PRODUCTIVITY COMMISSION

NATIONAL DISABILITY INSURANCE SCHEME (NDIS) COSTS – POSITION PAPER

OCCUPATIONAL THERAPY AUSTRALIA (OTA) SUBMISSION

JULY 2017

Occupational Therapy Australia Limited ABN 27 025 075 008 | ACN 127 396 945
6 / 340 Gore St. Fitzroy VIC 3065
Ph +61 3 9415 2900 | Fax +61 3 9416 1421 | Email policy@otaus.com.au | Website www.otaus.com.au

Introduction

Occupational Therapy Australia (OTA) welcomes this opportunity to comment on the Productivity Commission's position paper on National Disability Insurance Scheme (NDIS) costs.

Occupational Therapy Australia is the professional association and peak representative body for occupational therapists in Australia. As of December 2016 there were more than 18,000 nationally registered occupational therapists working across the government, non-government, private and community sectors in Australia. Occupational therapists are allied health professionals whose role is to enable their clients to participate in meaningful and productive activities.

Occupational therapists provide services such as physical and mental health therapy, vocational rehabilitation, assistive technology prescription, home modifications and chronic disease management, as well as key disability supports and services.

OTA is a strong supporter of the NDIS and the scheme's focus on providing individualised support for participants with informed choice and control over their plans. Occupational therapists worked across all NDIS launch sites and contributed to the design and implementation of the scheme during its trial period. They are continuing to support participants as the scheme transitions to full rollout.

OTA commends the Productivity Commission for its comprehensive analysis of the NDIS rollout and its identification of the scheme's strengths and weaknesses. The following observations address some of the position paper's specific recommendations.

OTA agrees with draft finding 2.4, that the NDIS is improving the lives of many participants and their families and carers, but also agrees with the observation that some participants, notably those with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes. OTA draws the Commission's attention to our submission to an inquiry conducted by the Australian Parliament's Joint Standing Committee on the NDIS into *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*. This submission is available on the Committee's website or at: https://www.otaus.com.au/sitebuilder/advocacy/knowledge/asset/files/107/otasubmission-provisionofservicesunderthendisforpeoplewithpsychosocialdisabilities.pdf

Scheme eligibility

OTA notes that the Commission is seeking feedback on the advantages and disadvantages of maintaining List D – Permanent Impairment/Early Intervention, Under 7 years – No further assessment required. OTA has received feedback from families of children that the delays between receiving approval for NDIS funding and the plan being developed and operational, places them under emotional and financial stress to continue providing therapy supports for their young children. Families have often needed to complete a prolonged and expensive assessment process in achieving a diagnosis. OTA supports any initiatives that reduce the burden on families to access early intervention. Families need to be educated and supported at each plan review to ensure that their child is benefitting from the supports and that they are achieving their goals.

OTA has noticed with concern the haste with which state and territory governments are scaling back or dismantling the supports and services on which disabled people have depended for decades. This course of action reflects a belief on the part of these governments that disability support is soon to become exclusively the concern of the federal government. This is not the case, and OTA shares the grave concerns of those caring for people who have been, and those who will be, deemed ineligible

for the NDIS. What is to become of these people as their traditional supports and services are withdrawn?

OTA notes that any disabled person aged over 65 years is, ipso facto, ineligible for the scheme. And confusion over eligibility for the NDIS is perhaps most pronounced for those experiencing mental health problems. Given the lack of clarity around the access criteria for the NDIS for people with mental illness, it is clear that a significant number of people will be deemed ineligible. It was recently reported that more than 100,000 people with severe mental illness who are currently receiving services will not be eligible for the NDIS.[1] There will only be 64,000 NDIS places allocated for people with psychosocial disabilities once full rollout of the scheme is complete, meaning that many people could miss out.

