the participant.

Our members report that this issue is substantially aggravated by rigid rules about eligibility which result in services being ceased by one provider (often in the public sector) and the NDIS-participant's service provider needing to bear upfront (and often significant) costs involved in the transfer well before the fee for the service rendered is paid.

The policy arrangement must be able to accommodate some sort of 'contingency' payment in order to facilitate the communication and preparation at the community end.

It also suggests that the NDIS may need to find ways that it can create incentives for the physiotherapy providers to engage actively in the transition to digital records and digital interfaces with other providers.

Our members are also concerned about the reports that changes in funding arrangements in so-called mainstream services (e.g. Home and Community Care funded services) are leaving people who are not NDIS eligible with no service.

3.7 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?

Our members are concerned that there are inadequate mechanisms to identify, address and report (conflict of) interests in the ILC and LAC initiatives.

Our members see a need for the establishment of partnerships between the ILC initiatives, LAC's and services.

They are concerned, however, that the ability to bid for ILC initiatives is dependent on having sufficient existing capacity and 'connection' to the NDIS, leading to a favouring of 'in-group' ILC initiatives.

The Tier 2 funding and projects need to be set up to provide more generalised supports that do not require individual funding and supports.

4. Planning processes

As we understand it, once a person's access to the NDIS is confirmed, they will be contacted by a representative of the NDIA to have a planning conversation.

We understand that a number of participants in the NDIS will be able to hold this planning conversation and get their 'first plan' without additional support.

We are concerned by reports about what happens for some participants who need support – arguably those in need of most assistance.

These reports suggest that a number of participants are contacted by NDIA after their eligibility is determined and put in contact with a Local Area Coordinator (LAC).

We understand that the LAC's are usually employed by non-government organisations (NGOs).

These NGOs, according to our members, are often also service providers.

Our members have expressed the view that there is an obvious bias in the way that some LAC's act – that they are directly clients to services provided by the NGO for whom the LAC works.

We are concerned that the degree to which there is informed consent is limited, particularly as these clients are reliant on the support of the LAC to 'navigate' the NDIS and the service system. We have had reports of clients being unaware that their participation in the NDIS would allow them to choose a provider who is not registered with the NDIS and/or they are not provided this option because the person 'managing' their funds is employed by an NGO providing some or all of the other services they need.

We are concerned that this mechanism has the effect of channelling participants away from private practices, because participants have been guided to join or continue with NGOs. It is unclear what audit process would occur to ensure that the choices (effectively) made by a LAC in these circumstances are the most appropriate.

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

Our members report that, in specific localities, a meaningful increase in capacity from the NDIS has assisted to improve access. This suggests that it would be prudent to review the way in which resourcing needs are calculated.

Our members report that the interfaces with the NDIA and NDIS remain relatively inaccessible for people with lower levels of literacy or less understanding about their needs, the types of support that would help meet those needs, and the types of support available locally. Our members suggest that further effort needs to be made to support people with limited communication capabilities or higher levels of intellectual disability.

4.2 How should the performance of planners be monitored and evaluated?

Before the performance of planners can be monitored and evaluated effectively, it is important to clarify the purpose of this role.

It appears that there may be four different possible reasons for having this role in the overall Scheme:

- A financial role – as the ‘delegate’ of the NDIS who authorises the monetary quantum of the support package
- A fiduciary role – as a safeguard for the participant against conflicts of interest in the providers of the participant’s support package
- A service planning support role – as the NDIS agent for assisting participants in the NDIS to develop high value plans using the funds in the participant’s support package
- A care coordination role – as the point at which care is coordinated across different funding systems.

We believe that the role needs to be clearly defined, and that it not to include a service planning support function.

It is our view that it may be appropriate for planners to hold the role as ‘delegate’ for the NDIA and be a point at which the authorisation of the funding package can occur.

It is appropriate for the NDIS to maintain a fiduciary role. Our members are reporting instances where planners are closely tied to service providers and are directing referrals to and planning service provision by, these service providers. The NDIS has an appropriate duty to ensure, for example, that service planners declare and manage their conflict of interest.

