aftercare

# Productivity Commission Review: National Disability Insurance Scheme (NDIS) Costs

## Aftercare Submission

July 2017


*'Flying the Flags of Wellbeing in Brisbane'*

Participants shared their wellbeing tips and encouraged people to be mindful of the five ways to wellbeing: connect, be active, take notice, keep learning and give.

# Introduction

As Australia's oldest provider of mental health support services, Aftercare has been continuously providing support for those with psychosocial disabilities since 1907. We currently operate services for over 6,000 clients at 54 sites in New South Wales, Queensland and Victoria.

Aftercare has embraced the introduction of the National Disability Insurance Scheme (NDIS) and is now providing services to over 140 NDIS funded clients and is currently assisting with the transition of up to 60 more eligible persons. At a systemic level, the change in funding arrangements from block funded services to individually funded packages marks a powerful shift towards the creation of a person-centred model of support, which can only benefit those with a mental illness.

The establishment of the NDIS however, and the way in which the roll-out has been managed, has had some significant immediate consequences for the service economy and for the viability of services for those suffering from psycho-social disability.

In considering your draft report, we believe there are some systemic issues which have emerged during the trial and establishment of the scheme's operations, which are having a significant impact on our clients. These include:

- The creation of gaps in service type and availability
- Reducing the skilled workforce, especially in regional locations
- Maintaining quality and measuring outcomes
- Transition and market pressures
- Protecting the most vulnerable, especially in relation to access to the scheme, inconsistency of decision-making, and information

We have discussed these issues below.

## Gaps in service type and availability

The redistribution of funding away from existing PIR and PHaMs programs and into the funding pool for packages was based on the assumption that all of those currently receiving service supports would continue to do so under the new arrangements.

This is not the case. Additionally, in some communities the withdrawal of funds from community based support services will mean that many who currently access psychosocial supports will no longer have access to a service, even though their need for support remains.

*While the government has committed that no-one will be worse off, it remains unclear as to how alternative services will be funded for those who will not be eligible for NDIS assistance.*

In some communities the withdrawal of block funded services will create a gap in the provision of services, especially community interaction and support services. As these are not clinical in nature, it is unlikely that the programs that might be offered in the future through primary health networks will address this need.

While the needs of some individuals may be better addressed under the new arrangements, the needs of others and the broader needs of the community may not be so well met. In Cunnamulla, QLD for example, the interdependency of the predominantly Aboriginal community service operations supports not only the immediate participants in the PHaMs program (one of those scheduled to be abolished), but also provides the workforce and infrastructure for other community assistance, including the operation of the local Meals on Wheels.

Of the current 56 participants, it is likely that 12 will receive NDIS assistance because of the age cohort and diagnosis requirements in this small remote town. The town has a fly-in GP and no other health support services. Once funding for the PHaMs program ceases as part of the transition, even those individuals funded by NDIS will not be able to access support services, as it will not be viable to operate them and many providers, including Aftercare, may not be able to sustain a service footprint.

## Reduction in the skilled workforce

It is a likely consequence that the skilled workforces currently providing support services will be reduced, as the current pricing schedule for NDIS does not appear to take into account the currently mandated wage and skills levels for workers in the PIR and PHaMs programs. The skills developed in delivering these services will be lost to the sector overall as redeployment opportunities are limited, especially given the current prohibition on service providers bidding for Local Area Co-ordination contracts.

While the risk of conflict of interest is understood, both the current pricing regime and the procurement rules combine to limit the opportunity to effectively use the skills developed in these Government funded transition programs especially with regard to co-ordination of supports.

We believe the effect of this will be further exacerbated in rural and regional communities where the provider market is likely to shrink, thereby limiting employment opportunities. Individual employment arrangements and direct contracting as a hypothetical model might alleviate some service gaps, but for skilled psycho-social supports, the likely effect is that skilled workers will relocate out of the geography or out of the sector in order to retain or improve their remuneration levels.

This may reduce the availability of assistance and ultimately distort access to the scheme itself,

Within the Hunter trial site, for example, we have a number of clients who are now in receipt of their second plans, and have had their funding reduced because of underspending in plan one; this underspend is the result of being unable to source a suitable provider, not because of a change or reduction in need.

