Australian Government
Productivity Commission

National Disability Insurance Scheme (NDIS) Costs

Productivity Commission Position Paper

June 2017

This position paper has been prepared for further public consultation and input. The Commission will finalise its report after these processes have taken place.

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The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

Opportunity for further comment

You are invited to comment on this position paper by written submission to the Productivity Commission by Wednesday 12 July 2017. Further information on how to provide a submission is included on the study website: http://www.pc.gov.au/inquiries/current/ndis-costs/make-submission.

The final report will be prepared after further submissions have been received.

Commissioners

For the purposes of this study the Commissioners are:

Angela MacRae	Commissioner
Richard Spencer	Commissioner

Terms of reference

REVIEW OF NATIONAL DISABILITY INSURANCE SCHEME COSTS

I, Scott Morrison, Treasurer, pursuant to Parts 2 and 4 of the Productivity Commission Act 1998, hereby request that the Productivity Commission (the Commission) undertake a study into the National Disability Insurance Scheme (NDIS) costs.

Background

The Heads of Agreement between the Commonwealth and the States and Territories (States) on the NDIS stated that the Commission would undertake a review of scheme costs in 2017. This review is intended to inform the final design of the full scheme, prior to its commencement.

Scope of the study

The Commission should address the following issues identified in the Heads of Agreement for the review of scheme costs:

- the sustainability of scheme costs;
- jurisdictional capacity;
- cost pressures (including wages pressures);
- changes in the agreed escalation parameters;
- if efficiencies have been achieved within the scheme;
- whether there has been any impact on mainstream services; and
- examine the most appropriate levers to manage any potential cost overruns.

In addressing these issues, the Commission should consider:

1. Commonwealth and State funding and governance arrangements for the NDIS, including financial contributions and risk-sharing;
2. the interaction with, and role of, other services in meeting reasonable and necessary support for people with severe and profound disability; and

3. whether there are any issues with the scheme's design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with severe and profound disability.

In conducting the analysis, the Commission should take into account its 2011 report into disability care and support and subsequent agreements between governments for the implementation of the NDIS. The Commission will be provided with all the data on scheme rollout it considers necessary for the analysis.

Process

The Commission is to consult broadly, including with the Australian, State and Territory Governments.

The Commission will report within eight months of receipt of the terms of reference, or by 15 September 2017, whichever is later.

Scott Morrison
Treasurer

[Received 20 January 2017]

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Abbreviations

AAT	Administrative Appeals Tribunal
ANAO	Australian National Audit Office
CALD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DRC	COAG Disability Reform Council
DSS	Department of Social Services
ECEI	Early Childhood Early Intervention
FCA	Federal Court of Australia
FTE	Full-time equivalent
IAC	Independent Advisory Council
ICT	Information and communication technology
ILC	Information, Linkages and Capacity Building
LACs	Local Area Coordinators
NDA	National Disability Agreement
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NIIS	National Injury Insurance Scheme
OECD	Organisation for Economic Cooperation and Development
PC	Productivity Commission
PEDI-CAT	Paediatric Evaluation of Disability Inventory-Computer Adaptive Test
WHODAS	World Health Organization Disability Assessment Tool