We have had reports of ‘stronger’ planners being prepared to deny aspects of plans which have been agreed in similar circumstances for participants with similar needs. This may be a function of the roll-out, with limited comparative data at hand.

However, our members have suggested that participants who are less strong in their personal advocacy or have supporters who are less vocal advocates are being consistently disadvantaged. This argues for better, and more transparent decision-making algorithms.

It is appropriate for an insurer to have a degree of compliance monitoring – to ensure that the legislative and regulatory criteria for determining whether a support may be included in a participant’s plan are met.

However, this is a ‘transaction cost’; and in a mature NDIS, it should be regarded as a residual safeguard to other forms of ‘regulation’, including regulation by the ‘market’ of the NDIS (including its informed participants) and professional self-regulation.

Our members have reported incidents in which either staff of the NDIA or LAC's have advised families that the family will need an Australian Business Number (ABN) in order to self-manage. We are concerned by the consistency of information being provided by the NDIA and LAC's. However, we understand that planners may have an important role in helping monitor sound approaches to purchasing by individual participants or intermediaries.

Our members report that service planning is being undertaken by staff who have little competence in the specific field of disability relevant to the participant's needs and thus that service plans are at odds with the needs which the NDIS is designed to meet.

Our members are also reporting instances where planners are making referrals to services that are demonstrably and adversely impacted by the profession in which they were trained.

Our members have reported situations where LACs have not funded equipment that has been prescribed by a therapist (who has used sound clinical reasoning to determine that the equipment is an appropriate choice) and have not been required to provide the evidence for their refusal to fund the equipment.

Such interventions by planners and coordinators can be matters of safety – for example where the equipment is to reduce risk for the child.

In circumstances such as this, the refusal is seen by our members as a clear indication that the NDIA/NDIS is prepared to assume responsibility for the risk and any adverse outcomes.

Separating the service planning role from that of the planner would reduce the likelihood that the NDIS would be involved in this suboptimal decision-making.

In our view, the function of service planning is one that should be undertaken by the person participating in the NDIS. To the degree that this person needs support to undertake the service planning, that function needs to occur through the participant's delegate, not a functionary of the NDIS.

Our members are also concerned that planners are undertaking roles that involve them in deciding when the funding from one agency ends and the NDIS funding begins. Together with this, and even more worrying to our members, are reports that planners are being asked to undertake roles in coordinating services – which services will continue and which will not; which will start and which will not – at the point of entry for some NDIS participants.

This complex care coordination activity needs to have a clear 'owner' – a person with authority on the 'NDIS-side' – and that person needs to have some financial delegation (e.g. to make some 'contingency' arrangements while the planning and plan implementation is finalised).

Alternatively, there would need to be some clear obligation on the 'discharging' service and funder to maintain the services until the plan and the plan's implementation are complete (which appears, in some cases, to take months).

4.3 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 assessment process and tools must have credibility to participants and service providers. Unless this is the case, the NDIS will have substantial, ongoing 'delivery' costs associated with defending its position on these matters. These delivery costs will play out in administrative review of decisions and in marketing and communications costs (at least).

A key implication is that the NDIS will need to invest in meaningful discussions with professional peak bodies as partners in improvement.

Depending on the model of planning and assessment which is adopted, it is our view that a critical task will be to determine a sustainable caseload for both financial delegates of the NDIS and service planners.

We are concerned by ongoing reports of delays in interactions with planners and with LAC's. Poor projections of the caseload that can be managed by planners, leading to unmanageably large caseloads may be a part of the reason for this delay.

This model will need to take account of the impact of strong support for self-managed plans, and for plan development in which the participant has supporters who are not within the service provider sphere (e.g. relatives and friends or other advocates).

Our members are concerned that 'assessment' is becoming characterised as an event, rather than a process, and that there is little focus on incremental re-appraisals of the appropriateness of plans and budgets.

