

**Feedback on the Draft Report  
Disability Care and Support**

**Presented to the Productivity Commission**

**April 2011**

**Authorised by:**

Melissa Locke  
President  
Australian Physiotherapy Association  
Level 1, 1175 Toorak Rd  
Camberwell VIC 3124  
Phone: (03) 9092 0888  
Fax: (03) 9092 0899  
[www.physiotherapy.asn.au](http://www.physiotherapy.asn.au)

**Australian Physiotherapy Association**

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups. The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 12,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and its current submissions are publicly available via the APA website [www.physiotherapy.asn.au](http://www.physiotherapy.asn.au).

## Response to the Draft Report on Disability Support and Care

### Background

The Australian Physiotherapy Association (APA) is pleased to receive the Productivity Commission's draft report on its inquiry into disability support and care in Australia. The Commission's finding that overall the disability support system is 'inequitable, underfunded, fragmented, and inefficient and gives people with disability little choice'<sup>1</sup> reflects clearly what Australian physiotherapists have thought of the existing disability support system.

The APA strongly supports the proposal that a well-implemented series of changes are required to address the shortcomings in the existing system.

The APA strongly agrees with many of the Productivity Commission's findings and is in full support of the development of a national no-fault long-term scheme to provide disability care and support, as well as a parallel no-fault scheme to address injury arising from catastrophic events

Additional specific comments are also included in this submission below.

### General Comment

#### Service navigation

As described in our earlier submission to the Commission, health professionals, such as social workers, psychologists, occupational therapists and physiotherapists, can play the role of a 'navigator' and 'planner' of disability services for people with a disability and their carers.

For cases where an individual's mobility is limited by a disability, physiotherapists are ideally placed and possess the appropriate training and knowledge to engage with the specific care needs (including the likely progression of an individual's condition) of people with disability.

Physiotherapists already engage in a number of activities, including assessing an individual's capacity to move and keep moving, providing therapy to maximise function, mobility and for falls prevention, and prescribing appropriate aids and equipment. Physiotherapists have a vital role to play in the initiation, facilitation and provision of care for people with a disability. Physiotherapists are well-placed to perform specific physiotherapy interventions to optimise health and wellbeing and to assist people with disability and their carers to set goals, and plan long term management. Physiotherapists also build strong rapport with the individual with disability and their carers, can help raise their self-efficacy and can anticipate and help solve problems related to their disability.

As described from our previous submission, an APA physiotherapist demonstrated the potential breadth of this role through her own experience with a patient:

*Lately John has been very keen to drive. As his physiotherapist part of my role is to achieve that goal. Maximising his strength, range of motion and co-ordination is a given, but as John started driving lessons it became apparent he would need extra time to get his learner's permit, required a modified car to achieve this as well as a current vision assessment as his driving instructor noted he had problems with depth perception.*

*My physiotherapy role changed: helping him advocate for extra lessons prior to decisions being made about his capacity to LEARN to drive, liaising with an optometrist and occupational therapist to assess his vision and visual co-ordination and helping him find the best modified car to suit his physical needs.*

Another APA physiotherapist adds:

*As physiotherapists' we are often the people who are working very closely with patients and their families and carers. There is often a lot of trust placed in us and our opinions are valued. Because of this we often assist patients in navigating the health service about issues both physical and non-physical. We make recommendations/give education about physiotherapy and exercises, equipment to assist in mobility, how carers can help and manual handling risks. However, we also give advice on: when to seek medical or other allied health professional advice, appropriate recreation and leisure activities and holidays, how to access services and carer support and we often provide counselling to patients and their families.*

Many parts of this role have been identified by the Commission in the draft report as the role of the 'intermediary' to the person with a disability.

However, the APA strongly believes that a physiotherapist or other health practitioner acting as an intermediary for a person with a disability can also play a significant role in assisting a person with a disability develop their initial personal plan early in the self-assessment process.