OVERVIEW

Key points

- The National Disability Insurance Scheme (NDIS) is a complex and highly valued national reform. The scale, pace and nature of the changes it is driving are unprecedented in Australia. If implemented well, it will substantially improve the wellbeing of people with disability and Australians more generally.
- The level of commitment to the success and sustainability of the NDIS is extraordinary. This is important because 'making it work' is not only the responsibility of the National Disability Insurance Agency (NDIA), but also that of governments, participants, families and carers, providers, and the community.
- Based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling. While there are some emerging cost pressures (such as higher numbers of children entering the scheme), the NDIA has put in place initiatives to address them. The benefits of the NDIS are also becoming apparent. Early evidence suggests that many (but not all) NDIS participants are receiving more disability supports than previously, and they have more choice and control.
- Nevertheless, the speed of the NDIS rollout, as specified in Bilateral Agreements between governments, has put the scheme's success and financial sustainability at risk. It has resulted in the NDIA focusing too much on meeting participant intake estimates and not enough on planning processes, supporting infrastructure and market development.
  - This focus is manifest in poor outcomes such as confusion for many participants about planning processes; rushed phone planning conversations; inadequate pre-planning support for participants; problems for providers with registering, pricing and receiving payment; and a lack of effective communication with both participants and providers.
- For the scheme to achieve its objectives, the NDIA must find a better balance between participant intake, the quality of plans, participant outcomes, and financial sustainability. Steps are now being taken by the NDIA to better balance these aspects. Greater emphasis is needed on pre-planning, in-depth planning conversations, plan quality reporting, and more specialised training for planners. The Commission is unable to form a judgment on whether such a refocus can be achieved while also meeting the rollout timetable.
- The interface between the NDIS and other disability and mainstream services is also critical for participant outcomes and the financial sustainability of the scheme. Some disability supports are not being provided because of unclear boundaries about the responsibilities of the different levels of government. Governments must set clearer boundaries at the operational level around 'who supplies what' to people with disability, and only withdraw when continuity of service is assured.
- A significant challenge is growing the disability care workforce required to deliver the scheme — it is estimated that 1 in 5 new jobs created in Australia over the next few years will need to be in the disability care sector. Present policy settings are unlikely to see enough providers and workers as the scheme rolls out. Some emerging shortages need to be mitigated by better price monitoring and regulation; better tailored responses to thin markets; formal and informal carers allowed to provide more paid care; and a targeted approach to skilled migration.
- NDIS funding arrangements could better reflect the insurance principles of the scheme, including by allowing more flexibility around the NDIA's operational budget and providing a pool of reserves. Funding contributions made 'in-kind' must be phased out.

Overview

This position paper outlines the Commission's early thinking on the National Disability Insurance Scheme (NDIS) Costs study. The purpose of this position paper is to seek feedback on the Commission's preliminary conclusions and draft recommendations, and on any additional issues that should be considered before the public release of the completed study in September 2017. The Commission welcomes further written comment on this paper, and will undertake consultations to facilitate feedback from participants to inform the preparation of the study report.

More data and information, while still only reflecting the transition stage of the NDIS, will be available before the study's final report is released. As such, the recommendations made in this paper should be viewed as indicative.

1 About the National Disability Insurance Scheme

The NDIS is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability (a disability that substantially reduces their functional capacity or psychosocial functioning). The scheme seeks to create opportunities for people with disability to live 'an ordinary life'. The NDIS is currently being rolled out across Australia. At full scheme, about 475 000 people (460 000 participants under the age of 65 years, and 15 000 aged 65 years and over) with disability will receive individualised supports, at an estimated cost of $22 billion in the first year of full operation.

The NDIS is based on the premise that individuals' support needs are different, and that scheme participants should be able to exercise choice and control over the services and support they receive. The scheme differs from previous approaches in a number of ways:

- it adopts a person-centred model of care and support
- it is an insurance-based scheme — it takes a long-term view of the total cost of disability to improve participant outcomes and to meet the future costs of the scheme (box 1)
- funding is determined by an assessment of individual needs (rather than a fixed budget)
- it is a national scheme.

The NDIS funds reasonable and necessary supports for Australians with permanent and significant disability. Reasonable and necessary supports are those that help participants live as ordinary a life as possible, including care and support to build their skills and capabilities, so that they can engage in education, employment and community activities.

Box 1 **The NDIS is based on insurance principles**

The National Disability Insurance Scheme provides universal coverage by pooling risk across all Australians and taking the risk of disability support costs away from individuals. It is based on four insurance principles.

1. Actuarial estimate of long-term costs — updated to reflect the experience of the scheme, and used to help ensure the scheme is financially sustainable and continuously improved.
2. A long-term view of funding requirements — takes a lifetime view of participant needs and seeks early investment and intervention for people in order to maximise their independence, and social and economic participation, and reduce their long-term support requirements.
3. Investment in research and innovation — to encourage and build the capacity and capability for innovation, outcome analysis and evidence-based decisions on early interventions.
4. Investment in community participation and building social capital — to make the community accessible and inclusive for people with disability, and provide participants and non-participants with necessary supports outside of the scheme, through: mainstream services; Information, Linkages and Capacity Building initiatives; and education programs.