We understand that NDIS participants and providers are having to undertake 'workarounds' in cases where the participant's circumstances have changed and the review process is cumbersome.

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

Given the complexity of some of the issues and the level of funding at stake, some of our members have expressed the view that it may be useful to establish expert review panels.

Our members also support a view that the resolving of disagreements needs to be accompanied by a requirement to move through certain stages within pre-determined timeframes.

5. Market readiness

The degree to which the 'market' for the NDIS is ready depends on the readiness of:

- the consumers (potential and existing participants in the NDIS, their families and friends)
- the providers, and
- the NDIA and NDIS.

Our members continue to voice concerns about whether the NDIA and NDIS are sufficiently prepared for the roll-out. For example, we continue to hear of substantially varied information being provided by staff who answer telephone calls associated with the NDIS. This suggests to us that the NDIA and NDIS are not ready for the roll-out and need to put both systems and training in place to prevent the costs for participants and providers associated with acting on inaccurate information.

Our members report that it is difficult for anyone to interact with the Scheme at present. They report lengthy delays on the 1800 number, and that the use of intermediaries such as support co-ordinators or LAC's mean that messages are mixed or diluted.

We continue to be concerned about the problems with payment systems, including reports from our members that they receive delayed and lump-sum payments, making it challenging to reconcile the payments with services provided. We are also concerned that the transaction costs associated with rectifying these problems continue to be passed to providers who do not create the problems. We see this as unjust.

5.1 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?

One of the factors that will affect the supply and demand for workers in this field will be the way in which services are subsidised by other insurance schemes.

The NDIS is one amongst a range of insurance schemes. Most other insurance schemes overtly preclude or discourage models of support that include physiotherapy assistants. In contrast, in some areas of high acuity such as hospitals, sophisticated models encompassing the role of physiotherapy assistants have evolved. In terms of a market model, there will be ongoing barriers to the deployment of high-value models of support involving physiotherapy assistants until there is a threshold volume of subsidies/rebates to enable a sustainable model. This runs the risk of distorting the market towards larger sized organisations that are able to deploy such models across a larger population. Such a model will substantially disadvantage small, specialised and rural providers.

Delegated models – where the physiotherapy assistant is delegated tasks, rather than substituting for a physiotherapist – can bring good value because of the combination of the oversight of the treating physiotherapist and the rigour of comparatively low cost direct-care personnel. As a result, a model which has barriers to the role of physiotherapy assistants may encourage the purchase of low cost, but comparatively low-value services which do not bring the expertise of physiotherapists into the process.

A focus on price, rather than value, by the NDIA will exacerbate this problem.

Our members have expressed the view that it is essential for the NDIS to devise a model that allows sustainable placement of physiotherapy students. The provision of opportunities for student education is both an obligation to the future profession by our members and an important mechanism to expose students to the area. It is thought that student placements have a significant impact on workplace choice post-graduation.

Unless the NDIS can find a mechanism to fund placements outside its fee-for-service driven model, then our members will have limited options. These include passing the cost of education onto individual clients and refusing placements. Our members think that an effective model may involve the NDIS sequestering funds for the provision of professional supervision and for funding some time for services provided by students under supervision, rather than asking participants to fund these activities on a fee-for-service basis.

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

We are concerned about the impact of an ageing population on the supply and demand for carers for people with disability, including the impact on the availability of informal carers.

In addition, we believe that it would be prudent for the Productivity Commission to model scenarios which use other caretaker ratios.

We believe that the supply and demand for both informal and formal carers will also depend on other important social changes. These include:

- the increased level of participation by women in the workforce
- the interrelated increase in the burden of debt that will require household members (including potential sibling and child/young person carers) to hold paid work
- long term economic forecasts, and
- changes in cultural norms in our ethnically diverse society.

5.3 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?

Our members have suggested that increasing the NDIS workforce to that which is projected as being required will not be possible in the current policy settings.

They have advised us that demand for services has already stripped supply of providers.