As described above, physiotherapists have the knowledge and training to anticipate when and what interventions, aids and equipments are needed through the lifespan of a person with disability. Acting as an intermediary, the physiotherapist can also assist a person with a disability by liaising with trained assessors and the case manager through the assessment, and advocating for the individual with disability which can expedite the process.

The APA believes that health practitioners acting as intermediaries should be appropriately remunerated. The APA recommends that a rebate could be received when the plan is submitted, as it would be a disincentive and a financial barrier if people with a disability and their carers are faced with out of pocket expenses for these services. The APA recommends that the Commission explores the implementation of a rebate to this effect.

In remote and rural regions or other areas of workforce shortage, the APA contends that, with appropriate checks and balances, a *registered* health practitioner acting as an intermediary should

be allowed to also provide the relevant services – for example a physiotherapist acting as an intermediary should also be allowed to provide physiotherapy.

In 2009, according to the Department of Health and Ageing, based on the Australian Standard Geographical Classification of Remoteness Area (ASGC-RA) there were some 2,339 APA physiotherapists spread across the vast area outside RA1 (Major Cities of Australia).<sup>2</sup> In contrast to the 7118 physiotherapists in RA1 alone, the figures comparatively describe the vast difference in the accessibility of physiotherapy services. The APA contends that preventing intermediaries from also providing services will exacerbate this situation.

While cognisant of the potential risks of this arrangement raised by the Commission, the APA believes that a strong auditing process should identify any anomalies or discrepancies. If peer review were to be used as one of the mechanisms for auditing, specialist physiotherapists (described further below) can be engaged to review treatment plans. A registered health practitioner would also risk facing disciplinary action from the relevant board for any fraudulent claims or breach of professional ethics.

#### Use of the physiotherapy workforce - specialist physiotherapist

Specialist physiotherapists have extensive experience, knowledge and skills across a sub-discipline area, for instance musculoskeletal, neurological or paediatric physiotherapy. As referred to above, specialist physiotherapists can be effectively engaged to review individual treatment plans. This arrangement is currently employed by Workcover authorities.

They can also act in the capacity of a consultant and be involved in the management of complex cases.

While physiotherapists who are not specialists but who possess a comparable level of training and experience may also act as a consultant, specialist physiotherapists are clearly identifiable by their membership of the Australian College of Physiotherapists.

#### Use of the physiotherapy workforce - physiotherapy assistants and other support workers

The physiotherapist workforce is supported by physiotherapy assistants and other support workers. A physiotherapist may allocate work to a physiotherapy assistant or other support worker who then has responsibility for the completion of that task. In this situation the support worker is responsible for completion of the task however the registered practitioner retains accountability.<sup>3</sup> The physiotherapist is still responsible for any decision making and maintains ongoing involvement with the care and treatment of the patient or client.

The APA believes that this arrangement of task delegation is efficient and cost effective, freeing the physiotherapist to work on more complex cases.

The APA defines a physiotherapy assistant as a practitioner who works under the supervision of a registered physiotherapist and who holds a Certificate IV in Allied Health Assistance (Physiotherapy) or equivalent (course code: HLT42507). With this level of training, the APA believes that these workers have a range of skills which allow a physiotherapist to confidently delegate a higher level of tasks.

There are other support workers who also work under the supervision or delegation of physiotherapists, for example indigenous health workers, personal trainers, paid carers, massage therapists, rehabilitation therapists, etc. Support workers are not regulated and there is no minimum certification required, however the APA's position is that support workers should hold a minimum qualification of Certificate III in a field relevant to their area of work. In some circumstances equivalent on the job training may be considered adequate.<sup>4</sup>

There is at present no accurate data on the numbers of physiotherapy assistants, and the numbers and qualifications of support workers in the disability workforce (and no mechanism to collect this data). However the APA is aware that several vocational training providers offer the HLT42507 course. These include the Gold Coast Institute of TAFE, Canberra Institute of Technology, and Kangan Institute etc.