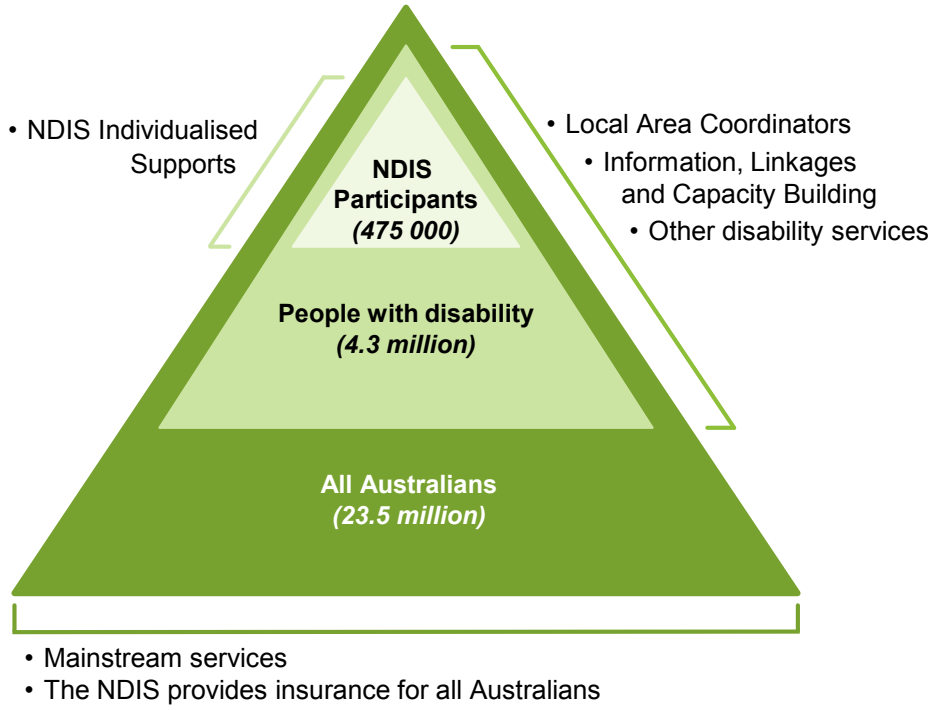
The NDIS also funds supports for people who meet early intervention criteria. This covers cases where early intervention can significantly improve an individual's outcomes and is cost-effective. The focus on early intervention reflects the lifetime approach of the scheme (which is consistent with insurance principles, box 1).

Individuals eligible for the scheme are assessed, and individualised support packages are developed and funded for them. Individualised supports will be available for about half a million people at full scheme (figure 1). NDIS access, planning and payments are managed by the National Disability Insurance Agency (NDIA). (In Western Australia, arrangements are different to reflect a recently announced Bilateral Agreement with the Commonwealth, but the scheme in Western Australia is intended to be consistent with the NDIS.)

Information, Linkages and Capacity Building (ILC) services will also be provided under the NDIS from July 2017. ILC services will provide information about, and referrals to, community and mainstream services (including health, education, employment, transport, justice and housing). These services will be available to the 4.3 million people with disability in Australia (figure 1).

The governing legislation for the NDIS is the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act). The Act also establishes the NDIA, the independent statutory agency responsible for administering the NDIS. The NDIS Rules and Operational Guidelines set out the operational details of the NDIS. Funding for the NDIS is shared by the Australian, and State and Territory Governments.

Figure 1 **The NDIS is part of a broader system of supports**[a]



[a] Number of Australians and those with disability are based on 2015 data. NDIS participants are the projected number of people eligible in 2020.

Some background to the scheme

The Commission's inquiry in 2011 on *Disability Care and Support* found that Australia's system of disability support was inequitable, underfunded, fragmented, inefficient, and gave people with disability little choice and no certainty of access to appropriate supports. The Commission recommended a new national scheme to provide insurance cover to all Australians in the event of significant disability. This recommendation was based on the finding that such a scheme would generate substantial benefits, including:

- improved wellbeing of people with disability (and their families and carers)
- better options for people with disability for education, employment, independent living and community participation
- efficiency gains and cost savings in the disability support system and savings to other government services.