Under previous policy settings, payment for disability services was prospective. In larger organisations this allowed for workforce to be trained and deployed as funds for workforce education were held by the organisation (as a part of its overall personnel costs); and a small workforce could be deployed to existing clients whilst additional staff were trained.

This approach to workforce training is not viable under a fee-for-service model.

Additionally, the choice of service providers to upskill through continuing professional development requires that the providers both anticipate sufficient service demand to make education worthwhile and sufficient ongoing demand in order to maintain competencies in the field. The current roll-out model provides little certainty. If providers upskill too early, then there will be a requirement for them to undertake even further education to demonstrate currency of competence.

Additionally, we believe that it would be prudent for the Productivity Commission to consider the inadequate incentives for physiotherapists (and other relevant workers) to establish themselves in regional and rural locations. Our members also suggest that it is possible that physiotherapists attracted to work in this area may be, disproportionately, young women, and that they may take higher rates of leave than their male counterparts during the years in which they start families, having an adverse impact on the growth of the workforce.

Arguably, it is in the interests of the NDIA to work with peak professional bodies to develop high quality post-entry education that can be deployed to regions as the roll-out occurs.

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

We are strong supporters of digitally-mediated services. Such services need to have the same risk analysis applied to them as do other services – the risks and benefits of the use of technological solutions need to be weighed up on both an individual and collective basis.

In this context, we take the position that there should be no impediment to payment for a synchronous audio-visual encounter, or other online services where the provision of these services has been determined to be appropriate, safe and of good value. Our members advise us that they already face substantial challenges in providing optimal services for their clients who are geographically remote. They advise us that this is particularly a problem when the disability is of comparatively low prevalence and the size of the provider population with expertise in the area is very small.

Our concern about technological improvements is echoed in the current issues surrounding the provision of prostheses in the private health insurance sector.

We foresee substantial gains in value being made through the use of advanced technologies such as 3-D printers and robotics. The issue is in part, who will bear the (usually) high costs for early adoption.

We recommend that attention be paid to the long term strategy and 'regulatory mechanisms' that will be used to balance the individual benefit of providing high cost technology against the opportunity costs for the Scheme and equity of opportunity for other participants. We recommend that consideration be given to a national approach to the introduction and access to high cost technologies across insurance schemes (given the size of the Australian market), including the sorts of processes used by the Pharmaceutical Benefits Advisory Committee (PBAC).

5.5 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?

In terms of physiotherapy and activities delegated by physiotherapists to, for example, physiotherapy assistants, our members see the use of skilled migration as a false economy.

Although skilled migrants with training in physiotherapy will meet the standard for registration as a Physiotherapist, their clinical knowledge and skill level is likely to be commensurate with an entry level physiotherapist. It is unusual for these migrants to be familiar with the systems and tools available (e.g. benchmarking, outcome tools) that are used to monitor, evaluate and improve a service (i.e. demonstrate value). As a result, these migrants would not increase the pool of sufficiently skilled and experienced physiotherapists needed to fill the workforce gaps.

Additionally, it is our experience that these migrants rarely have a sound understanding of the Australian health and social services system.

The complex interactions between insurance schemes in Australia – between universal arrangements such as Medicare and the NDIS, and between state-funded and/or managed and federally funded services result in the need for health professionals to understand the arrangements in order to be able to provide authoritative information to people using their services. Our experience is that Australian graduates learn this through their exposure to the Australian context as citizens and as workers. Our experience is that it is quite difficult for overseas-trained graduates to grasp the multiple parties who can be responsible for aspects of a person's support.

As a result, our members have the view that the investment in ensuring that skilled migrants can provide services of equivalent quality would be better spent in creating incentives for Australian graduates and other workers to meet the needs, especially in rural and regional locations.

We suggest that the Productivity Commission look at the direct and indirect costs of using skilled migration and consider how this investment (by various Departments) might be used to support incentives for Australian workers.