Although OTA is supportive of the NDIS, it is critical that funding for the scheme does not come at the expense of existing programmes and services for people with mental health conditions. The growing focus on the NDIS has meant that other federally funded initiatives have become something of an afterthought, despite the fact that people with mental health conditions who are not eligible for the scheme are likely to significantly outnumber those who are. Following the release of the NDIS Quality and Safeguarding Framework in early February, industry stakeholders immediately raised concerns that the rights of people with disability who are not NDIS participants would not be protected.[2]

It is feared that the transition of funding for federal programmes and services to the NDIS will increase pressure on the very state-funded services that it now appears are being scaled back, leaving many worse off. This is despite the Federal Government's commitment to ensuring continuity of care for those who are ineligible.

Occupational Therapy Australia joins with Mental Health Australia in calling on the Federal Government to provide separate funding for Personal Helpers and Mentors (PHaMs) services, rather than draw on funds from the National Disability Insurance Agency (NDIA) budget. This will ensure that funding that has been set aside for the NDIS can be directed towards those with severe and complex mental illness. Additionally, we endorse Mental Health Australia's recommendation that $150 million be provided for the Partners in Recovery (PIR) initiative once it transitions to the NDIS, in line with the estimated cost of PIR when it was announced in 2011.

OTA believes that one area that should be given particular consideration within the scope of this inquiry is early intervention. While the NDIS has the potential to benefit a great many people with disability, the scheme's focus on investing in people early on to improve their outcomes later in life opens up significant opportunities for children with disability. Occupational therapists are key providers of early intervention services to children through the Helping Children with Autism (HCWA) and Better Start for Children with Disability (Better Start) initiatives. It is understood that children receiving services through these initiatives will transition to the NDIS if they are deemed eligible, while those who are not eligible will continue to receive support through these existing programmes.

Occupational therapists are well placed to provide practical, thoughtful and functional support to children and parents with mental health concerns. Our members who provide services to children through government programmes such as HCWA and Better Access to Mental Health (BAMH) have

[1] http://www.theaustralian.com.au/national-affairs/health/100000-mentally-ill-lose-ndis-cover/news-story/3f2363653fc5e86044f4ae2116395273

[2] https://probonoaustralia.com.au/news/2017/02/concerns-ndis-quality-safety-framework-forgets-majority-people-disability/

found that the number of focussed psychological strategies and/or interventions approved through these initiatives is very limited. This is causing families great financial burden. Additionally, strategies and interventions that are funded do not always take into account the skills that occupational therapists can offer children and their families.

Occupational therapists are further hampered by the fact that general practitioners and paediatricians often overlook the services that occupational therapists provide, resulting in limited referrals for their services.

Consideration should be given to increasing the number of assessment and treatment services available through programmes such as HCWA and BAMH. This will ensure adequate support for people who are not eligible for the NDIS. We also recommend that the number of claimable allied health services available through the Medicare Benefits Schedule (MBS) be increased to allow for follow-up and other evidence based best practice interventions that are currently excluded.

General Practitioners should be provided with comprehensive information on the various services funded through Medicare to ensure that referrals are consistent with a client's therapy needs – for example, referring a client with mental health concerns who requires a functional needs assessment to an occupational therapist rather than a counsellor.

Scheme supports

OTA supports draft recommendation 4.1. There is a widely held belief among participants, carers and providers that phone planning is an inadequate means of assessing a participant's needs. Phone planning should not be used in the development of a participant's initial plan and, if it is to be retained for plan reviews, new protocols should be introduced to improve its effectiveness.

Draft recommendation 4.2 is strongly supported.

OTA believes that occupational therapists should play a key role in working alongside NDIS Planners to assess and understand the functional needs of NDIS participants. Following extensive consultation with OTA members, it is apparent that Planner inconsistency is a significant issue nationwide. The quality of NDIS plans varies considerably from person to person, and depends on the Planner's level of experience and understanding of the different services available to participants. This is true for people with a range of disabilities, and not limited to those noted in the report as requiring 'specialist knowledge, such as psychosocial disability'.