The Commission's recommendations on the national scheme were largely accepted by Australian governments. The *Intergovernmental Agreement for the NDIS Launch* was signed by the Commonwealth and all States and Territories in December 2012.

2 What we have been asked to do and our approach

In the Heads of Agreement on the NDIS signed by the Commonwealth and the States and Territories in 2012 and 2013, it was agreed that the Productivity Commission would review NDIS costs in 2017 to inform the final design of the full scheme prior to its commencement. The Commission has been asked to look at:

- the sustainability of scheme costs, including current and future cost pressures, and how to manage any potential cost overruns
- whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- how the NDIS impacts on, and interacts with, mainstream services
- whether efficiencies have been achieved within the scheme
- whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with profound or severe permanent disability
- funding and governance arrangements.

What factors drive scheme costs?

Assessing the sustainability of the scheme involves examining the factors that drive costs. The majority of NDIS costs are for individualised supports, but there are also the costs of operating the scheme and funding ILC activities.

Key factors driving scheme costs include the:

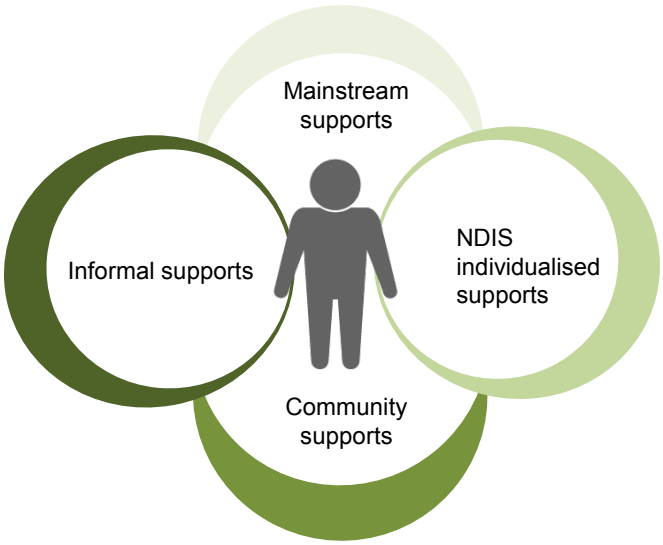
- number and characteristics of scheme participants
- scope of supports provided to scheme participants
- quantity of supports received by scheme participants
- proportion of supports in a plan that is utilised by a participant
- price paid for supports under the scheme
- costs associated with operating the scheme.

Scheme culture will also be an important driver of costs. Moving away from the welfare culture of current disability systems to one of providing reasonable and necessary supports, and managing down the total cost of disability over a participant's lifetime, will be critical for the financial sustainability of the scheme.

Other support systems can also affect scheme costs. The NDIS, as a person-centred approach to providing disability supports, relies on supports and services outside the scheme, including informal supports (family, friends and neighbours), community supports

(local sporting teams, social and interest groups), and mainstream supports (public transport, health and education), to help people with disability to live ordinary lives (figure 2). If these supports are not available, people with disability could seek NDIS funding to fill the gap, and this could pose a risk to scheme costs.

Figure 2 **A person-centred approach relies on supports beyond the NDIS**



Costs are just one side of the equation

While the focus of this study is on scheme costs and the financial sustainability of the scheme, the Commission examined costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally, using a wellbeing framework (figure 3).