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

To date, the price-setting mechanisms of the NDIA have not been transparent to the physiotherapy profession. Thus, it is difficult to comment on whether these prices are set at an efficient level.

It is important, in the first instance, to explore what is really meant by 'efficient'. Our members are concerned that this means only technical efficiency and has no focus on allocative efficiency.

We think that it is important for the Productivity Commission to overtly discuss the impact of pricing on allocative efficiency.

Additionally, our members are concerned that 'efficiency' suggests a focus on a very short horizon, not on the sustainability of high quality services over the long term.

We believe that it would be prudent for the Productivity Commission to overtly consider long term sustainability, not only short term viability, when looking at whether prices are 'efficient'.

We are concerned about what appears to be poorly informed discussion about fee/price differentials between NDIS-funded clients and clients funded by other insurance arrangements.

A recent study amongst our members suggests that there is widespread stinting on key costs that are less obvious to their clients (e.g. capital and equipment; and time spent mentoring and supervising entrants into the field or physiotherapists developing specialised skills).

This stinting on these aspects of care is driven in some part by low rates of subsidy by major insurance schemes (e.g. Medicare, the Department of Veterans' Affairs and private health insurance).

It results in a number of tactics by physiotherapists, including cross-subsidisation of service costs by clients with more capacity to pay and the scheduling of patients for shorter periods than optimal. It can also result in problems in growing specific skill sets within the profession and in services that are viable in the short run but not sustainable in the long run.

The low level of subsidies suggests a deliberate policy choice by some insurers to 'require' cost-sharing by people covered by the Scheme. It will be prudent for the NDIA to make clear and for the Productivity Commission to consider, the policy which the Scheme has for cost-sharing with participants.

In other insurance schemes across Australia, price setting has involved the 'bundling' of a number of different service elements into the price. These elements can vary between travel (which includes the opportunity cost of providing other services and the direct cost of the transport), extensive report preparation for third parties, and transaction costs involved in communications with the insurance scheme.

Our members are concerned that the NDIS will replicate the problematic models of some of these schemes, including models that bundle professional services costs such as liaison with other services into the costs of a 'consultation' or treatment but fail to include the costs of these services in the fee.⁶

We are very concerned that there will be little consistency and little transparency in what is 'bundled' into the services when price setting occurs.

We are beginning to see a tactic by some service providers to get their staff to do the planning and other administrative work in front of the parent. Although this is not necessarily an effective use of time, we need to understand how the real cost of undertaking such activities

is funded. If it is within the service fee, the model needs to ensure that the cost cannot be shifted to other funders or the participant in other ways.

In this context, we believe that it would be useful for the Productivity Commission to consider the costs involved in achieving both transparency in the price-setting and consistency in the elements of the services priced.

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

Our members see a substantial investment in ‘in-kind services’ being provided by family members.

Although the support of families is often seen as being about supporting activities of daily living, in the interaction with a substantial social insurance scheme, some family members play a distinct role as supporters for the planning and negotiation with ‘the insurer’. Our members suggest that it is important to support participants and family members to see the ways in which the Scheme operates (at a number of levels). Families and clients often do not see the ‘behind the scenes’ work (e.g. sourcing the right equipment, writing applications, trial and scripting complex equipment, training to support workers in safe drinking/eating procedure).

When participants and families see these activities it assists them to include these essential supports into their plan and over time to be better advocates for themselves and their peers. Our members see potential within the ILC arrangements to provide structure to this ‘on-site learning’.

5.8 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?

Our members seek, where possible, to embed safeguarding mechanisms such as complex case review, practice leadership, and professional supervision. A recent study of costs amongst our members suggests that they may not include the costs of such important initiatives in their routine fee calculations.

In order to ensure that there is sustainable capacity amongst providers, our members will need to ensure that consumers and funders understand the long term safety, quality, and sustainability implications of subsidy levels.

This requires education amongst some providers and amongst some participant groups who seek to pay low prices, not recognising the impact that this has on safety, quality and sustainability.

