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Productivity Commission
Level 12, 530 Collins Street
Melbourne VIC 3000, Australia

To Whom It May Concern,

RE: Submission to the Productivity Commission's Inquiry into National Disability Insurance Scheme (NDIS) Costs

Please find attached our submission to the Inquiry into National Disability Insurance Scheme (NDIS) Costs. This submission responds directly to the Terms of Reference for the Inquiry, with an emphasis on equitable access to human services by Aboriginal people and those factors necessary to enable Aboriginal people to exercise informed choice and control over the care they receive.

Thank you for your consideration of the matters raised in this submission.

Yours sincerely

Jill Gallagher AO
Chief Executive Officer

Response to Productivity Commission Inquiry into National Disability Insurance Scheme (NDIS) Costs

Please note: In this submission the word “Aboriginal” refers to both Aboriginal and Torres Strait Islander People. Direct reference to Torres Strait Islander people and the word “Indigenous” have been used where these are part of a title or direct quote.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) was established in 1996. VACCHO is the peak body for Aboriginal health and wellbeing and also represents Aboriginal community controlled organisations (ACCOs) in Victoria. The role of VACCHO is to build the capacity of our members and to advocate for issues on their behalf. Advocacy is carried out with a range of private, community and government agencies, at state and national levels, on all issues related to Aboriginal health.

Nationally, VACCHO represents the community controlled Health sector through its affiliation and membership on the board of the National Aboriginal Community Controlled health Organisation (NACCHO). State and Federal Governments formally recognise VACCHO as the peak representative organisation on Aboriginal health and wellbeing in Victoria. VACCHO’s vision is that Aboriginal people will have a high quality of health and wellbeing, enabling individuals and communities to reach their full potential in life. This will be achieved through the philosophy of community control.

VACCHO and our members welcome the opportunity to respond to the Productivity Commission’s “Inquiry into National Disability Insurance Scheme (NDIS) Costs”. This submission responds directly to the Terms of Reference for the Inquiry, with an emphasis on equitable access to human services by Aboriginal people and those factors necessary to enable Aboriginal people to exercise informed choice and control over the care they receive. Responses to specific requests for information are incorporated where appropriate.

Our input is drawn from the experience and expertise of VACCHO membership in Victoria. Our Member ACCOs have a cooperative membership structure and offer a range of services to their local communities, including but not limited to primary health services. Other services vary across the members but will often include housing, justice, child and family, social and emotional wellbeing, aged care and disability services and may be affected. As such Member ACCOs have a core role in addressing the social determinants of health. NACCHO uses the term ACCHOs (Aboriginal Community Controlled Health Organisations) which includes VACCHO Member ACCOs.

VACCHO acknowledges the Commission's concerns about scheme costs and the interests of the Commonwealth in managing cost pressures to ensure sustainability of the scheme. However, without further investment to ensure equitable access by Aboriginal people with disability, the existing investment will not be effective and will continue to fail the needs of this group. While this paper is grounded in the obligations and moral imperatives to equitably support Aboriginal people with disability, it also points to the substantive economic benefits underpinned by the insurance principles of the scheme[1] and opportunities to ensure that savings are identified and reinvested in the scheme.

Issues with the Scheme Design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with profound or severe permanent disability

Five years ago the Productivity Commission warned that the proposed NDIS may not deliver adequate care and support to Aboriginal people with a disability. The report also flagged the possibility that it may be necessary to block fund some service providers to support Aboriginal people with a disability if they were to have an increased likelihood of overcoming the additional barriers associated with social and economic disadvantage and address the higher incidence of disability and the disproportionately low numbers of people engaged with disability services than the non-Aboriginal population.[2]

VACCHO is disappointed that the special measures of this type, to ensure equity of access by Aboriginal people, have not been introduced.

VACCHO is similarly concerned that a 'one size fits all' approach to market principles will undermine formal commitments and specific measures to achieve health and other outcomes for Aboriginal peoples.

The Commonwealth has unique responsibilities in relation to Aboriginal people. For example, the Statement of Intent to Close the Gap commits the Commonwealth to work together to achieve equality in health status and life expectancy between Aboriginal people and non-Indigenous Australians by 2030. This includes the recognition that specific measures are needed to improve Aboriginal peoples' access to health services, and that Aboriginal peoples must be actively involved in the design, delivery and control of these services. [3] Key commitments include:

- Ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gaps in health standards by 2018.
- Ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.
- Working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.
- Building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.
- Supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.
- Respecting and promoting the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality. [4]

It should be noted that the National Disability Insurance Scheme Act 2013 (Cwlth) provides that:

> People with disability should be supported in all their dealings and communications with the Agency so that their capacity to exercise choice and control is maximised in a way that is appropriate to their circumstances and cultural needs.[5]

and that, any act or thing covered by the legislation is done, in so far as practicable, in accordance with the principle that: "the cultural and linguistic circumstances, and the gender, of people with disability should be taken into account".[6] The legislation also requires that the objects of the Act, in conjunction with other laws, give effect to certain obligations that Australia has as a party to, including:

(i) the International Covenant on Civil and Political Rights (16 December 1966 ([1980] ATS 23)); and
(ii) the International Covenant on Economic, Social and Cultural Rights (16 December 1966 ([1976] ATS 5)); and
(iii) the Convention on the Rights of the Child (20 November 1989 ([1991] ATS 4)); and
(iv) the Convention on the Elimination of All Forms of Discrimination Against Women (18 December 1979 ([1983] ATS 9)); and
(v) the International Convention on the Elimination of All Forms of Racial Discrimination (21 December 1965 ([1975] ATS 40)).[7]

In addition, the NDIS *Aboriginal and Torres Strait Islander Engagement Strategy* includes a principle that "Country, Culture and Community should be central to any policy that affects Aboriginal and Torres Strait Islander peoples with disability".[8]

ACCOs have a proud history as sustainable, grassroots organisations that assist in building community capacity for self-determination. Aboriginal peoples have the right to self-determination. Under the United Nations Declaration on the Rights of Indigenous Peoples this includes the right to "freely determine their political status and freely pursue their economic, social and cultural development" and to "autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions."[9]

Community Control is a practical expression of self-determination, which is supported by the Turnbull Government and reflected in the governance and service models of VACCHO's Member ACCOs. The Board of Directors have direct responsibilities and accountability to their communities.