Due to the fact that Planners are recruited from a variety of backgrounds, their understanding of appropriate options to support participants to achieve their goals, and the role of occupational therapists in this process, is often poor. It is clear that NDIS Planners frequently underestimate the hours of therapy required for a participant to achieve their goals, which subsequently affects the quality of their plan. OTA acknowledges that some Planners do have an allied health background and have developed plans that adequately reflect the complexities of a participant's needs. But many NDIS participants and their carers have been left frustrated by a lack of face-to-face contact with Planners. Moreover, Planners are often difficult to reach, resulting in providers having to advocate on behalf of participants.

There are also inconsistencies with regards to Planners requesting reports from therapists in support of a participant's need for particular services. When reports are requested, therapists are often given insufficient time to provide these to Planners. Providers frequently request plan reviews if a participant's plan does not adequately reflect their needs, or if their circumstances change and they

require additional supports. These reviews can take months to complete, resulting in added frustration for families and potentially affecting the relationship between participant and provider. In addition, the long wait associated with plan reviews frequently results in any progress that the participant has made towards their goals being lost due to lack of continuity. This ultimately results in increased supports being required to re-establish progress.

OTA believes that the training provided to NDIS Planners should be revised to provide for more comprehensive participant plans and to reduce the frequency of plan reviews. Our understanding is that the in-house training provided to Planners is very much focused on the policies and processes of the NDIA rather than the roles of health professionals who deliver supports. Planners should be required to have a minimum understanding of disability related function and goal setting, therapeutic supports and their value in assisting participants to develop key skills and enhance their independence. An important example may be the need to anticipate and include in a plan therapy time for the prescription of, and progression to, more supported assistive technology, such as a motorised wheelchair for an individual with a progressive neurological condition. Should a Planner lack skills to anticipate this need, a plan review will be required.

OTA recommends that consideration be given to how the skill level of Planners can be increased with respect to occupational therapy practice. We also call for the training of NDIS Local Area Coordinators (LACs) and Support Coordinators to be enhanced to allow for greater understanding of the roles of different health professionals. NDIS providers should be consulted throughout the process of developing or refining training material.

OTA is engaged in ongoing discussions with Allied Health Professions Australia (AHPA) around developing material to increase Planners' knowledge of the different allied health professions. OTA believes that the NDIA should develop a set of key performance indicators (KPIs) to monitor and assess the performance of Planners and the overall effectiveness of the NDIS planning process. There should also be clear timeframes for Planners to action requests for plan reviews and to respond to queries from participants and providers. The NDIA should consult more widely with participants and providers on the planning process to address specific concerns and ensure that the performance of Planners is in line with community expectations.

To support participants and the planning process, OTA also supports draft recommendation 4.1 that the NDIA implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review. This recognises that life circumstances can undergo degrees of change. It also enables some flexibility when the therapy supports required to work on goals are not initially planned for appropriately by less experienced Planners.

OTA members have also reported that NDIS Planners often do not appreciate how important it is for occupational therapists to perform assessments and provide services within the environment in which the client primarily functions on a daily basis (eg. home, school, workplace, residential aged care facility).[3]

[3] There is considerable academic evidence to support the need for occupational therapists to observe how a client functions across a range of settings. Howe and Briggs (1992) state that it is the responsibility of the occupational therapist to consider the whole context when undertaking an assessment, including the home, school, workplace and community. Dunn et al. (1994) state that occupational therapy is most effective when it is embedded in real life – that is, when the occupational therapist can modify an occupation in the actual setting where it takes place. Ciampa et al. (2016), in a study looking at work integration, also support the need to undertake assessment in the setting where the occupation takes place.

This will subsequently affect the quality of care that a client receives, as home assessments are an integral part of occupational therapy. Assessments designed to determine a client's need for assistive technology and home modifications simply cannot be done in a clinic or over the phone, and private practices will be reluctant to offer these services to NDIS participants if the amount they can claim for travel does not reflect the costs incurred. This dilemma is particularly pronounced for people living with disability in regional and remote areas, participants who have already been identified as most at risk from any shortcomings in the scheme.