#### Assessment tools

The APA is pleased that the Productivity Commission has recommended the use of the International Classification of Functioning, Disability and Health (ICF) as the framework for which assessment tools will be based and/or developed.

It is important that assessments tools measure an individual's *capacity* rather than *functional range*.

For example, item d4503 (mobility) "Walking around obstacles" on the ICF is described as a measure of how capable would an individual be in negotiating obstacles while walking – probable situations include walking around a busy street. In this case, an assessment of the function range of the individual's limbs would be grossly insufficient, as it would not take into account other necessary functions, for example sight and cognitive capacity.

An individual's *capacity* may also change in different situations, as described by an APA physiotherapist:

*A really good example is that of a growing adolescent with cerebral palsy. They are undergoing rapid and constant changes in their musculoskeletal and neuromotor systems. They may be able to walk independently in the home environment, but require sticks in the classroom and a manual or powerchair for the community as fatigue, self consciousness and need to get somewhere in an allotted time impacts. Many adolescents hate 'holding their friends up' when out and about, as they feel they are taking too long to get where they are going or they may fall and embarrass their mates.*

#### Training requirement for personal support workers

The APA contends that a minimum training requirement should be necessary for personal support workers. This training does not have to be a formal certification, and may be offered on the job under guidance and supervision from a professional with experience in the area – for example, for safe and proper lifting techniques of a person who required such assistance this guidance can be provided by a physiotherapist.

Using the example above, there can potentially be very serious consequences including the risk of injury to both the support worker and the person with disability through improper lifting techniques, insufficient familiarity with equipment and the lack of safety awareness (e.g., risks posed by objects in the environment, etc).

#### Use of lists to determine eligibility to interventions, supports and aids

As a component of assessments for eligibility of services and supports, for example aids and equipment (assistive technologies), the APA acknowledges that for practical reasons a "list" would be the most efficient method and can be quickly used to determine eligibility.

However, while the majority of requests would be met by this "list" there may be gaps where cost-effective interventions or supports may be overlooked or excluded. For example, some interventions or equipment may cost more, but produce far better outcomes for certain impairments – such as being able to bring a person with a disability to a level of functioning that would allow a higher level

of independence to self-manage care or return to work. Another concern would be when the 'list' prescribes that the use of certain equipment is unnecessary (for example, when it can be assumed that another equipment item already funded for would produce the same outcome), when it can actually greatly benefit an individual:

*There is an amazing piece of equipment that is a sit to standing frame. It is a great appliance but very costly. As people with a disability get heavier, they find it harder to stand for long periods of time in a standard frame. Also the time and effort (by the individual and carer's to get them into frames for short periods) become a disincentive to their use even though the person realises that standing is of benefit for kidney / bladder function, bone density, postural responses, strengthening torso musculature, minimising deformities of the lower limbs and assisting in self esteem by being upright. This revolutionary device allows people to stand in the frame up to an hour or more but allows them to sit down (via a hydraulic or electric lever) when they are fatigued. Then stand again when they are recovered. Some government agencies will not supply a standing frame if they have supplied a person with a wheelchair (even though both have very different functions).*

In addition, for some individuals, needs considerably differ to others with a similar disability, for example:

*A young adult with osteogenesis imperfecta recently approached us for assistance with prescription for her motorised chair. She required a chair for mobility in the community with a height adjustable seat base that could also be lowered to ground level. This equipment item would not usually be available on a core list of equipment.*

The APA reiterates the need for a process that manages requests for interventions and equipment outside a "pre-approved list". This process should be informed by a representative panel of experts relevant to the condition and the intervention or equipment.

The Commission could also explore a parallel process for equipment manufacturers to apply to have aids or equipment included on the list.

The APA also recommends that regular reviews should ensure that commonly requested interventions or equipment with demonstrated evidence of cost-effectiveness and efficacy could be included on the "pre-approved list". Research to determine the expected life cycle of equipment items on the core list may also be required.