In accordance with these rights, VACCHO believes that each Aboriginal community needs its own community based, locally owned, culturally appropriate and adequately resourced primary health care facility. NACCHO outlines the difference in Aboriginal and western understandings of health:

> The Aboriginal understanding of health is holistic and includes land, the physical body, clan, relationships and lore, it is the social, emotional and cultural wellbeing of the whole community, not just the individual.[10]

Accordingly, notions about the roles and responsibilities of individual consumers and service providers must be considered in a cultural context and cannot be translated directly from western models and concepts.

There is a preference among Aboriginal people for Aboriginal organisations.[11] ACCOs are the dominant choice of Aboriginal people in all geographical areas in which they are located, and many Aboriginal people travel considerable distance to access them, often passing by mainstream services to do so.[12] Aboriginal people are more likely to seek health and community services from a provider that offers cultural safety, and understands the multi-layered concept of Aboriginal health. On the other hand, Aboriginal people may delay seeking medical advice if these services are not available to them.[13]

Where they are available, ACCOs are best positioned in Victoria to achieve strong outcomes for Aboriginal people. With strong networks into the communities they serve, the range of services they offer means that many Aboriginal people with disability will already be accessing them, even if not seeking support for their disability needs. For example, reviews of sample data provides strong support for the notion that people with disability are already accessing their local ACCO's primary health care services. VACCHO also anticipates there are high numbers of people with disability accessing family and community services, out of home care programs,[14] early childhood, tenancy support, justice programs, and employment programs and so on. Combined with targeted community engagement strategies, this existing infrastructure and relationship provides unique opportunities to better identify people with disability in the community and facilitate access to the support that they need.

The application of market principles in the interests of user choice must take into account the unique cultural, social and health needs of Aboriginal people and the right to choose an Aboriginal organisation.

The National Disability Insurance Scheme emphasises choice and control for individuals. However, it has no investment in the viability and sustainability of organisations, which has implications for the capacity of Member ACCOs to offer their unique service model (which has demonstrated benefits) and/or a culturally safe service.

Where a Member ACCO is not available, does not deliver the service in question or are not the first choice of an Aboriginal person, Aboriginal people maintain their right to cultural safety in accessing mainstream services. User choice for Aboriginal people is meaningless without this standard of service quality.

The Productivity Commission has pointed out elsewhere that, where user choice is not feasible or desirable, "there may be other options for empowering users – such as governments and providers taking greater consideration of user preferences in decision making".[15] VACCHO recommends that the Commission take into account the preferences of many Aboriginal people for community controlled organisations and ensure policies and programs support access to this choice. VACCHO challenges the finding by the Productivity Commission that social capital benefits are not exclusive to one type of provider[16] and asserts that the community controlled sector provides unique benefits that cannot be delivered by government, mainstream not for profit or for profit providers.

Smaller specialist providers such as ACCOs are unable to compete with the economies of scale available to large providers, including but not limited to for profit providers. At the same time, there are insufficient requirements, or even incentives, for large providers to respond holistically to the complex needs of Aboriginal people and limited capacity for cultural safety without the active support of an Aboriginal organisation.

The Australian Council of Social Service (ACOSS) point to the limitations of competition policy to deliver outcomes in 'thin' markets. Where government providers are also unavailable, "market failure poses another challenge that could have considerable negative impacts".[17] These markets are not only thin in remote Aboriginal communities, but also in regional and urban settings. For example, for Aboriginal people with disability the absolute number of Aboriginal people seeking a service might be low in any of these settings, even where they experience much higher incidence of disability than the general population.[18]

The Department of Prime Minister and Cabinet (PMC) report that in many Aboriginal service delivery settings (especially but not exclusively in remote settings) "markets are not sufficiently well-developed that competition principles are readily applicable".[19] In urban and well-serviced regional settings, they argue that "the story is different" because many Aboriginal people use the same services as non-Aboriginal Australians. This argument does not take into account the cultural safety, quality or effectiveness of the mainstream services for Aboriginal people, or the number of people who, consequently, do not access services they need. For example, a study of 759 Victorian Aboriginal adults found that 29% had experienced racism in a health setting in the last 12 months.[20] In 2012-13, 30% of Aboriginal people reported they did not access a health service when they needed to.[21] The Aboriginal and Torres Strait Islander Health Performance Framework uses the higher levels of discharge against medical advice (which in major cities specifically is 2.6 times the rate of the non-Aboriginal population) as an indication of "significant issues in the responsiveness of hospitals to the needs and perceptions of Aboriginal and Torres Strait Islander peoples".[22] PMC do acknowledge that many urban Aboriginal people prefer to use community controlled primary health care and that "services will be more effective and provide better user outcomes where Indigenous-targeted or –adapted services are available".[23]

Therefore, VACCHO questions the basis for their finding that "market principles which can be usefully applied to mainstream services will affect Aboriginal and Torres Strait Islander populations in broadly similar senses"[24] and points in contrast to the 'thin markets' for high quality, culturally safe and effective services for Aboriginal people in all geographic locations.

In the *Aboriginal and Torres Strait Islander Engagement Strategy*, NDIA recognises the need for the involvement of "Indigenous registered providers of support" but commits only to a "deliberate focus on options" to grow the number of these providers.[25] Similarly, the commitment to community capability and capacity to grow local solutions does not take into account the need for resourcing and flexibility within the scheme to ensure local solutions can be achieved in practice.[26]

In line with the Commonwealth's commitments, targeted investment is needed in the following:

- Investment in community engagement and awareness strategies that ensure Aboriginal people understand their rights and entitlements.
- Provision of resourcing for cultural workers (e.g. Aboriginal Health Workers or other frontline staff) to assist with paperwork and attend appointments through assessment and planning processes and development of a culturally safe assessment framework. This requires a recognition of the barriers to access for Aboriginal people and recognition of the role that Aboriginal community controlled organisations will play in facilitating access to the scheme.
- Introduction of Aboriginal Cultural Support as a funded Support Category to ensure the cultural needs of Aboriginal people with disability can be taken into account when planning for access to an 'ordinary life' and/or introduction of weighting of packages for Aboriginal people.