Capacity shortfalls which have existed for some time in the old funding and service provision model are being worsened by the accelerating pace of withdrawal of services from the market.

## Impact of Pricing - Travel

Other service model changes being forced on providers by virtue of the pricing scheme include a reduction in the amount of travel that can be undertaken by staff. Costs associated with travel are not consistently included in funding packages by the NDIA. Services in regional and rural areas currently operate on the basis of considerable travel by support workers, because those skills are not readily available in a single community and access to those skills is therefore viable only when shared across communities. However the NDIS pricing model does not allow for worker travel to be included within the plan and budget, creating a significant cost pressure for providers to bear.

Our own internal modelling indicates that given our service to remote communities, the inclusion of travel costs as an overhead would make delivery of support services involving more than 30 minutes of travel non-viable. Our support workers will need to be providing client facing services for 90% of their rostered working days in order for us to cover the overall operating costs of the organisation (exclusive of travel).

Whereas previously transporting clients was considered to be part of service delivery, we no longer can provide this service, unless the client is specifically funded for it in their plans. Where we previously maintained a fleet of vehicles (thereby contributing indirectly to the larger economy through the purchase, maintenance and running costs of those cars, as well as to the service of our clients), we now no longer do so.

Given the longer distances travelled to access services in country areas, our analysis shows that it is likely that the pressure on rural communities will grow if appropriate cost recovery for travel is not available for skilled workers. The cost

constraint is exacerbating already the existing constraint on trained and skilled workers in the sector.

Again, it appears that the actuarial model used to generate pricing schedules for the NDIS was developed without true reference to or reflection of the workforce shortages that exist for skilled and experience workers. In a market where the demand for specialist as well as non-specialist support work is certain to increase, pricing seems to focus on the lowest mean wage for support tasks.

For example, the prices for services requiring a degree qualified mental health support worker sit below the hourly rate and qualification levels mandated in the Government supply contract for PIR workers. The only way to sustainably deliver these services therefore will be to use a less qualified and experienced workforce, creating significant risk for both client and worker.

## Maintaining quality and measuring outcomes

The cost of compliance and of maintaining accreditation and quality control across service delivery has not been taken into account as part of NDIS pricing. We are not referring to the cost of business insurances and the like, but processes such as working with children checks for staff, accreditation processes for the operation of support services, certification of qualifications and meeting state requirements for accreditation with the children's guardian etc. On average the cost of these services annually is in excess of $100,000. We believe these compliance and accreditation arrangements to be essential to the delivery of appropriate care to the most vulnerable, but note that they reduce our competitiveness in an environment where there is no evidence that an equitable compliance and enforcement regime will be a part of the administration of the scheme by the NDIA.

We also have a strong commitment to quality improvement and use internationally recognised tools such as the RAS and WHO-DAS to assess our client's progress against their goals. This work and the analysis of the outcomes costs Aftercare in excess of $270,000 per annum and contributes directly to the development of academic research and tools and therapies to support suicide prevention and the management of recovery programs.

Our opportunity to continue this work is actively constrained by the failure of performance and outcomes measurement to be included within NDIS activity descriptions, and by the pricing regime which does not allow for costs associated with quality improvement to be included in operational overheads.

## Transition and market pressures

As previously discussed, the progress of transition is not going smoothly, with significant delays in clients being able to access services because of delays in processing applications, assessment and finalising plans.

In its current trajectory, the roll out of the NDIS is not taking into account the impact on the community as a whole, nor is it taking into account the preparedness of the health, housing and education sectors to adapt in pace with the roll out of the scheme.

In one recent example, we were asked to provide accommodation and services to Boarding house residents with psycho-social and intellectual disabilities, when the owner of the Boarding House terminated his leases and closed the services. Clients were all recipients of NDIS benefits, but not supported living allowances, and therefore needed to be re-assessed. This process was “fast-tracked” on agreement between ADHC NSW and the NDIA – but still took 6 weeks.

Clients were evicted and had to be placed in emergency accommodation until the assessments could be completed and they could be relocated into a permanent group home. We undertook responsibility for establishing a group home and completed safety assessments and set up within 2 weeks while awaiting the NDIA assessment, but this would not have been possible without a grant from ADHC NSW to cover the cost of fit-out (furniture, crockery, sheets etc). The NDIA allowance does not cover the cost of any capital outlays.

