24 March 2017

Review of NDIS Costs
Productivity Commission
GPO Box 1428
BARTON ACT 2600

Dear Productivity Commission

RE: Review of NDIS costs

Calvary Health Care Bethlehem (CHCB) provides specialist expertise in clinical management, treatment and assessment of progressive neurological diseases. The Statewide, Level 5 service is based on the principles of neuropalliative rehabilitation and sees people with progressive neurological disease from early diagnosis. With a focus on wellness and active engagement in life, the multidisciplinary team work collaboratively with patients and their other local health care providers as partners in care. As a State wide provider CHCB has a role in leadership, liaison, research and education and support for other services.

CHCB have had approximately 10 patients transition to NDIS supports to date. We are registered as a NDIS provider but have not launched provision of services. Our feedback is related to our experience to date.

Calvary Health Care Bethlehem Feedback

Section 3: Scheme Boundaries	
The intersection with mainstream services	
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?	The split is mostly clear. In cases where a health condition causes disability and that condition is not static but progressively declining, there will be a need for both health and NDIS to provide services. How this model is achieved in an integrated, person centred way requires further development.
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?	We have been involved in one case where a gap was identified: the NDIS plan seemed inadequate to meet the therapy support needs for equipment prescription and home modifications, and the Community Health Service who had previously provided that sort of work no longer was able to do so because the plan was insufficient to cover their costs. CHCB were asked to provide services instead as a health service, but the woman was outside our home-visiting catchment area.
How has the interface between the NDIS and mainstream services been working? Can the way the NDIS interacts with mainstream services be improved?	NDIS planners need to be aware of what mainstream supports are being provided within health for a participant. The NDIS planner needs to work with the participant and the health providers to negotiate what will continue to be provided in health and what supports will

	be provided under NDIS to ensure they have access to the right level of care, there is no duplication of effort or service gaps. Service models need to be integrated between mainstream supports and NDIS to ensure a holistic approach for the participant.
Section 4: Planning	
Is the planning process valid, cost effective, reliable, clear and accessible? If not, how could it be improved?	We have evidence that the planning process does not always provide the necessary supports to implement the plan, for example provision of suitable equipment required, and also inadequate therapy supports to assess, prescribe, order and train the participant in use. The planning process does need to ensure it includes information from health professionals in the provision of supports for people with progressive conditions who may be adjusting to their diagnosis and the rapidly progressive nature of their condition and may not be in a position to advocate for their future needs.
How should the performance of planners be monitored and evaluated?	Quality measures need to be in place to confirm if the plan provides supports that meets the participant's goals adequately and monitor gaps. This could include feedback from the NDIS participant to the NDIA. It would also be important to monitor equity of plans across the country. There could also be a feedback opportunity for NDIS support providers to comment on their perception of the appropriateness of plans that have been developed.
Reasonable and Necessary Supports	
Are the criteria for participant supports clear and effective? Is there sufficient guidance for assessors about how these criteria should be applied? Are there any improvements that can be made, including where modifications to plans are required?	For people with progressive disorders, the person's needs can change more rapidly than expected, so there needs to be sufficient flexibility in the plan being reviewed and amended to accommodate unforeseen needs arising. This needs to happen in a timely manner.
To what extent does the NDIA's budget-based approach to planning create clear and effective criteria for determining participant supports? To what extent does it lead to equitable outcomes for participants? What improvements could be made?	The development of reference packages where applied is appropriate. Where a package is found to be outside this, a review by an independent panel including relevant consumers and professionals could assess the plan for advice to ensure equity of access to supports. Individual health planners are not necessarily in a position to ensure supports are appropriate or equitable acting alone.
What implications do the criteria and processes for determining supports have for the sustainability of scheme costs?	Capping certain items is a straightforward way to achieve sustainability (either caps in hours of support that can be provided or cost of equipment items). There also needs to be an opportunity to challenge those caps for exceptional

	circumstances with a clinical review process.
Will providers be ready?	
Are prices set by the NDIA at an efficient level?	The prices for some aspects of the NDIS price guide are too low to achieve viable business models for providers.
What are the barriers to entry for new providers, how significant are they, and what can be done about them?	The main barriers are around price for the provision of some services where the workforce industry standards (EBA) are above the NDIS Price Guide – for example provision of maintenance therapy by an allied health assistant, support coordination provided by a social worker, psychologist, occupational therapist, and group and centred based activities as defined in the guide to suitability. These are issues for CHCB transitioning to NDIS.
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?	The statewide model of care for people with progressive neurological disorders is based on collaboration between providers to ensure the right level of care is provided at the right time. To ensure person centred, proactive care that enables people to meet their goals and maintain their independence, the model needs to ensure integration and good communication between providers. This may be undermined with multiple clinicians from different organisations, without a collaborative approach. There is some risk that clinicians may not have the level of expertise for complex conditions and models that ensure appropriate support need to be considered, within a competitive model. In a competitive market collaboration is challenging.
How ready are providers for the shift from block-funding to fee-for-service?	The pricing for the fee for service does not meet the workforce costs, provided in the block funding. This will be monitored to ensure feasibility of the service.

Yours sincerely,

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cc (if applicable)