An occupational therapist working in a regional area noted that they can spend two to three hours driving to see a client. This provider's clients have complex support needs, and as such it is not practical for the client to travel in all cases. Furthermore, the complexity of the clients' needs means that a smaller pool of therapists with particular expertise are required to consult with these clients. It is becoming increasingly difficult to have travel included in NDIS plans, and this occupational therapist feels that clients' choice and control is being undermined as a result of therapists' travel being restricted in some newer packages.

OTA notes that there is a lack of clarity around the issue of claimable travel related to therapeutic supports. The 2017-18 Price Guide which appears on the NDIS website and was updated as recently as 1 July this year, states:

Providers can claim travel time at an hourly rate for the relevant support item for travel in excess of 10km, up to a maximum annual limit of $1000 per participant (per annum).

Does this mean a participant has a maximum of $1000 per annum to offset the travel costs of a team of different providers or $1000 per annum per service provider? If the former, it is conceivable that one provider who sees the client multiple times within a short period may fully expend the funds available, leaving nothing for another provider who may need to consult with the client at a later date.

It is paramount, and also best practice, for functional assessments to be conducted in the participant's environment. The potential for an occupational therapist, in particular, to have restricted access to a participant's environment will restrict service provision and potentially compromise clinical outcomes.

Our members have also reported that it is difficult for providers to keep track of the amount that has been spent and what remaining funds are available. While therapists can try to see multiple clients in the same geographical area on a particular day, this is not always possible and does not give participants choice and control over their supports – in this case, choosing where they would like to see a provider. One therapist reported that they work predominantly with children and sometimes provide services in schools. They try to schedule appointments at times that are most suitable for the school, however this may not be possible if travel costs are capped at $1000 per year. The same therapist noted that they currently charge a flat rate based on overall kilometres travelled (beyond 10 km from their place of work), as they are currently working across funding streams and charging for provider travel at the hourly rate is out of scope for other government-funded programmes. In effect, this provider is not being paid anywhere near the amount that is stipulated in the Price Guide. They also work in a rural area that does not seem to be classified as such in the Price Guide, and are regularly required to travel up to one hour each way to consult with clients.

Finally, members have noted that there is a lack of clarity around the circumstances in which the travel limit applies (eg. when participants are self-managing part of their NDIS funding or if their plan is being managed by someone else). All OTA seeks for the profession is that travel, which is an

essential tool of trade, be fairly reimbursed. It is not about assisting practitioners to make a profit – it is about fairly covering costs.

Just as occupational therapists must travel to consult with clients, they are also obliged to complete more written documentation than other allied health professionals. Traditionally this has involved significant report writing around initial and subsequent client assessments, and the considerable paperwork around the design of home modifications and the prescription of assistive technology.

Under the NDIS, the assessment role is effectively shifted to the NDIS Planner, and is based largely on goals and issues identified by the client or carer. It is then that the occupational therapist is approached with these identified issues. This has significant implications for the occupational therapist's documentation process. The occupational therapist may have to evaluate the assessment of a new referral in order to address the goals as identified by the Planner, but this time may not funded. When occupational therapists receive new referrals under the NDIS they need to incorporate any report writing into the session time, unless funding is provided for written reporting. Unless report writing occurs during session time or is funded, it represents a threat to a practice's ongoing viability. Medico-legal considerations and the requirements of the Australian Health Practitioner Regulation Agency also dictate that thorough client records be maintained by our members at all times. So the paperwork burden is constant but, under the NDIS, sometimes uncompensated.

Any price review of the NDIS needs to address this reality and develop a means of incorporating this professional necessity into funded services. And again, Planners need to understand the extent to which report writing is a core element of the occupational therapist's service provision, and of the importance of factoring funded report writing into a participant's service agreement.

OTA would be happy to assist in the development of training modules that promote and support this understanding on the part of Planners.