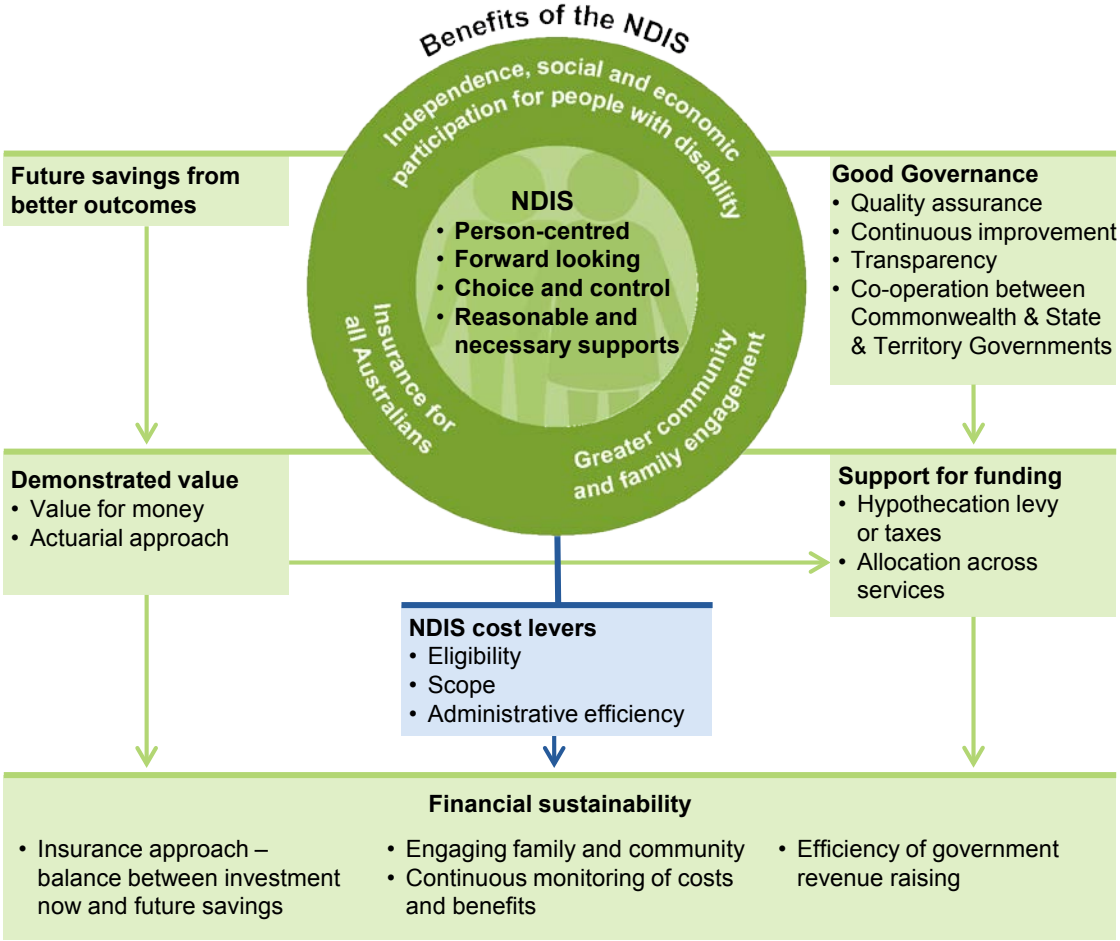
The NDIS was introduced because it has potential to improve the lives of people with disability and the community more generally (by providing insurance for all Australians and lowering future costs of providing disability support). It is therefore essential that the costs to the community are considered in the context of scheme outcomes.

Taxpayers' willingness to fund the NDIS will depend on their perception of value for money, in terms of:

- people with disability experiencing better lives as a result of the scheme
- the scheme making it easier for families and carers to play a supporting role
- the way the scheme invests in people with disability
- the supports that are funded (and the evidence base to support what is funded)

- efficiency gains and cost savings in the disability support system and other government services.

Figure 3 **A wellbeing framework for considering costs and benefits**



While the NDIS is sometimes described as an 'uncapped scheme', the ultimate cap — and test of financial sustainability — is taxpayers' continuing willingness to pay for it. In line with this, the NDIA defines financial sustainability for the NDIS as:

- the scheme is successful on the balance of objective measures and projections of economic [and] social participation and independence, and on participants' views that they are getting enough money to buy enough high-quality goods and services to allow them reasonable access to life opportunities — that is, reasonable and necessary support; and
- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute.

The NDIA's actuarial estimates of long-term costs (which reflect the experience of the scheme and management responses to cost pressures) play an important role in demonstrating to the Australian community that the scheme is sustainable.

Perceptions about the governance arrangements for the NDIS are also important. For example, the community expects planning processes to be in line with the objectives of the scheme and that services meet quality standards. Governments also need to demonstrate that the NDIS funds are dollars well spent, and that funding the scheme is not to the detriment of other important social expenditure (such as health and education).

Financial sustainability of the NDIS also needs to be considered in the context of the efficiency and effectiveness of the NDIA, the readiness of participants and providers, and the integration of the scheme with mainstream and other disability services. Only a system that is integrated and holistic in its focus will bring the benefits that the scheme is expected to deliver.