This requires recognition that cultural safety and access to culture and community are inherent rights of Aboriginal people with disability and cannot be separated from their 'disability' needs', and that the concept of an 'ordinary life' for Aboriginal people is rendered meaningless by a failure to embed culture into planning and implementation of disability supports.

- Continued access to Support Coordination to ensure assistance with system navigation for Aboriginal people with disability with high complexity of need.
- Up-front investment in the viability and sustainability of Aboriginal community controlled organisations to facilitate choice and control for Aboriginal people with disability, including the right to cultural safety and the right to choose an Aboriginal organisation. This requires recognition of the unique service models and benefits available through member ACCOs and the challenges faced by small organisations who are delivering to a 'thin market' with high complexity of need, including in regional and urban areas.

Consideration of cost pressures arising from these recommendations should take into account:

- Savings to Commonwealth and State and Territory Governments through social return on investment (SROI) of effectively supporting Aboriginal people with disability
- Opportunities to identify and demonstrate these savings through SROI methodologies
- If agreement to do so can be reached, identified savings can be re-invested into NDIS.

In 2011, the Productivity Commission anticipated the NDIS would generate profound economic benefits and that a key source of these benefits would be "increased economic participation for people with disabilities … and their informal carers." [27] If, for example, Australia achieves anticipated employment ratios for people with disabilities, the economic impact would translate to around $32 billion for one year by 2050. Combined with other benefits, including wellbeing benefits and their economic effects: "The bottom line is that the NDIS would have substantial economic impacts, and its benefits would significantly exceed the additional costs of the scheme."[28] VACCHO recommends a long term view in regards to the economic costs of the scheme, with regard to the insurance principles and both tangible and intangible benefits of investment.

In addition to the key points above, this submission addresses a number of the questions in the Issues Paper as follows:

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

In the North East Melbourne (NEMA) region NDIA advised that Australian Healthcare Associates (AHA) had been subcontracted by the agency to assist them in meeting established targets for the region. AHA contacted people already receiving support from a defined program that was deemed to be supporting people with higher complexity of need. This contact was made by phone, in lieu of a face to face meeting with the Local Area Coordinator, and was intended to facilitate transition from the defined program to NDIS through development of the first plan. While it is not clear if this process was also used to further determine eligibility it was motivated by the need to meet targets and was a crucial pathway for access to the scheme.

Conducting this initial engagement by phone is completely inappropriate for Aboriginal people with disability and risks outright disengagement from the scheme. While Aboriginal people were meant to be offered a face to face meeting, anecdotal information suggests this did not always occur.

VACCHO is concerned that this method was used for programs associated with higher complexity of need and cautions strongly against phone based contact in the next stages of the rollout.

Community Mental Health Australia point out that increasing the numbers in the NDIS was the driver for the move to telephone interviews, which may reduce initial costs "but then lead to an increase in the number of people asking for reviews or appeals which actually then increases administrative costs".[29]

How will the full rollout of the NDIS affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?

VACCHO shares the concerns of Community Mental Australia that there will be a significant gap in services for people with serious mental illness who are not eligible for NDIS,[30] and suggests that this could have disproportionate impacts on Aboriginal communities.

A culturally safe functional assessment for mental illness is urgently needed. Without a tool of this nature, there will be inconsistencies in access to the scheme and variations in plan quality. It also makes it difficult for organisations to ensure participants are informed about their entitlements, without raising undue expectations. Once a functional assessment for mental illness is identified, work needs to be done to ensure any tools are validated in the Aboriginal cultural context, and that evidence provided by culturally appropriate specialists (e.g. which may be a GP working in an Aboriginal Community Controlled Health Organisation) is given appropriate weighting.

VACCHO is concerned about how a distinction between the 'health' and 'disability' needs of a person is being applied, especially in relation to the social and emotional wellbeing of Aboriginal people, and advocates for inclusion in the Price Guide and participant plans of culturally relevant evidence based best practice for supporting the complex needs of Aboriginal people experiencing mental illness.

Is the range and type of services proposed to be funded under the ILC program consistent with the goals of the program and the NDIS more generally?

The range and type of services to be funded under ILC is broadly consistent with the goals of the program and NDIS more generally, but the demand will be much higher than the level of funding allows. In addition, some people found ineligible for a package are still likely to require ongoing one on one support that cannot be met by mainstream services or individual capacity building, or if the ILC program is granted on a time limited basis only (e.g. as seed funding). In relation to Aboriginal people with disability, VACCHO anticipates there will be very high levels of unmet need and notes the costs to all levels of government if that need is not effectively addressed.

The ILC program is one model for funding community engagement and awareness strategies that ensure Aboriginal people understand their rights and entitlements under the scheme and support access to NDIS or mainstream services where people are ineligible. However this needs to be available to every ACCO to adequately address the gap in service access.

Local Area Coordination is not currently meeting its commitments to connect people who are outside of the NDIS to informal supports, but rather in Victoria is "focused almost entirely on moving in scope and new participants into the scheme to meet targets, creating a gap in meeting the needs of those ineligible for the NDIS."[31]

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?

The Local Area Coordinators (LACs) need to ensure cultural safety in service delivery to be effective for Aboriginal people. Provisions to ensure clear accountability are needed in relation to cultural competency of the organisation and individual staff and a range of specific measures such as mandated employment of Aboriginal staff, mandatory cultural safety training which is specific to the cultural protocols of local communities, effective community engagement and partnerships and/or co-location with Aboriginal organisations. It is not adequate to rely on the goodwill or priorities of the organisations being funded as LACs. The best way to do this is through the development of a national cultural safety accreditation standard, and inclusion of this standard in the National Quality and Safeguards Framework for all NDIS providers, including the LACs.
While this standard is under development, it would be appropriate to apply the *Cultural Respect Framework 2016 to 2016,* which commits the Commonwealth Government and all states and territories to embedding cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services. The framework outlines six domains that underpin culturally respectful health service delivery:

- Whole-of-organisation approach and commitment
- Communication
- Workforce development and training
- Consumer participation and engagement
- Stakeholder partnerships and collaboration
- Data, planning, research and evaluation.