Transition timing has not taken into account that alternative service models may take time and money to establish and that in the transition current service providers may leave, thereby creating gaps in service provision which have the potential to cause major disruption in people’s lives.

Disconnects mean that parts of the system already under pressure and struggling to keep pace with demand are already at risk of failure.

## Transition timing and market readiness

There appears to have been limited coordination regarding the timetabling of the withdrawal of both Commonwealth and State based funding and services.

In relation to the PHaMs program for example, we were notified of the timetable for withdrawal and implemented a business restructure to address the forecast withdrawal of funds. The timetable for withdrawal was based on the concept that clients would transition into the NDIS immediately. However, the staged implementation for the commencement of NDIS has meant that funds have been withdrawn overall, affecting revenue in areas where clients are not yet eligible to apply for NDIS, meaning no alternative source of revenue is available to support these services or the clients that need them. The degree of cross subsidy required to

keep programs operating in areas where NDIS is not available is significant and administration of this is complex, especially as reporting requirements regarding the management of the grant funding remain.

While Aftercare has moved quickly to embrace a mixed service model, and has upgraded systems to manage services with both grant and NDIS income, the unpredictability of NDIS clients receiving funding is challenging to forecast and to allocate resourcing.

Even in areas where the NDIS is officially available, the process of clients applying for assistance, being assessed and being awarded a plan is taking a minimum of 8-12 weeks. The average time taken to determine eligibility for our NSW clients is currently 16 weeks. There have been instances of up to 22 weeks' time elapsed before eligibility has been confirmed by the NDIA. Finalising a plan through the LAC is commonly taking a further 8-12 weeks.

There are also frequent requests from LACs for services to be provided once a plan is activated but for billing to be delayed for between 4-6 weeks, to allow for "set-up".

This means we can be providing services for clients in transition to the NDIS without funding for up to 6 months.

## Investment in market readiness

The rate at which revenue is being withdrawn presupposes a 100% conversion rate for participants in the program. Our own estimates are that for current participants in the PHaMs programs nationally, (based on their age, diagnosis status and the functional impact of their illness) no more than 67% of current participants will be eligible to receive NDIS assistance under the current guidelines.

The degree of conversion will vary significantly from site to site where current programs are being delivered and may mean that some areas will not have sufficient NDIS clients to provide a revenue stream to support continued operation of the service.

DSS has recently acknowledged that both the rate of transition and the numbers of clients eligible to transition may have been overestimated and have offered a one-off supplementary grant to assist.

The impact of the withdrawal of funds ahead of NDIS funds becoming available to clients has put considerable strain on the cash flow of many providers.

This was further exacerbated in 2016, when the NDIS provider portal failed. Even with manual payments commencing 6 weeks after the problems with processing payment were first identified by providers, many, including Aftercare, experienced delays of up to 3 months in receiving payments for services provided.

Through our on-line directory service ESPYConnect, we received reports of many small providers experiencing severe financial distress, with many forced to lay off staff, and take out loans to cover their operating costs.

While Aftercare was able to call on reserves to cover the period of time in which its' NDIS income was delayed, this event was a significant factor in our decision to withdraw services in WA. The risk to the organisation of disrupted or delayed cash flow is significant and under this pressure, continuing to operate a marginal service with no certainty of revenue growth was perceived as an unreasonable risk.

Our clients in WA have now been transitioned to other services. This has been a setback with regard to our business objective to be a national organisation, but given the uncertainty of revenue forecasts in the current transition environment, we have withdrawn our services, rather than continue to operate at a significant loss whilst waiting for clients to be eligible for NDIS.

In the case of 2 communities in WA, our withdrawal means that the available service capacity in those geographies has been halved. When more clients receive their NDIS assistance, it may be that other providers will be able to expand capacity to meet demand, if they can source the specialist workforce to provide services.

## Protecting the most vulnerable

### Effective planning and clarity along a client pathway

A significant part of the current role for both PIR and PHAMs is taken up with sourcing information and supporting clients to support themselves effectively. For some clients, supporting them to build capacity so they can engage with GPs, assessors and planners is a considerable undertaking. We estimate that for most clients with complex needs (more than 65% of our client population) it takes a minimum of 100 hours of face to face time to prepare an appropriately detailed impact assessment and complete an NDIS application. We are frequently asked to provide this assistance to non- clients as well, as there is limited if any assistance provided via other Government agencies. We are aware of other providers and advocacy groups charging up to $500 per person for this assistance. Currently, we do not charge for our service.

