National Disability Insurance Scheme (NDIS) Costs

Overview

The comments below relate to direct care work. A lot of generalisations have been made about the pricing of supports. Providers in general refer to the price for direct care work being below cost while participants claim they are being charged more by some providers. This usually relates to Allied Health and other services, but not direct care work. The NDIA claims they are receiving divergent views on pricing but never mention which supports are being referred to and therefore little analysis is provided on the different pricing of supports.

We are aware that some agencies, based on online employment platforms, can provide direct care for below the NDIA price. This is because of their business model which links participants with workers and has very low overheads. They do not organise the support, they do not do rostering, they do not directly supervise workers, the participant has to replace the worker if they are sick or on leave, they do not provide training for workers and leave the determination of the quality of the work up to the participant. This may suit some people who self manage and have the time to undertake these tasks. The fact they do not provide an holistic service and therefore have a lower cost that should not be the basis for assessing the direct care cost for participants who want a service provider to provide the above tasks as part of their support.

For evidence of the price issues raised below please the National Disability Services paper: https://www.nds.org.au/news/ndss-submission-to-ndis-price-controls-review-highlights-inadequate-prices-for-ndis-supports

I have also attached the Ella Centre's submission the NDIA on their Price Control review which outlines the issue on the impact of the NDIA pricing with specific evidence on the Ella Centre.

INFORMATION REQUEST 6.2
What changes would be necessary to encourage a greater supply of disability supports over the transition period? Are there any approaches from other consumer-directed care sectors — such as aged care — that could be adopted to make supplying services more attractive?

The maximum price for direct care work and its limitations, such as it being based on SCHADS Award grade 2, the expected face to face contact time (95%) and very limited training time, leave little time for creativity, innovation or skill development. It limits staff as there is no progression up the levels of the award as is it is a fixed price. Aged care do not have a set price per support as per the NDIS price guide that limits support on a per hour unit and the rate a staff member can be paid.

The NDIS is supposed to involve a shift away from a block-funded welfare model of support, to a fee-for-service market-based approach. The market based approach is hindered by the NDIA setting maximum prices. There is no reward for organisations or staff to provide high quality services, which have a cost, as you cannot be compensated accordingly. It means all workers have to do is the bare minimum to keep participants happy so they will stay with the service. There is a conflict of interest with the NDIA setting prices and also being responsible for the financial sustainability of the scheme. We have already seen the planning process impacted by the NDIA as they seem more concerned to get through the expected numbers of participants rather than develop quality plans. The same thing can happen with the costing of supports if it is left up to the NDIA. They can contain costs by limiting the pricing to stay on budget.

In a true market prices would be set by competition, not by the organisation vested in keeping to a budget. We would rather rely on the quality of our service, based on the how we would cost it to include staff development, innovative practices and a participants well being, rather than an artificially low price that only allows for a very basic service and in most instances does not cover the real cost. The unit cost does not allow much time for planning and no time for thinking strategically to look at innovation or creativity at the direct care level.

The NDIA only allow for 8 cancellations. In a true market an agency would be able to charge for every cancellation where it has been financially impacted by a participant cancelling within a specific time frame. It means after 8 cancellations an agency bears the cost of staffing and resources where adequate notice has not been given to redeploy or use such resources. This encourages the use of casual staff, rather than permanent staff, who can be asked not work, providing enough notice is given.

A significant aim of the NDIS is to it substantially improve the wellbeing of people with disability This will only occur if people have choice and receive a quality service. The current pricing is not an encouragement to develop and maintain a highly skilled and experienced workforce. It encourages a low skilled casual workforce to keep costs down. This then inhibits the supply of supports at the lower end of the pricing.

More money into the scheme does not translate to better outcomes for participants, or the viability of the scheme, if certain supports are funded below industry benchmarks and the actual costs of providing certain supports is below there actual cost. If the real cost of providing direct care is not met by the NDIA then service providers will not deliver those services. This will mean a lack of direct care providers and there will be a concentration of agencies only delivering supports that are financially attractive and viable, such as Allied Health.

To meet the needs of NDIS participants, there needs to be an increase in the quantity, quality, range and responsiveness of disability supports supplied. This will not happen if the pricing is not suitable to attract the staff to deliver the service.

INFORMATION REQUEST 7.1
What is the best way for governments and the National Disability Insurance Agency to work together to develop a holistic workforce strategy to meet the workforce needs of the National Disability Insurance Scheme?

Ensure there is scope for skilled and experienced direct care workers to be paid more than a set maximum wage which is currently grade 2 in the SCHADS award. There is no reward for longevity, experience and knowledge and therefore no motivation to stay in the sector. It attracts university/TAFE students looking for work while they study and then once qualified they move on as there is little career advancement in direct care work and people do not go to university to be paid around $25 an hour for the rest of their career. Staff also prefers to work with people with a disability who have less complex needs as there is little compensation for working with complex needs and those with challenging behaviour. While a few dedicated people take on extra training and do work with such participants they are not compensated for their time and effort and locked into one level of the award.