These domain areas "provide an overarching platform of activity to strengthen the cultural respect of staff and organisations."[32] This framework could guide the National Disability Insurance Agency (NDIA) as well as the LACs and other NDIS providers through the National Quality and Safeguards Framework.

VACCHO acknowledges the commitments to Aboriginal recruitment and cultural competencies made in the NDIS *Aboriginal and Torres Strait Islander Engagement Strategy*[33] but asks that the efforts go further to ensure effective engagement and outcomes for communities.

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

See comments and recommendations above about the culturally safety of the Local Area Coordinator. If this key role in the scheme is not culturally safe in all aspects of service delivery then the planning process is not accessible, valid or reliable.

In addition to the recommendations above regarding accountability provisions in the accreditation process and/or contracts with the LACs, the planning process could also be improved by funding to support the inclusion of appropriate cultural workers in the planning process. This could be Aboriginal Health Workers or other key staff who have a relationship with the potential participant and can assist them to understand and navigate the requirements of the scheme, including assessment and planning processes. This would also support access to LAC by people found ineligible for NDIS, who may need support in accessing mainstream services.

In addition, dedicated Aboriginal community engagement workers in each region could support the provision of pre-planning information to the community, including information about the documentation needed, goal setting, involvement of support people and available services. While the Victorian Department of Health and Human Services have funded a role of this nature in the North East Melbourne Region on a time-limited basis, NDIA have not invested in this area and no commitments have been made for rollout in other regions.

How should the performance of planners be monitored and evaluated?

A national cultural safety accreditation standard provides a mechanism for monitoring the performance of planners in relation to cultural safety. Alternatively, specific provisions can be incorporated in the contract to ensure accountability. The development of program logics and evaluation frameworks should incorporate cultural safety as a key objective of the program.

Do NDIA assessment tools meet these criteria? [valid, reliable, accurate, efficient] What measures or evidence are available for evaluating the performance of assessment tools used by the NDIA?

Assessment tools need to be validated for use in Aboriginal communities and then implemented under a culturally safe assessment framework. Without comprehensive consideration of the impacts of cultural difference, assessment may not be valid, reliable or accurate and may create a barrier to access to the scheme.

VACCHO recommends measuring the effectiveness of assessment tools against projected numbers of Aboriginal peoples with disability as a minimum baseline, but cautions that this won't in itself be adequate because there is a high likelihood that these projected numbers are an under-estimation. It is well established that Aboriginal people with disability are under-counted through Census data and other disability survey data, on which these projections tend to rely, and that they are not accessing disability services at the same rates as non-Aboriginal people.[34] Qualitative studies using Indigenous research methodologies that are focussed on the performance of assessment tools for Aboriginal people with disability will also be important.

There is a need for more transparency about the assessment criteria for NDIS. As noted above, further clarity about the functional assessments that are recognised for mental health and the level of specialist sign-off required would assist potential participants and their supporters to make better judgements about the likelihood of eligibility and the documentation required.

Additionally, it is important to note that the cost of some specialists will be prohibitive for many Aboriginal people and will act as a significant barrier to access to the scheme. Recognition of the distinctive expertise of GPs working in community controlled primary health settings is vital if equitable access to the scheme is to be achieved. There is also a need for funded support for Aboriginal Health Workers to equivalent to attend specialist appointments to ensure cultural safety through the process and support the validity of the assessments undertaken.

What are the likely challenges for monitoring and refining the assessment process and tools over time? What implications do these have for scheme costs?

A key goal needs to be equitable access by Aboriginal people to the scheme, which will involve increasing the number of Aboriginal people accessing the scheme. If the assessment process and tools are culturally safe and these increases are achieved, it will have implications for scheme costs, through the investment in those tools and processes and the resulting increases in participant numbers, but these costs will be offset through the insurance principles of the scheme.

It is imperative that improvements to the NDIS assessment process and tools are timely, to avert immediate risks of disengagement across the community. That is, if early experiences of the scheme are negative, this will be shared by word of mouth and deter others from accessing the scheme.

VACCHO is concerned about the view that "equity of access to services might be achieved by providing the services to all members of the community on the same terms" [35] and notes that equity of access must include the capacity to overcome obstacles to access in order to achieve fairness.

The insurance principles of the scheme support the view that those costs are offset in other areas (e.g. health, education, employment, criminal justice, out of home care) and recommends the use of social return on investment methodologies to track and even reinvest the savings in these areas. As one example only, a recent cost benefit analysis of the benefits of early intervention for children with autism suggests a return on investment of between 4.1:1 and 11.3:1.[36] It is likely that the returns for Aboriginal children would be even higher, given the over-representation of Aboriginal children, and Aboriginal children with disability in particular, in out of home care.[37] Similarly, VACCHO believes that increased participation in the scheme by Aboriginal people would significantly increase workforce participation by people with disability and their carers thus reducing the overall costs to the Commonwealth. In *Indigenous Australians and the National Disability Insurance*, Biddle et al point out that a substantial proportion (30 per cent) of Aboriginal service users were accessing open employment services, which assist people with disability to find or retain employment in the open job market.[38]

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?

Access to appropriate cultural support needs to be integrated across a participant's plan and staff developing, approving and reviewing the plans require training in how to apply a cultural lens in relation to assessing a person's disability needs. This should include but not be limited to a funded support category for Aboriginal Cultural Support in the NDIS Price Guide, to ensure items not available under the other support categories can be funded as required. However it should also be embedded across all the other support categories. For example, access to cultural healing camps may be recognised under community and social activity costs, or community participation activity costs, while return to country (previously funded under Flexible Support Packages) may need to be funded under a stand-alone category.

Applying a cultural lens would ensure that an assessment of the risk of social isolation takes into account that risks of isolation from the Aboriginal community may have comparable impacts on health and wellbeing.

If training for all planners and assessors cannot be achieved, VACCHO recommends the use of dedicated staff who do have the requisite training to ensure culture is appropriately considered and applied within the plans of participants identified as Aboriginal, both by the LAC in development of the plan and by the NDIA in plan approvals or amendments.

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?