Our profession is keen to provide high quality support to physiotherapists. The question that the Productivity Commission might consider is the degree to which the beneficiary of that (the NDIS) should contribute to the costs of that support.

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

The proposition that providers need to be ready for a shift from block-funding to a fee-for-service model appears to be grounded on a particular perspective of who the ‘providers’ are.

Many physiotherapy providers have not been funded on block-funding models. They are ready to provide services on a fee-for-service basis, but are questioning whether traditional models of fee-for-service for individual occasions of service are what will really create value in the NDIS.

What is less clear is the degree to which the market of private practice physiotherapists are ready for the competition that vertically integrated organisations will present. Many of these vertically integrated providers have developed skills in tendering, and will be advantaged by a market in which service packages, purchased by intermediaries for participants, will be a substantial market segment.

Our members see some risks in a fee-for-service and market-driven approach. They appreciate the need for sound self-regulatory and peer/profession-support mechanisms to assist some providers stay within their scope of practice. Physiotherapy is proud of its history in working successfully in a self-regulatory mode.

This would be supported by information from the NDIS, provided on a regular basis, about any issues of poor quality or low levels of safeguarding, as the profession has a number of mechanisms that it can use to support its members.

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

Depending on the transaction costs, the barriers for new providers may be substantial.

We hear mixed reports about the size of the following transaction costs:

- Interaction with the NDIS (including registration and other administrative interactions)
- Third party accreditation of the safety and quality of the service.

Our members have raised concern about the variability of the information and advice provided when they make contact with the NDIA/NDIS. In some cases, this advice has involved foresight and anticipated issues that may arise, allowing a smooth and efficient entry to being a registered provider.

In other cases, it has involved long delays in phone contacts, limited ability to facilitate the engagement of the provider, and the provision of inaccurate information which has delayed participation or encouraged a service provider to remain outside the registered 'pool'.

Our members also indicate that they are still unfamiliar with the processes. Some of this unfamiliarity arises from the marginal importance that the NDIS has until it rolls out in the provider's locality. This suggests that the NDIS may need to undertake a national 'sign-up' roadshow, aligned with the geographic roll-out.

5.11 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?

It is our view that the NDIS will need to create meaningful recognition and reward for participating in 'thin' markets.

Usually, these markets have existing, and high quality providers, but their volume is low. We believe that attention needs to be paid to the role of technology in supporting clients in 'thin' markets.

It is possible that some of the issues can be addressed through the provision of 'remote' expertise to local practitioners who have existing local networks and infrastructure. This means, however, that remoteness would need to be a factor in costing the service plan.

It is our experience that it will be of relatively low value to facilitate fly-in fly-out models.

It is our experience that it will be important for the NDIS to support indirect costs such as recruitment and orientation of staff including specific safety training for providers in rural locations.

It will be necessary for the NDIS to consider specific funding such as funding to overcome the issues of telecommunications 'black spots' which discourage service providers from outreach.

We support the principles articulated in the National Aboriginal and Torres Strait Islander Health Plan 2013-23, and their application to this arena of insurance. These include:

- taking an equity and human rights approach
- ensuring Aboriginal and Torres Strait Islander community control and engagement, and
- accountability.

In our view, it will be important for the NDIS to overly support similar enablers to those articulated in the National Aboriginal and Torres Strait Islander Health Plan. If that is done, then we are confident that the needs of Aboriginal and Torres Strait Islander Australian will be able to be met.

5.12 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?

Our members have expressed the view that the market model will have a significant and negative impact on collaboration and co-operation between providers. Although our profession places substantial emphasis on professional ethics and our members would endeavour to ensure that participants were not disadvantaged, the structural arrangements appear to mitigate against this.

6. Governance and administration of the NDIS

6.1 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?

We are concerned about the impact of the existing administrative and governance arrangements on the way in which the NDIS operates and on the long term costs of the NDIS.

The payment failure in 2016 illustrates our concerns.