#### Bureaucratic red-tape should be minimised

The APA is concerned that individualised checks as proposed by the Commission throughout the assessment process and through the process to determine entitlement to packages of support may result in extensive delays to people with a disability receiving the appropriate supports. It is crucial that this must not occur.

#### Accessible and user-friendly information

Information on the NDIS website should be easily accessible and user friendly. Simple, easy to understand language should be used where possible (or information provided in complementary "easy English" versions).

The NDIS website should provide and maintain service provider directories – this is also useful for people considered to be in Tier 2 of the scheme.

An example of an easy to use service provider directory is the APA's "Find a Physio" utility. The APA's "Find a Physio" utility is used by the public to search for an APA physiotherapist

geographically closest to a chosen suburb or region. “Find a Physio” also allows one to include further search criteria, such as to only list specialist physiotherapists or APA physiotherapists with an interest in a particular condition.

The APA suggests that, if not already present in one form or another, other health professional associations should develop a similar a utility for their profession. These search utilities can thus all be linked from the NDIS website as part of the abovementioned service provider directory. Further development of the site over time may include more lifestyle and leisure options for individuals such as gymnasiums, exercise class locations or accessible swimming or hydrotherapy pools.

### Funding for acute and unexpected care episodes

The APA is concerned that in some circumstances an individual's condition may seriously deteriorate and result in unexpected care and treatment at significant cost to return the individual to the previous level of functioning.

This may be as simple as when a person with a disability who uses a manual wheelchair to move around becomes infected with the flu – in addition to the respiratory conditions that can develop, the person can also become too physically weak to operate the manual wheelchair and thus require additional care and support to maintain their mobility.

The APA recommends that the Commission explores the options for funding these care episodes.

## Specific Comment

**The APA fully supports the following recommendations:**

3.1, 3.2, 3.5, 3.6, 4.1, 5.1, 5.2, 5.5, 5.9, 6.7, 6.8, 6.9, 7.4, 7.5, 7.10, 7.13, 8.1, 8.2, 9.1, 10.3, 11.1, 16.1, 16.4, 17.3, 17.4.

The APA also has comments on the following recommendations:

### Chapter 3: Who is the NDIS for?

#### 3.3 Identifying less restrictive disorders when determining eligibility to be in the NDIS

The APA supports the provision of advice by the NDIS to people about those instances where support would be more appropriately provided through non-NDIS services. Attention must be paid when identifying support needs that would be more appropriately met by the health and/or palliative care systems, particular identifying less restrictive musculoskeletal and affective disorders.

The APA recommends that input must be sought from the related professions / peak groups to inform of the conditions that fall into this category.

For people who would be considered to be in Tier 2 of the scheme, the APA is concerned that some may still encounter a fragmented service system. This is likely to occur where there are perceived opportunities by different agencies and organisations to cost shift.

An APA physiotherapist described the experience of a family member with motor neurone disease (MND):

*He called MND the disease of exclusion and that is because he felt that as soon as he was given the diagnosis then everyone said that they could not do anything for him.*

*He had to really fight to have access to Botox treatment for the spasticity in his lower leg, and regular physiotherapy which he had monthly up until the time of his death.*

*He received little support during the initial stages of his disease and after a period of hospitalisation was offered a palliative care package of support.*

*The support was discontinued as he had not passed away within the timeframe specified for the support package, and at the age of 50 he was given an extended aged care at home (EACH) package.*

*Unfortunately this meant that he had to change service providers and return multiple items of essential equipment to the palliative care provider.*

The APA recommends that the Commission explores disincentives to cost shifting.

#### 3.4 Ensuring individuals do not fall between the cracks

The APA strongly supports that a memoranda of understanding is established. Unfortunately there will inevitably be the small possibility that someone may “fall between the cracks” - it would be helpful to consider a “catch-all” mechanism built into the NDIS. However it is important to ensure that individuals who are rightfully eligible for benefits are able to appeal through a one-off independent process if they have been overlooked using existing criteria.