VACCHO is concerned that the baselines prices in the NDIS Price Guide do not support the development of a long term high quality workforce, but rather pressures organisations to engage entry level workers only, and on a casual basis. Our member ACCOs are a major employer of Aboriginal people and this pricing model will have flow on impacts into Aboriginal communities. The combined impacts of the baseline prices and associated trends towards casualisation will have implications for the retention of Aboriginal staff who have developed trust relationships within communities.

It is vital that any consideration of workforce takes into account the need for an Aboriginal workforce and VACCHO recommends work and investment into an Aboriginal recruitment attraction and retention strategy.

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?

This goal will be very difficult to achieve under present policy settings. As a stand-alone goal it also fails to take into account turnover within the workforce, and the impacts on service quality as the more experienced staff leave the sector. VACCHO recommends changes to the NDIS Price Guide based on a review of the reasonable cost model in relation to personal and community support. In particular, the staff pay point and staff utilisation rates are likely to have negative impacts on the capacity to attract and retain high quality staff over time. Changes to this model would have ramifications for scheme costs, which may be offset in part by the workforce participation and wages of the emerging workforce, and by improved outcomes for participants who are supported by more experienced, longer term staff.

As noted above, targeted investment in Aboriginal recruitment and retention would support the development of this workforce in particular. The recruitment and retention of high quality, long term Aboriginal staff facilitates the development of trust relationships which are essential to achieving effective outcomes for Aboriginal clients.

VACCHO agrees with Community Mental Health Australia that implications of the current pricing potentially include:

> The exclusion of participants with higher needs that require higher levels of staff support from these services, and the withdrawal of service providers [and] the loss of existing skilled and qualified staff and a de-skilling of the workforce. In time providers may well opt to hire the lower-skilled staff they can afford to be able to offer NDIS services. This will impact on recovery-focused psychosocial rehabilitation supports which will develop into generalist disability supports.[39]

What scope is there to expand the disability care and support workforce by transitioning part-time or casual workers to full-time positions? What scope is there to improve the flexibility of working hours and payments to better provide services when participants may desire them?

VACCHO's member ACCOs service very thin markets. In this context, there are significant challenges guaranteeing funds for full time or even part time positions. As noted above, the member ACCOs are a major employer of Aboriginal people and impacts on the pay and working conditions of the workforce will have detrimental impacts on the whole community.

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

Technology can make a big difference in the efficiency of the workforce, including but not limited to the use of CRMs and mobile technologies which can increase the client utilisation rates (client facing hours). However member ACCOs operating in thin markets are finding the upfront costs of investment in these technologies highly prohibitive, and unlikely to be recouped through the margins they can achieve. They are also concerned about the impacts on service quality if they achieve 95% utilisation rates, through the impacts on access to supervision, training and flexibility in working holistically with the needs of the client. These impacts are exacerbated by the baseline wage levels factored into the NDIS Price Guide, encouraging reliance on junior or entry level staff for the provision of client facing services.

If ACCOs are recognised for the unique and vital role they can play in improving access to services for Aboriginal people with disability, upfront investment in IT must be made to ensure they are financially viable under the NDIS model.

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?

Achieving equitable outcomes for Aboriginal participants requires that cultural needs and relevance is a major criterion for determining participant supports.

A budget based approach to planning that treats everyone as 'the same' will not meet the obligations above or achieve equitable outcomes for Aboriginal people with disability. Recommendations made above include introducing a new support category for Aboriginal cultural support and applying an (appropriately trained) cultural lens across all the existing support categories. Consideration of culture must be included in the reference packages, with appropriate weighting as required.

What implications do the criteria and processes for determining supports have for the sustainability of scheme costs?

Appropriately and effectively addressing the disability needs of Aboriginal people may increase the costs to the scheme in the short term but will have long term economic benefits.

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

NDIA must ensure the cultural competence of reviewers, which may be achieved through employment of Aboriginal staff, cultural safety training, and training in how to apply a cultural lens to the NDIA planning process. If this cannot be achieved for all non-Aboriginal staff, then the plans of participants identified as Aboriginal should be reviewed by dedicated and appropriately trained staff.

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

The prices set by the NDIA are too low for providers operating in thin markets without economies of scale and for servicing people with additional and complex needs. VACCHO advocates for an increase in baseline pricing as well as weighting of packages supporting Aboriginal people with complex and/or cultural needs.

VACCHO agrees with ACOSS that:

> Competition increases the risk of highly vulnerable clients 'falling through the cracks' due to the onus on the individual to navigate the market, and the fact that incentives are generally insufficient to engender sustained provider engagement with service users with complex needs.[40]

The Department of Prime Minister and Cabinet agree, noting that if "appropriate metrics for quality and appropriateness of services for Aboriginal and Torres Strait Islander clients are not in place (or if inappropriate metrics are in place)" then the specific needs of Aboriginal users may be overlooked by potential providers.[41]

In addition, the allowances and rules for travel are inadequate for rural providers, who frequently travel much greater than 20 minutes, and for urban providers where they are the only ACCO in a much wider radius.

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

VACCHO has been working with member ACCOs in Victoria to support their preparation for participation in the scheme. At the time of writing, none of the 30 member ACCOs had commenced service delivery, although a small number are very close to this point. Many of the ACCOs have indicated they will not deliver under the scheme or have very significant concerns about delivering under the scheme. This is consistent with the Productivity Commission's Issues Paper, which points out many providers have questioned "the adequacy of prices to reimburse existing providers for the cost of providing supports."[42]

The Issues Paper also points to the NDIA's government stewardship role in "enabling existing and emerging suppliers to mature at an appropriate and sustainable rate".[43] Each of the ACCOs considering participation has to take into account the thinness of the market and the financial risk of moving to the scheme, particularly under the current Price Guide.
Many of the ACCOs are concerned about:

- being able to deliver culturally appropriate quality services under the NDIS Price Guide,
- the impacts on their workforce and capacity to attract new staff where required
- their capacity to invest upfront in the IT infrastructure necessary to achieve the efficiencies required under the scheme
- the restrictions on funding for provider and participant transport and their capacity to carry those costs where needed
- the impact on their relationship with their communities in moving to a fee for service model, as this necessitates adopting a 'business approach' to client needs in contrast to block funding which has often provided important flexibility in meeting the cultural needs of their clients.
- The absence of bridging funding as clients move to NDIS packages before the organisations have established systems or economies of scale to break even as providers
- that they will be never be able to break even with the client numbers they can reasonably anticipate and, conversely, the impact on those clients if they make a decision not to participate. If they make a decision to cross-subsidise the model, they know those funds will have to be taken from other areas of critical community service.