The Final Report on the MyPlace Portal Implementation Review indicates that:

“... the change effort and overall program was under-resourced and underprepared in order to provide the accurate and timely support required by participants and providers when faced with ICT challenges. ...

The NDIA was less effective at managing the inherent risks of complexity, maturity and scale against a finite completion date.”⁷

We are concerned that the operating costs of the Scheme were inadequate for such an important activity and arguably, the operating costs need to be considered in the light of the work planned, including the ability to manage risk and prepare for such major changes.

We are concerned that an imperative to move quickly through a roll-out will have ongoing effects.

As a result of the (under)resourcing at this point in the roll-out of the Scheme, we foresee substantial, avoidable costs being incurred through the way in which the Scheme is managed.

The first of these costs is likely to be in the human resource costs of the NDIS. Our members have reported a number of instances in which staff delivering the telephone services of the NDIS have made overt, negative statements about the NDIS.

From our perspective, this signals a significant problem with staff morale which is likely to lead to high rates of avoidable leave, compensation claims and turnover. We believe that it would be prudent for the NDIS to systematically explore the issue and make provisions for the current and future cost of this situation; and more importantly, for its remediation.

The second of these costs is likely to be in the ‘marketing’ and ‘communications’ area of the NDIS. As a result of problems in a number of areas, including those with the payment gateway and those with delays in planning, we believe that the NDIS has lost the fundamental trust of many of its stakeholders. Our members have told us that there is, increasingly, an ‘in’ group of stakeholders and providers; and an ‘out’ group. We are concerned that this is a sentinel signal of an ‘exclusive’ approach by the NDIS.

Our members believe that the culture of the NDIS needs transformation in order to improve the managerial and administrative arrangements that are central to the provision of services and to creating high value for the delivery costs incurred.

Rebuilding trust incurs a real cost to the NDIS – one that we believe will be substantial as the NDIS must demonstrate its reliability and consistency at all levels. It will also need to demonstrate a different tone to many of its communications, as these are seen by members as defensive and demonstrating a lack of willingness to work authentically with key stakeholders.

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

Regulatory safeguards and quality controls need to be seen in the context of three other mechanisms for regulation – regulation by the market, and professional self-regulation (at the level of the individual professional and of the profession as a whole).

We support a model of ‘modern regulation’.

In some environments where there is insufficient workforce, significant distances between some providers and participants and diverse needs in the client population, there is a demand on some therapists to work across all age groups and often all disability types. Although the physiotherapy profession is active in promoting the need to remain with scope

of practice, the way in which provider registration occurs sends some signals that a wide scope of practice is accessible once registered.

There are a number of mechanisms that will assist to ensure safety and quality which we canvass in the following section.

While commending the principles of the Scheme, our members are concerned about a risk that they envisage for those people who are eligible for a Disability Support Pension and entry into the NDIS subsequent to conditions of persistent/chronic pain.

Our work suggests that the majority of the community, many patients experiencing such conditions, and indeed many health practitioners, hold outdated views regarding ongoing and complex pain states. This includes a poor understanding on the underlying pathology in such cases, and what are appropriate care and management strategies.

It is recognised that there is a risk that a person in this cohort may choose to access care that research would suggest is of no benefit or indeed be detrimental to the management of a pain condition. They may believe having the chance to receive more passive modalities is preferable than those that are based on principles of self-management of chronic conditions where active approaches are key.

This may unwittingly be supported by administrators within NDIA if they lack the expertise and experience to recognise a treatment idea as inappropriate. There is a need to ensure the management that is funded is appropriate and delivered by clinicians whose practice is informed by evidence based care.

The worst result for clients is that a care plan may be devised that, rather than being beneficial, is actually harmful to a person's long term health status. If this is sanctioned by the NDIA, in addition to bringing poor clinical outcomes, it will be an inappropriate use of limited resources.

A potential solution may be that care plans for this group of people with persistent/chronic pain are required to be supervised and approved by clinicians working in the specialty field (e.g. Pain Medicine Consultants, or Physiotherapists or Occupational Therapists who are recognised through their enhanced qualifications in pain science and pain management or through their job title or description) as being able to ensure any care plans are informed.