Similarly, participants need to be made fully aware of the fact that the prices set for therapeutic supports take into account preparation time and report writing.

Boundaries and interfaces with the NDIS

Draft recommendation 5.2 addresses service gaps arising as mainstream and disability services interface due to uncertain arrangements and service access limitations in a range of jurisdictions.

OTA considers that the NDIA should not only report on, but address, known boundary issues relevant to mainstream and disability service interface as they are playing out on the ground. A significant example is reported by occupational therapists working with school-aged students with disabilities, resulting in vast differences in access to therapy services for children living in different jurisdictions across Australia. Discretionary access to NDIS-funded therapy services in the school environment, based upon principal and school jurisdiction preference, means that the education/disability interface is seamless for some, and acts as a significant barrier to both funding sources for therapy for others. For example, children with a disability living in Queensland have vastly improved access to school-based occupational therapy services compared with those living in Victoria. Such inequity needs to be addressed via a national disability scheme.

OTA has addressed this issue in detail in our submission to the 2015 Senate Inquiry into Students with Disability. In the Senate Committee's report, released in January 2016, recommendation 9, made to government, states: "The committee recommends the government work with states,

territories, experts, stakeholders, school systems, parents and students to establish a national strategy to improve the education of students with disability". The full report accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/students_with_disability/Report

Provider readiness

OTA supports draft recommendation 6.1 and makes the following observations.

The body tasked with price regulation for the scheme and the collection of data on providers' characteristics and costs should take into account the various expenses incurred by the different provider groups. As noted above, occupational therapy involves much greater travel and paperwork than the other allied health professions.

OTA endorses the recommendation that any price model be reviewed and published on an annual basis and be the subject of public consultation.

OTA notes draft finding 6.1 regarding thin markets and shares the Productivity Commission's concern that market failure is likely to occur without effective government intervention. Such failure would adversely affect some of Australia's most vulnerable people so OTA would support the implementation of some or all of the courses of action suggested by the Productivity Commission, namely:

- Cross-government collaboration;
- Leveraging established community organisations;
- Using hub and spoke (scaffolding) models;
- Relying on other mainstream providers; and/or
- Block-funding or the direct commissioning of disability supports.

Workforce readiness

OTA strongly endorses draft recommendation 7.1 and commends in particular the suggestion that state and territory governments play a greater role in the identification and amelioration of problems relating to the development of an effective disability workforce. Irrespective of funding arrangements, the NDIS must not be seen as an opportunity for state and territory governments to withdraw from the disabled sector.

With regard to information request 7.1, OTA notes that one factor affecting the supply and demand for allied health professionals in the disability sector is the availability of mentoring and clinical supervision for new graduates. It is critical that clinicians who have recently entered the workforce have access to professional development opportunities to enable them to adapt to a changing market environment and to prevent high turnover rates.

OTA believes that funding should continue to be provided for workforce readiness initiatives in the form of workshops and training programmes that promote evidence based interventions for people with disability. This should include training for allied health professionals to assist them to transition to the NDIS. OTA is supportive of initiatives such as the Sector Development Fund (SDF) and Innovative Workforce Fund (IWF), which allow individuals and organisations to apply for grants to support the development of the disability workforce.

There is ongoing concern about the availability of disability care and support workers in rural and remote areas, particularly in the Northern Territory. In particularly remote areas, where the market is small, a service provider may also have to serve as a participant's support coordinator, giving rise to possible conflicts of interest through no fault of their own.

There is also the ongoing problem of relatively inexperienced service providers working in remote areas where there are minimal, if any, supervision or mentoring structures in place.

Providers working in areas that are especially remote can be also be disadvantaged by a lack of Internet access. OTA acknowledges that providers will often be required to travel considerable distances to deliver services to clients in remote communities. However, more should be done to improve the quality of service delivery in remote Indigenous communities, such as consulting with Indigenous elders. Ensuring that providers are equipped to provide culturally responsive services to Indigenous Australians will remove many of the current barriers to servicing this client group.