If Aboriginal organisations cannot establish financial viability and service quality under the pricing models available this leaves the market chronically under-serviced in relation to culturally safe options for Aboriginal people. This extends the failures of the current system in servicing Aboriginal people with disability into the new NDIS scheme.

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

Many of VACCHO's member ACCOs are Home and Community Care (HACC) providers within a broader context of holistic wrap around support, such as primary health, family services, early childhood, and employment services and so on. As they are not specialist disability providers. The transition to NDIS may be more difficult than for specialist providers. For example, it makes it difficult to anticipate or guarantee the size of market and to make decisions about and prepare for unfamiliar service types. It is also difficult to make informed and responsible judgements about investment in the necessary infrastructure including whether to cross-subsidise this work using funds from other critical health and community services areas.

Expanding the range of disability services from those provided under HACC only, requires effective recruitment, training and other systems to upskill staff. For example, family outreach services may need training so that they can support their existing clientele in a new and more targeted way. Similarly, as noted already, there are other demands on organisations such as professional registration and accreditation requirements (one member reports they already have 22 accreditations and 674 standards to meet), and substantive information technology requirements if the scheme's expected efficiencies are to be achieved.

For member ACCOs considering participation in the scheme as new providers in the market a lot of work is needed to reorient the service to the new funding paradigm. Unlike disability specialist providers, this transition occurs and must compete for attention with significant funding reforms across family violence, child protection, primary health and others. With organisational capacity for transition and reform severely stretched through these processes, NDIS does not appear an attractive proposition when considered from an organisational lens only.

In contrast to specialist disability providers, the driver of undertaking transition will not be based on organisational survival or growth, but rather a recognition of the level of unmet need and commitment to better outcomes for community. If organisations are not better supported to meet this need, however, they may face putting the viability of other services and/or the broader organisation at risk. Many will simply be unable to proceed.

Despite this, a number of Victorian ACCOs have spoken about the moral imperative to support members of their community who experience disability. Aboriginal people with a disability may be under-serviced by disability specialists but ACCO service data suggests this group is often accessing other forms of support within the ACCO through the primary health and community services (including but not limited to early childhood services). Member ACCOs offer unique benefits to the sector through their holistic service model. They are culturally safe and trusted by community, and will often be the most likely point of access to any service by Aboriginal people with disability in the community.

Biddle et al point out that the expensive and limited infrastructure in many communities, and need for professional support and backup to service workers, supports consideration of building disability services on the existing health care system, "especially where these community health services have developed strong community bonds." [44] Biddle et al also caution, however, that disability support must not follow a simple medical model, and that inappropriate stress should not be placed "on already stretched services which cannot fully meet existing demand".[45]

ACCOs in Victoria have much experience integrating primary health with a community services model. While VACCHO agrees with Biddle et al that care must be taken not to over-stretch these services, Member ACCOs in Victoria are already servicing small, dispersed populations and, with the right organisational resources and support, can supplement NDIS packages with wrap around supports that meet the broader needs of the client

Biddle et al point out that the concept of disability in Aboriginal communities has a troubled past, noting that labelling an individual as having a disability "might not only cause shame but also may threaten their place in the community, with many Indigenous Australians having experienced family members being removed because of physical or mental impairment."[46] The First People's Disability Network Australia also point to the reluctance of Aboriginal and Torres Strait Islander people with disabilities to identify as people with disability, presenting "a fundamental barrier for the successful implementation of the NDIS."[47]

This means that, as new providers, member ACCOs are also servicing a 'new market', which will compound the challenges of implementation. It places intensive demands on organisational resources, for example, to effectively reach this market through community engagement, including provision of culturally relevant information and orientation to the scheme. If more people are to access NDIS, work needs to be undertaken with community to build understanding of the concept of disability and its relevance for Aboriginal communities, as well as understanding of the scheme and how to access it. ACCOs are best placed to do this work but cannot be expected to independently resource this engagement.

The disability service system has long been failing Aboriginal people. There is an absolute necessity to do things differently under NDIS instead of recreating the old system and getting the same result – the under-servicing of Aboriginal people. The increased involvement of member ACCOs in the sector would be an effective strategy to achieve better community engagement and outcomes for individuals.

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?

Member ACCOS in Victoria will be supplying thin markets on the basis of:

- geography (with most Victorian ACCOs in rural areas);
- Aboriginal status (creating a thin market in urban as well as rural areas); *and*
- participants with complex and specialised needs (including cultural needs and right to cultural safety).

Some Member ACCOs are considering service delivery to non-Aboriginal participants where they do not already do so, but for other ACCOs this would require significant constitutional change.

Please refer to the recommendations in the responses above in relation to:

- Investment in community engagement and awareness strategies;
- Provision of resourcing for cultural workers to support the assessment and planning process;
- Introduction of Aboriginal Cultural Support as a funded Support Category;
- Training in assessment of cultural needs as they impact on disability needs for the purposes of plan development, approvals and reviews;
- introduction of weighting of packages for Aboriginal people;
- Continued access to Support Coordination;
- Up-front investment in the viability and sustainability of Aboriginal community controlled organisations to facilitate choice and control for Aboriginal people with disability; and
- Development of a national cultural safety accreditation standard.

Block funding to ACCOs may be the best avenue to provide some of this support (e.g. community engagement, cultural support workers and investment in infrastructure), as well as a mechanism to support ACCOs which are unable to break even while servicing a thin market. This is consistent with the Productivity Commission's findings that a purely market based service delivery system would not deliver adequate care and support to Aboriginal people with disability and that it may be necessary to block fund some service providers in order to overcome the additional barriers that Aboriginal people face.[48]

How will the changed market design affect the degree of collaboration or co-operation between providers? How might this affect the costs of the scheme?