Because we operate a number of different services, both clinical and integrated care models, we have multiple referral pathways, including from both PHNs and LHDs, as well as the NDIA LACs.

Aftercare has established strong relationships with both the PHNs and LHDs with whom it works. One area of particular focus is the development of hospital diversion and transition programs. Aftercare has been running transition programs for 110 years, since its first operations commenced at Gladesville Hospital in 1907. On the basis of that long experience, we believe the current issues lie with the coordination of support services and the agility with which a response can be activated.

To that end, we have been piloting a service in QLD "Floresco". Floresco combines a GP service, with housing, employment and other community support services in the one location. The service also has the capacity to act as a hospital diversion support service, as well as assist PHNs to plan services for those with a psycho-social

disability. The model is based on a well-established approach that exists in Europe. We are seeking to establish these centres in other locations, in collaboration with interested PHNs.

In the context of the interface between care given in an acute setting and what may need to occur to provide lifelong support under the NDIS requires further policy and process development. If taken from a client perspective, a move back into the community following an acute episode resembles a steeplechase – a winding road filled with hurdles, taken at a speed likely to cause further injury. There is no consistent point of coordination between the health entities and with the NDIA for these clients, and the fixed nature of the planning and review process is not responsive to those who may have an illness that is remitting and recurring.

One emerging area of critical failure is assisted accommodation; short term, respite and long term. The weaknesses in the existing system for the provision of accommodation as well as the capacity issues that exist across Australia (and especially in regional areas) have been exacerbated by the advent of the NDIS, which has only served to increase demand.

Connections between agencies for access and placement have deteriorated as the States withdraw from service provision, as has continuity of care and supports. For example, one residential service in Mackay was formally closed on the basis that State funding was being withdrawn as part of the NDIS Agreement. 3 months' notice was given for the dissolution of the service. Clients were relocated, leases terminated and staff given notice. Six weeks after closure, Aftercare was requested to re-open the service as additional funding had been found – for 12 months.

Resident Clients are now being assisted to apply for the NDIS packages. Depending on the time taken for assessments to take place and plans to be put into effect there may again be a gap in revenue to cover the operation of the service – which will only be funded by the State until the end of July of this year. Unlike our experiences with establishing a group home for former Boarding house clients in NSW, there has been no interest or support in pursuing a similar model in Mackay, and we have now transitioned clients to other providers and withdrawn from service in the area.

## Inconsistency in the assessment process and in the provision of information

Our consistent experience over the full period of the operation of the scheme to date is that the eligibility criteria does not adequately consider the episodic nature of psychiatric disability/ mental illness, and the focus on diagnosis rather than physical and psychosocial impact disqualifies many with a demonstrable need for assistance under the scheme.

This can create circumstances where treatment and support needs are not able to be met, leading to the worsening of the person's illness and even the creation of new health conditions. For example, one client suffers from bouts of severe depression as the result of a brain trauma. When in the midst of an episode, he is unable to

attend to basic personal hygiene, clean his house or eat properly. His initial assessment based on his diagnosis resulted in a package that entitled him to counselling, but did not take into account the impact of his condition on his general wellbeing, so he was not provided with assistance for a personal helper, cleaner etc. He is therefore at risk of disease relating to malnutrition, bedsores and skin disorders, which have resulted in extended (avoidable) hospital stays.

*When the impact, rather than merely the diagnosis, is taken into account the suite of care that is identified better meets the objective of the scheme to assist people to lead their best and most productive lives. It is also more cost efficient, reducing the risk of extended and often unnecessary hospital stays.*

In addition to the challenges faced with regard to eligibility definitions which privilege physical disability rather than mental illness, for many of Aftercare's clients the experience of completing an application form is a traumatic and confusing one. The process itself is made more difficult by the limited access to information. In a recent survey of clients, less than 24% used or had access to a computer, so the online application process has been a major challenge.