This may slow processes down, and create extra administration costs at the beginning. However, this will bring significant savings by ensuring providers are offering only the most relevant and effective care options.

Although these concerns are predominantly for those NDIS participants whose primary disability arises from complex and persistent pain conditions (e.g. significant low back pain that is preventing engagement in vocational activities), it is a concern for many people experiencing other disabilities.

The co-morbidity of pain is a major compounding factor in the care of numerous other life-long conditions, and will need to be addressed rigorously in order to ensure that participants, the Scheme and the community reap the most value from the model that rolls out.

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

Our members are concerned about the way in which the NDIS will manage a number of key tasks that may be seen to be part of its market stewardship.

One of these is the way in which the NDIS will manage calls for third party accreditation of the safety and quality of services.

Physiotherapy, judged on criteria such as the rate of physiotherapists who are subject to notifications to the Australian Health Practitioner Regulation Agency (AHPRA) and the cost of professional indemnity claims, is a comparatively safe service. To date, many members have indicated that the economic case for third party accreditation has not been made. This is because:

- the models of third party accreditation remain comparatively costly, and
- the data such as that referred to above demonstrates their adherence to standards is high.

We continue to see inconsistency in the recommendations and requirements for quality markers at practice/organisation level, including differences between the Third Party Verification requirements in New South Wales and those elsewhere.

We are aware that the Council of Australian Governments (COAG) agreed in December 2016 that work would begin to implement a National Quality and Safeguards Framework. Although we have been advised that this is expected to simplify the registration requirements for providers, it is unclear whether the Framework will impose a model of third party accreditation.

We continue to be concerned that the NDIS may move to require third party accreditation for providers when there is limited evidence that the costs will incur a net benefit to the participants in the Scheme. We also believe that any requirement for third party accreditation will structurally disadvantage smaller providers and distort what is already a 'failed market'.

The APA is working consistently on safety and quality initiatives and our members consistently seek to improve safety and quality. What is at stake here is not our commitment to safety and quality, but access to services and the bearing of disproportionate costs.

A second central task of market stewardship which concerns our members is the way in which the NDIS will work with the professions in quality improvement.

Our experience has been that other insurers (e.g. our professional indemnity insurer and health insurers such as private health insurers) have been active in developing ongoing forums in which key data from their schemes is disclosed and issues of mutual concern are discussed. This interaction is a critical support for a profession that is active in self-regulation.

Our organisation is yet to be invited to any discussion about the trends in outcomes for participants in the NDIS, the related costs, service patterns, or variations by geography or other factors.

Although we understand that the roll-out is still underway, we are concerned that the NDIS sees professional peak organisations as only having a role as conduits of operational information to service providers.

Our organisation plays a critical role in supporting the profession with:

- specialised education
- clinical guidelines
- skills in costing and developing services
- ethical issues.

Members of the APA with a specific interest in the enablement of people with disability are beginning the task of developing specific guidance for their peers in the field who provide services subsidised by the NDIS.

This task would be substantially strengthened by information about the key areas of variation, in which support information may be of assistance. This model has been adopted by the

governments in their work with the Australian Commission on Safety and Quality in Healthcare, where we have been ongoing participants.

The governments concerned about this variation have funded the development of guidelines aimed at reducing unnecessary variation. We are keen to see the NDIS undertake a similar program, bringing participants, providers and independent experts together.

It is our view that a no-fault insurer, with few of the improvement 'levers' available to fault-based schemes, needs to take an active, inclusive and explicit path in this area.

7. Conclusion

The APA is committed to the success of a National Disability Insurance Scheme. This submission reflects the willingness of physiotherapists and the APA to collaborate with the NDIA and its stakeholders to ensure that consumers, providers, and the community generally derive maximum value from the investment that all are making in the NDIS.

Australian Physiotherapy Association

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 23,000 members who conduct more than 23 million consultations each year.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

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