VACCHO shares the concerns of ACOSS about structuring competition into relationships which ought otherwise to be collaborative.[49] Aboriginal people will often depend on their local ACCO to support their access to non-Aboriginal) services, or to fill gaps left by the non-Aboriginal (or mainstream) service sector, although ACCOs are rarely funded to do this kind of work. ACCOs work with non-Aboriginal health providers to improve access, pathways, cultural safety and quality of health care for Aboriginal people, including advocating and supporting their health services to be more accountable for Aboriginal health outcomes. There are opportunities to expand this role in relation to non-Aboriginal disability service providers but this cannot be achieved without some mechanisms to ensure equitable partnerships with Aboriginal organisations and that resources are appropriate to the role and the best outcomes for community.

There are already examples of non-Aboriginal NDIS providers adopting a competitive approach when asked for support and collaboration by Aboriginal organisations. ACOSS has developed *Principles for a Partnership-Centred Approach for NGOs working with Aboriginal and Torres Strait Islander Organisations and Communities* which focuses on competitive tendering but warrants review in light of individual funding. [50]

Improved accountability of mainstream organisations is vital. This must include accountability for cultural competence which should be embedded in the operations of the organisation. As noted above, VACCHO recommends the development of a national cultural safety accreditation standard in the Quality and Safeguards Framework, and the application of the Cultural Respect Framework while this standard is under development. Government stewardship has a responsibility to actively support, monitor and uphold principles for partnership and accreditation in cultural safety.

How well-equipped are NDIS-eligible individuals (and their families and carers) to understand and interact with the scheme, negotiate plans, and find and negotiate supports with providers?

Aboriginal people are more likely to present with complex and chronic needs. In addition, for many mainstream service providers, Aboriginal peoples' cultural needs increase the complexity of quality service delivery.

Informed user choice will only contribute to the development of responsive and appropriate markets where users are sufficiently empowered to actively shape the service response, placing pressure on providers to understand and meet their needs.[51] Aboriginal people, in contrast, are often deeply disempowered, especially in mainstream settings with non-Aboriginal service providers and face unique and complex barriers to access.

Chronic under-servicing is the consequence when Aboriginal people are unable to navigate the service system to their benefit. For example, the Productivity Commission points out that, in addition to reluctance arising from cultural difference and negative experiences with mainstream services, some Aboriginal people may wish to engage but be constrained by a lack of knowledge about the requirements (e.g. paperwork and personal information) or lack confidence or understanding of their rights and entitlements.[52]

For some services, there is a lack of user-oriented information that would enable users to make choices. This includes information on the level of cultural competency demonstrated by mainstream services, information which is of vital importance to Aboriginal people as consumers but not effectively monitored, let alone publically available. In addition, for Aboriginal people, informed user choice requires the choice of an Aboriginal organisation. If the market does not provide, the safety net of block grant funding and other measures is required.[53]

VACCHO does not believe that, without special measures to provide a safety net, marketisation will provide for the needs of Aboriginal people or that they will be in a position as individual consumers to shape how those needs are met.

The Issues Paper notes that "if participants find it difficult to negotiate the right individualised supports, then the insurance approach of the NDIS will be undermined – if participants get the wrong supports at the wrong time, scheme costs would be expected to increase".[54] Similarly, difficulty finding providers and negotiating services could lead to failures to use the available supports, "with ramifications for the wellbeing of participants and future scheme costs."[55]

To support users to exercise informed choice where individual entitlement schemes are introduced, ACCOs should be funded to facilitate equitable access to quality. This should include funding for cultural support officers, outreach, culturally safe assessment, planning and reviews as well as support coordination and system navigation.

Investment is needed in community engagement and awareness strategies that ensure Aboriginal people understand their rights and entitlements. A block funding model such as the NDIS Information, Linkages and Capacity Building (ILC) Grants provides an example of how this could be delivered but needs to be targeted to Aboriginal communities and available to every ACCO to adequately address the gap in service access.

Other options identified above include weighted funding packages and/or funding for items within the packages that recognise the unique needs of Aboriginal people, which may partially alleviate the funding pressures on organisations who already have the incentives to assist.

Does the way that the NDIA measures its performance affect the delivery of the NDIS?

The NDIA Quarterly Reports and State and Territory Dashboards include a count of the number and proportion of Aboriginal people accessing the scheme and (in the Quarterly Report) the eligibility rates of Aboriginal people accessing the scheme. These figures (which have dropped with the rollout of the full scheme) must take into account the over-representation of Aboriginal people with disability.

If Aboriginal people have a disability at 2.2 times the rate of non-Aboriginal people,[56] then this rate of representation within the scheme, by jurisdiction, could be a KPI against which the NDIA is required to report. Further breakdown of Indigenous status in areas such as plan utilisation rates would also be of value. Both of these factors could drive more effective performance of NDIS in relation to participation by Aboriginal people.

It is also vital that the performance of the scheme is assessed comprehensively using Indigenous research methodologies to track the pathways and outcomes of Aboriginal peoples under the scheme, including people who do not access the scheme.

Monitoring of performance should also take into account the numbers of people asking for a review, the quality of the plans, carer experiences and measures of consumer satisfaction with their plan.[57]

As noted above, there is value in piloting social return on investment methodologies to track NDIS outcomes, including financial savings to both Commonwealth and State and Territory government.

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

See comments above regarding the development of a cultural safety accreditation standard.

What are the likely longer-term impacts of any cost overruns? How should any cost overruns be funded?

As above, Social Return on Investment methodologies could facilitate the identification of savings that are achieved in line with the insurance principles of the scheme. These savings can be used to reinvest into the scheme which would assist to fund cost overruns.