The NDIS will require around 70 000 additional disability support care workers or around 1 in 5 of all new jobs created in Australia over the transition period. It has been reported that present policy settings are unlikely to see enough providers and workers as the scheme rolls out. Emerging shortages are not just about the number of workers available. It is about attracting workers into the sector and providing workers with a reasonably paid job, with training opportunities and the possibility of career advancement.

INFORMATION REQUEST 7.2

How has the introduction of the National Disability Insurance Scheme affected the supply and demand for respite services? Are there policy changes that should be made to allow for more effective provision of respite services, and how would these affect the net costs of the scheme and net costs to the community?

The demand for respite remains high but the services that provided respite are changing as people get NDIS plans. Respite was always a dual service in that it directly supported the Carer to have a break from their caring role, while offering the person with a disability a quality recreational experience. The Carer was the key stakeholder for respite. The emphasis in the NDIS has the person with a disability as the key stakeholder and it would seem the needs of the Carer have been diminished. There seems to be an expectation with the NDIA that by supporting the person with a disability there will be a “respite effect’ for the Carer. This may have some truth and a limited benefit to it but it is not the same as when a service was based on the Carer’s needs. It changes the dynamic of the support and puts aside a Carers need which is a significant change from the previous system.

A number of services in the old disability system were Carer focused. This will disappear as the NDIS rolls out and the NSW State Government hands the money over to the Commonwealth for the NDIS. The needs of Carers will not be meet through the NDIS and the withdrawal of current services will leave a gap and Carers will be worse off than what they were under the current system. Respite is just one service that will be impacted.

Respite is a significant service for many Carers and should not be separated out, as it has been under the NDIS. A Carers ability to function has a direct impact on their son/daughter including their ability to provide informal support. Each participant requires a healthy and supportive Carer and respite was a service that assisted in maintaining a Carers well being.

INFORMATION REQUEST 8.1

Is support coordination being appropriately targeted to meet the aims for which it was designed?

There are two aspects to Support Coordination. The first being where it is being delivered by a Local Area Coordinator, LAC, and the second where it is part of a plan and provided by a service provider. Firstly there seems to be issues with LACs who have no or little experience in working with families who have a son/daughter with a disability. Many participants rely of coordination to be delivered by a person they can trust and have built up a positive relationship. The small amount of Support Coordination in many plans is also an issue. Having a system where a LAC helps a person set up there plan and then leave them to their own devices is a step backwards. This may be useful for some participants who can coordinate their own supports but is inadequate for those who cannot.

Under block funding there were elements of Support Coordination in many programs. This allowed for the answering of day to day questions, managing a person's support, referring people onto other services as required and adjusting support as required. The current support costs do not allow this to occur and has separated it out from being provided on a more holistic basis. Service providers and participants can be separated from contact and decision making with the participant dealing in the first instance deal with a LAC, then an NDIA planner and then a Support Coordinator before they have contact with a service provider. The NDIS system was about removing fragmentation and duplication, but has added an extra layer with LACs.

Support Coordination has added another layer that seems to do little to address the fragmentation that was identified in the previous service system. We now have agencies setting up just to provide Support Coordination and are therefore separate from the support system. While this may look good on paper to eliminate any perceived conflict of interest it creates another layer than participants have to deal with. Support Coordination does not do away with the need for the participant to deal with their service provider, it can just limit their contact.

INFORMATION REQUEST 8.2

Is there scope for Disability Support Organisations and private intermediaries to play a greater role in supporting participants? If so, how? How would their role compare to Local Area Coordinators and other support coordinators?

Are there any barriers to entry for intermediaries? Should intermediaries be able to provide supports when they also manage a participant's plan? Are there sufficient safeguards for the operation of intermediaries to protect participants?

Please also see response to Information Request 8.1

Yes. This is already happening informally. Current participants are seeking support from us as their current service provider. They have no real relationship with the LAC or NDIA and prefer someone they know and trust. They do not have the same access to LACs as they do to us. They see us regularly as we provide their service and they do not like the idea that they need to go elsewhere to ask someone to contact us about the supports we are delivering to them. It adds an unnecessary layer and is ineffective time wise.

LACs could be better utilised by advising new entrants who require support to enter the system and then give them options of the service providers in their area. The participant could then decide on which service could provide their Support Coordination.

Community Options is an example of a service where an organisation, similar to a Support Coordination in that it organised services for people with complex needs across a range of services and organisations. This included being auspiced by organisations that also operated other services. It worked reasonably well with very few concerns about conflict of interest.

Our experience is that most participants want a good relationship with their service provider. They want decisions to be made quickly, not through a 3rd party (ie not by a Support Coordinator separate from the organisation) and to deal with as few as people as possible to organise their support.

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