*The provision of online information and support documentation has proven to be a significant barrier to entry for many clients, who do not access information in this way.*

## Market Failure - coordination

In circumstances where the Government at State and Commonwealth level has been a major provider as well as funder, the withdrawal of services is having a profound effect on what is available in certain local markets. Within the construct of fixed pricing under the NDIS, many services which operated a range of different services are now reducing their service mix in order to focus on those services which will earn the greatest revenue. This is particularly the case with regard to coordination of supports, as an LAC service may not be viable in some communities unless linked to other service provision.

The problem is therefore two-fold:

a) wherever there is not sufficient number of NDIS recipients to allow for the operation of a viable support market, the spectrum of services is likely to shrink; and

b) where government services are withdrawn it may be that alternative providers do not emerge.

*Supports will not be available in the market for both those who <u>are</u> eligible and <u>are not</u> eligible for assistance. While there may be some instances where those with a disability are able to self-fund and purchase services, the majority of those with mental health related disabilities are unlikely to have sufficient income to purchase services in their own right.*

*There is no visibility about what level of funding will be available for those who are deemed ineligible or how this will be made available. The lack of visibility about these arrangements creates considerable uncertainty for providers, who have limited cash reserves. It is also creating uncertainty for clients.*

## Inconsistency, information and skills gaps in the operation of the scheme

The current rules regarding who may operate as a LAC fail to capitalise on the already well-developed, skilled workforce through the delivery of PIR programs - focussed on the tasks of service coordination and planning. Current providers delivering these programs are ineligible to apply for tenders to operate LAC services.

*The experience, network and infrastructure built up within the delivery of PIR programs appears to be redundant under the business rules imposed by the NDIA, and is a source of considerable frustration to clients, who would prefer to have their current arrangements for coordination of supports continue, with access to other services such as living skills development and community activity delivered by the same provider.*

Aftercare believes wholeheartedly in the diversity of our clients, however we are yet to observe that any two clients assessed by the NDIA have received the same package, even when the diagnosis and impact assessments have been highly comparable. Because our services operate across 3 states and a wide geography, we have regular experience of different information requests in different areas in relation to evidence submitted for assessment where the diagnosis and impact is the same or very similar.

Our experience is that there appears to be inconsistencies from geographical area to area as to how the assessment takes place, how long it takes and what evidence is required, as well as with the level of skills and experience an assessor has in relation to psychosocial disability . There appears to be a need for more information regarding criteria and an agreed process that is applied consistently across all geographies and with regards to review of diagnosis, needs assessment and

planning, as well as an upskilling of assessors to deal with the inclusion of psychosocial disability.

### Information for GPs

On the basis of our experience in the trial site and some market sounding we conducted in 2016, Aftercare has developed a toolkit for GPs to explain their role in the application process and how best to assist their patients to access the NDIS and support them to make good planning choices. GPs are inevitably key figures in the processes of NDIS assessment and planning however the feedback we have witnessed is that to date they have received limited assistance from the NDIA in explaining the scheme or what they need to do.

In order to address this information gap and ultimately assist our clients, we have developed materials to provide them with relevant information are in the process of distributing this to NSW, QLD and VIC GP practices at Aftercare's cost.

## Conclusion

Aftercare supports the recommendations of the Productivity Commission's NDIS Cost Position Paper regarding the sustainability and transition of the scheme. The establishment of the NDIS is one of the most profound social reforms in Australia, and we stand at the tipping point of success or failure, as the result of a poorly executed transition.

Many of the issues raised in the Productivity Commission report reflect gaps in policy development as well as implementation. While we remain committed to the further development of person centred funding and support services delivery, there is as yet no clear pathway for those who will not be eligible for the scheme but for him ongoing assistance will be required.

Not only is there no identified source of funds to support needed programs for those outside the scheme, the disruptions caused to current service delivery arrangements and the handovers between services as a result of a poorly delivered transition process, are actively undermining the very principles of the NDIS itself.

Aftercare would like to add one further recommendation to the Productivity Commission Report –

> *that the NDIA establish processes to consult and work collaboratively with providers through the next phase to transition and better utilise the insights regarding service models, cost to serve and coordination of support to improve implementation*

Aftercare has been committed to the delivery of person-centred supports for those with a mental illness for 110 years. We look forward to the establishment of the full

NDIS in the future, with the benefits it will bring for our clients on their journey to wellness.