ENDNOTES

[1] Productivity Commission (2011) *Disability Care and Support* Productivity Commission, Melbourne. p. 54-56.
[2] Productivity Commission (2011) *Disability Care and Support* Productivity Commission, Melbourne. p. 531
[3] Close the Gap: Indigenous Health Equality Summit – Statement of Intent (2008) Available at https://www.humanrights.gov.au/publications/close-gap-indigenous-health-equality-summit-statement-intent
[4] Close the Gap (2008).
[5] National Disability Insurance Scheme Act 2013 (Cwlth) ss 4(9).
[6] National Disability Insurance Scheme Act 2013 (Cwlth) ss 5(d).
[7] National Disability Insurance Scheme Act 2013 (Cwlth) ss 3(1)(i).
[8] National Disability Insurance Agency (2017) *Aboriginal and Torres Strait Islander Engagement Strategy* Available at https://www.ndis.gov.au/medias/documents/hcb/h31/8800389759006/Aboriginal-and-Torres-Strait-Islander-Strategy-3MB-PDF-.pdf Accessed 6 April 2017, p. 8.
[9] United Nations (2008). *United Nations Declaration on the Rights of Indigenous Peoples*. United Nations. Articles 3 and 4.
[10] National Aboriginal Community Controlled Health Organisation (2016) *NACCHO Submission to Inquiry into Human Services: Identifying Sectors for Reform*, Sub227 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p. 3.
[11] Aboriginal Health and Medical Research Council (2015) *Aboriginal Communities Improving Aboriginal Health: An Evidence Review on the Contribution of Aboriginal Community Controlled Health Services to Improving Aboriginal Health*, AH&MRC, Sydney. p.4.
[12] National Aboriginal Community Controlled Health Organisations (2016), p. 7.
[13] National Aboriginal Community Controlled Health Organisations (2016), p. 12.
[14] For the numbers of children with disability in out-of-home care, often without disability assessment or support, see for example Commission for Children and Young People (2016) '*Always Was, Always Will Be Koori Children': Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-Of-Home Care in Victoria* Commission for Children and Young People: Melbourne. p. 95.
[15] Productivity Commission (2016) *Reforms to Human Services: Productivity Commission Issues Paper*. Productivity Commission, Melbourne. p. 6.
[16] Productivity Commission (2016), p. 10.
[17] Australian Council of Social Service (2016) *ACOSS Response to Productivity Commission Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* Sub377 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. p. 12.
[18] Productivity Commission (2011) notes it is likely the estimated number of Indigenous people with a disability significantly underestimates the real figures, p. 537. See also N. Biddle, F. Al-Yaman, M. Gourley, M. Gray, J.R. Bray, B. Brady, L.A. Pham, E. Williams, M. Montaigne (2014) *Indigenous Australians and the National Disability Insurance Scheme* Australian National University Press, Canberra, p. 64, citing the 2008 NATSISS results showing nearly half of Indigenous Australians with severe or profound core activity limitations identified having problems accessing service providers.
[19] Department of Prime Minister and Cabinet (2016) *Submission to the Productivity Commission Review of Human Services* Sub265 into Human Services: Identifying Sectors for Reform. Productivity Commission, Melbourne. pp. 2-3.
[20] Kelaher, M, Ferdinand, A & Paradies, Y (2014), cited in Australian Health Ministers' Advisory Council (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AHMAC, Canberra. p. 142.
[21] Australian Health Ministers' Advisory Council (2015), p. 142.
[22] Australian Health Ministers' Advisory Council (2015), pp.146-7.
[23] Department of Prime Minister and Cabinet (2016), p. 3.
[24] Department of Prime Minister and Cabinet (2016), p. 3.
[25] National Disability Insurance Agency (2017), p. 6.
[26] National Disability Insurance Agency (2017), pp. 6, 18.
[27] Productivity Commission (2011), pp. 55.
[28] Productivity Commission (2011), pp. 54-56.
[29] Community Mental Health Australia (2017) *NationaDisability Insurance Scheme (NDIS) Costs - Productivity Commission Issues Paper* Sub0011 into National Disability Insurance Scheme (NDIS) Costs. Productivity Commission, Melbourne. p. 5.
[30] Community Mental Health Australia (2017), pp. 7-8.
[31] Community Mental Health Australia (2017), p. 9.

[32] Australian Health Ministers Advisory Council (2016) *Cultural Respect Framework 2016 to 2026 for Aboriginal and Torres Strait Islander Health* Available at https://nacchocommunique.files.wordpress.com/2016/12/cultural_respect_framework_1december2016_1.pdf
[33] National Disability Insurance Agency (2017), p. 11.
[34] Biddle et al (2014), p. 64.
[35] Productivity Commission (2016), p. 3.
[36] Synergies Economic Consulting (2013) *Cost Benefit Analysis of Providing Early Intervention to Children with Autism* Available at http://www.pc.gov.au/__data/assets/pdf_file/0004/215266/sub0032-ndis-costs-attachmenta.pdf
[37] Commission for Children and Young People (2016), p. 95.
[38] Biddle et al (2014), pp. 58-9.
[39] Community Mental Health Australia (2017), p. 5.
[40] Australian Council of Social Service (2016), p. 2.
[41] Department of Prime Minister and Cabinet (2016), p. 4.
[42] Productivity Commission (2017) *National Disability Insurance Scheme (NDIS) Costs Issues Paper*. Productivity Commission, Melbourne, p. 24.
[43] Productivity Commission (2017), p. 29.
[44] Biddle et al (2014), p. 125.
[45] Biddle et al (2014), p. 125.
[46] Biddle et al (2014), p. 18.
[47] First People's Disability Network Australia (2016) *Ten-point plan for the implementation of the NDIS in Aboriginal and Torres Strait Islander Communities.* Available at http://fpdn.org.au/ten-point-plan-for-the-implementation-of-the-ndis-in-aboriginal-communities/ Accessed 5 April 2017.
[48] Productivity Commission (2011), p. 531.
[49] Australian Council of Social Service (2016), p.3.
[50] Australian Council of Social Service (2015) *Principles for a Partnership-centred Approach for Non-government Organisations (NGOs) Working with Aboriginal and Torres Strait Islander Organisations and Communities*, ACOSS, Sydney. Available at *http://www.acoss.org.au/principles-for-a-partnership-centred-approach/*
[51] Productivity Commission (2016), p. 6.
[52] Productivity Commission (2011), pp. 539-40, 542.
[53] Productivity Commission (2011), p. 531.
[54] Productivity Commission (2017), p. 26.
[55] Productivity Commission (2017), p. 26.
[56] Productivity Commission (2011), p. 531.
[57] Community Mental Health Australia (2017), p.5.