#### 3.7 Determining entitlement to supports

The APA supports the use of a forward-looking assessment process – there should be consideration of whether a condition may rapidly deteriorate or require changing levels of supports and services. For example, an individual with cerebral palsy, spina bifida, polio and chronic chest conditions may

function well in the early years, but mobility can become increasingly limited as the individual ages, eventually requiring the use of mobility aids to maintain independent function.

Further to this, health practitioners acting as intermediaries should be encouraged to be involved in the initial planning process, which can give an early indication to what supports are likely to be needed over the lifespan of the individual.

## **Chapter 4: What individualised supports will the NDIS fund?**

### **4.4 Co-payment**

The APA supports arrangements for co-payment or payment of the full costs of services (primarily therapies) for which clinical evidence of benefits is insufficient or inconclusive. These services should be determined or informed by a representative expert reference or advisory panel, who can also determine an appropriate number of episodes that should be funded by the NDIS, following which co-contribution will be necessary. However, there should be no limits on the total number of episodes or services provided.

The APA argues that fees should not be prescribed as fee schedules stifle innovation, restrict the quality of services, are subject to constant disputes and are extremely difficult to maintain at appropriate levels.

### **4.6 Funding and oversight of the Disability Support Pension (DSP)**

The APA supports incentives provided for engagement in paid work and reiterates that incentives with appropriate supports, rather than penalties, encourage people to work.

## **Chapter 5: Assessing care and support needs**

### **5.4 Trained assessors**

The APA supports the undertaking of assessments by trained assessors, and the principle that assessors should not have a longstanding connection to the person. Further to this, it is of utmost importance that assessors should possess the qualifications and experience relevant to the condition being assessed.

### **5.3 & 5.7 Assessment tools**

The APA strongly supports the development and use of valid and reliable tools. It is critical that the scheme is consistent throughout all states and territories.

The APA also supports the establishment of a coherent package of tools suitable for various assessments. Reiterating a point made in the Commission's report, to protect the integrity of the scheme, the possibility that certain tools can exhibit bias towards a certain need must be eliminated or, where this is impossible, must be kept at a minimum.

### **5.8 Review of assessment tools**

The APA supports ongoing monitoring and evaluation of tools. There also should be a regular public review and consultation process to identify and address any anomalies.

## **Chapter 6: Who has the decision-making power?**

### **6.1 Self-directed funding**

The APA supports empowering individuals to direct their own funding. However, there should be more clarity over what assistance will be provided to facilitate this and how compliance will be managed.

### **6.2 Suggested self-assessment process**

The APA supports self-assessment if individuals are provided with the right tools and information to be aware of the supports available to them. People with disability and their carers should have access to intermediaries, especially those who are health practitioners to guide them through the disability support system as well as to assist with anticipating future needs and supports required when developing initial personal plans.

Health practitioners acting as intermediaries can play very important roles in the initial planning stage to anticipate future needs and plan realistic milestones. With a better informed initial plan there is also less of a need to 'cash out' NDIS-packaged supports at the later stage. The APA argues that this would effectively improve the efficiency of the process, while people with a disability and their carers can also be confident that a qualified and experienced health practitioner is advocating on their behalf.

As referred to earlier, the APA believes that in this pre-planning stage health practitioners acting as intermediaries should be appropriately remunerated.

### **6.6 Educative role of the NDIA**

The APA supports the NDIA's educative role. To complement our recommendation in relation to the pre-planning process referred to above, the NDIA should also encourage health practitioners to be intermediaries and raise awareness of their role in providing valuable insight to planning supports.

## **Chapter 7: Governance of the NDIS**

### **7.1 Establishing the NDIA**

The APA believes that it is a critical requirement that the Australian Government establishes the NDIA as a new independent Commonwealth statutory authority to administer the National Disability Insurance Scheme.

### **7.2 Governance of the NDIA**

The APA believes board members should have experience or knowledge specifically related to the disability sector.