Participant readiness

OTA members have supported participants who receive either support co-ordination or Local Area Co-ordination (LAC). It has been noted that the LAC had very limited time to support the participants to engage with providers and that the participants were reporting that they didn't feel they had the adequate skills to implement their plan. It will be important that LACs are sufficiently staffed to assist participants with building capacity to manage their own supports.

Governance

OTA endorses all draft recommendations under this heading and, in particular, draft recommendation 9.4 which calls for greater performance reporting by the NDIA and the direct measurement of performance against the scheme's objectives.

We also strongly endorse draft recommendation 9.5 which asserts that the NDIA needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.

With regard to information request 9.1, if a decision is made to delay the transition to the NDIS in some areas, slow down the scheme's rollout across the board, or prioritise some participants over others, any such decision must not adversely impact would-be participants. Once again, it falls to state and territory governments – who would presumably be party to any such decision – to ensure they have the necessary supports and services in place for those people put at risk by any changes to the scheduled rollout of the NDIS.

Funding arrangements

Existing escalation parameters are indeed unlikely to reflect the full increase in NDIS costs over time and this will result in the Australian Government bearing a higher share of the scheme's costs over time. It is also true that, as arrangements currently stand, the Australian Government "bears all the risk of any cost overruns, but not all the control".

This is the result of the scheme's flawed design and, unless addressed, threatens the scheme's long-term viability. All Australian governments should accept this reality and come together in a spirit of

cooperation to design a funding arrangement that more closely ties authority to manage risk with funding liability.

Other matters and conclusion

Occupational Therapy Australia agrees with the Productivity Commission's assertion that the NDIS, if implemented well, will substantially improve the wellbeing of people with disability and Australians more generally. However, and again as noted by the Commission, the speed of the rollout and a focus on participant intake rather than sound planning, is putting the scheme's success and financial sustainability at risk.

Of concern to OTA and our members is the failure of many of the scheme's Planners to recognise and allow for the costs incurred by given provider groups. In the case of occupational therapists these are primarily travel and paperwork related.

OTA also supports targeted investment in proven workforce readiness initiatives.

Another problem that needs to be addressed as a priority is the inadequate channels of communication between the scheme's key players. Participants and their carers should be able to reach the NDIA within a reasonable period of time, and the agency's undertakings to return telephone calls should be honoured. If the development of plans must be done over the telephone, which is by no means ideal, then new protocols and training should be implemented to ensure that Planners are well placed to produce evidence based plans that best reflect the support the needs of the individual participant.

Our members have reported that the provider section of the NDIS website can be difficult to navigate, as providers are required to sort through an abundance of information to find what they need (such as a particular set of guidelines). There is also a lack of user friendly information for prospective providers who are interested in learning more about the scheme. OTA believes that the NDIA should adopt a co-design approach to developing operational guidelines. Providers often have no input into these or any opportunity to submit feedback on whether what has been proposed will work in practice.

Some occupational therapists have reported that the registration process can be quite lengthy, which may deter some people from signing up as providers. As noted above, another issue is the fact that providers quite often receive no response to phone calls and emails from NDIA staff. This could present a barrier to entry for new providers who may wish to speak to someone or ask questions about the scheme.

OTA agrees with the Commission's observation that *Some disability supports are not being provided because of unclear boundaries about the responsibilities of the different levels of government* and strongly endorses the conclusion that *Governments must set clearer boundaries at the operational level around 'who supplies what' to people with disability, and only withdraw when continuity of service is assured*.

OTA accepts that shortages in the disability workforce may need to be mitigated by tailored responses, including better price monitoring and a degree of regulation.

Given that many of the existing scheme's problems stem from fundamental shortcomings in its design and governance, OTA believes Australian governments should come together in a spirit of

cooperation to design a funding arrangement that more closely ties authority to manage risk with funding liability.

Occupational Therapy Australia thanks the Productivity Commission for the opportunity to make a submission on these important matters.