### **7.3 Establishing an advisory council to provide advice to the NDIA**

The APA supports the establishment of an advisory council. The council should comprise representatives of people with disabilities, carers, suppliers of equipment and services and state and territory service providers and administrators. This is a significant feature and there should be an undertaking by the Agency (through legislation or etc) that commits to the formation of a representative council.

#### **7.12 Setting up an internal complaints office**

The APA supports the establishment of an internal complaints office. However, the NDIS should only publish outcomes of complaints and appeals where a complaint was upheld.

### **Chapter 8: Delivering disability services**

#### **8.3 Implementing a quality framework for disability providers**

The APA supports the proposal that the NDIA establishes an innovation fund to develop and/or trial novel approaches to disability services.

The APA supports graduated and rolling audits of service providers and complaints against them, and, subject to details and methodology, of community visitors and senior practitioners.

However, the APA does not support independent consumer surveys, surveillance by case managers and interrogation of the electronic disability record.

## **Chapter 11: Early intervention**

### **11.2 Building an evidence base on early intervention**

The APA supports building an evidence base on early intervention. Resources should be made publicly available. Where appropriate, there should be collaboration with the health professions so that the existing evidence base can be drawn upon.

## **Chapter 13: Workforce issues**

### **13.1 Attracting further support workers**

The APA supports marketing the role of support workers and the provision of subsidies to training.

Recognising that this is outside the domain of the scheme, the APA recommends that the NDIA advocates for further training in disability services, assessment and treatment of severe disability and catastrophic injuries to be introduced into pre-clinical units for physiotherapists and other health practitioners where this is not already present. Flexible opportunities for undergraduate health practitioners including physiotherapists to work in the disability sector during their student years should be encouraged.

The scheme however can fund volunteer programs to promote interest amongst younger physiotherapists and other health practitioners in working in the disability sector. Preliminary work to build the workforce will need to be commenced prior to implementation of the scheme.

Remuneration, career pathways and professional development for physiotherapists, other health practitioners and support workers working in the disability sectors should also be commensurate with that of their colleagues working in other sectors.

As referred to in our general comments, physiotherapy assistants and other support workers will be a key component of the physiotherapy workforce who will be delegated less complex tasks under supervision. They will contribute significantly as qualified and trained support workers in the scheme.

### **13.2 Police checks**

The APA believes that registered health practitioners who have already performed these checks as part of registration should not be required to undergo any other unnecessary police checks.

The APA believes that, further to police checks, a framework must be in place to ensure people with a disability who can be very vulnerable are protected.

## **Chapter 17: Implementation**

### **17.1 Timeframe for the implementing the NDIS**

The APA believes that positive change to the disability support system is long overdue and that a commitment to implement the NDIS within the specified timeframes will be a significant improvement to supporting people with a disability and their family and carers.

### **17.2 Establishing a taskforce to commence work on the NDIS**

The APA supports the Commission's recommendation. The person heading the taskforce should also have both insurance expertise and experience in the disability sector.

## References

1. Productivity Commission (2011) Disability Care and Support, Draft Inquiry Report, Canberra, p. 5.
2. Primary & Ambulatory Care Division, Department of Health and Ageing (2009), Physiotherapists by Australian Standard Geographical Classification Remoteness Area (ASGC-RA).
3. Chartered Society of Physiotherapy (2006) Supervision, accountability and delegation of activities to support workers: A guide for registered practitioners and support workers.
4. Australian Physiotherapy Association (2008) Position statement on Working with a Physiotherapy Assistant or Other Support Worker. Available from [http://physiotherapy.asn.au/images/Document\\_Library/Position\\_Statements/working%20with%20a%20physiotherapy%20assistant%20or%20other%20support%20worker.pdf](http://physiotherapy.asn.au/images/Document_Library/Position_Statements/working%20with%20a%20physiotherapy%20assistant%20or%20other%20support%20worker.pdf); accessed 29 April 2011.