Modelling costs

In 2011, the Commission estimated that a national disability insurance scheme would cover 411 000 participants and cost $13.6 billion (gross) at maturity. The NDIA's current projections are that the NDIS will cover 475 000 participants and cost $22 billion at full scheme commencement.[1] The NDIA's estimates are broadly consistent with the Commission's 2011 modelling (table 1).

There is an $8.9 billion difference between the Commission's original estimates and the NDIA's current estimates. This is largely the effect of pay rises awarded to social and community services employees by the Fair Work Commission in 2012, accounting for over $6 billion or 71 per cent of the difference. Combined with population changes and the cost of participants aged over 65 years (who entered the scheme when they were under 65 years of age), this brings the estimates to within one per cent of each other (table 1).

Table 1 **Comparing the Commission's and the NDIA's costings**

	Participant numbers	*Scheme costs ($ billions)*
Productivity Commission estimates 2011[a]	**411 250**	**12.82**
Population projections to 2019-20	49 544	1.54
Inflation in disability sector (wages)	..	6.38
Participants aged 65 years and older	15 285	1.09
Updated Productivity Commission estimates 2017	**476 079**	**21.84**
The NDIA's projections for participants 2017[b]	**473 653**	**21.76**
Difference (%)	2 426 (0.5%)	0.08 (0.4%)

[a] Excluding operating costs and offsets associated with the National Injury Insurance Scheme and assumed efficiency dividends. [b] Excluding operating costs ($1.5 billion), offsets associated with the National Injury Insurance Scheme (-$0.7 billion) and assumed efficiency dividends (-$0.3 billion).

[1] While the gross cost of the NDIS is estimated to be $22 billion in 2019-20, the scheme is expected to reduce the funding required for a range of government programs. A review by the Australian Government Actuary in 2011 estimated that these offsets were around $11 billion.

It is too early and the data are too limited for new cost projections

It is still very early days in the NDIS's transition to full scheme. And while the transition experience should inform estimates of full scheme costs, the data have too many limitations to update the prevalence and package cost assumptions. An important limitation is small and unrepresentative trial populations, but approaches to planning and assessments have also changed.

The Commission has not developed new projections of scheme costs for the position paper and will not, given the data limitations, be in a position to do so for the final report. Rather, we have assessed the risks to the financial sustainability of the scheme, including both those within and outside the control of the NDIA. Many of these risks cannot be modelled.

3 An enormous challenge

The NDIS is a major, complex national reform, the largest social reform since the introduction of Medicare. It will:

- involve a shift away from a block-funded welfare model of support, to a fee-for-service market-based approach
- increase funding in the sector from around $8 billion per year to $22 billion in 2019-20
- involve assessing the 'reasonable and necessary' needs of around 475 000 people
- require around 70 000 additional disability support care workers (or around 1 in 5 of all new jobs created in Australia over the transition period)
- substantially improve the wellbeing of people with disability and Australians more generally (if implemented well).

It is therefore no surprise that the NDIS has been described as a 'ground-breaking reform' and a 'once-in-many-generation reform'.

The level of commitment to the NDIS is extraordinary

There is an extraordinary level of commitment to the success and sustainability of the NDIS (and to preserving the core principles of the scheme) shared by governments, people with disability and their families and carers, providers of disability services and disability advocates (box 2). As the Australian Disability Discrimination Commissioner said:

> Yes — the NDIS is big, it is complex, and it changes everything, but it is the change that we need. And when we think about what life might be like for people with disability without the NDIS, I think it becomes clear that it is the change we cannot afford to prevent. … If we want real and lasting change for people with disability, we cannot absolve ourselves of our responsibility to make the NDIS work.

Box 2 **There is overwhelming support for the NDIS**

NSW Council for Intellectual Disability:

> … we have been strong supporters of the development of the NDIS and we continue to see [the] scheme as having a fundamental capacity to improve the lives of people with disability around Australia.

Flourish Australia:

> …. strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support.

JFA Purple Orange:

> … the NDIS is a major, once-in-many-generations opportunity to invest in the life chances of people living with disability, to achieve a fair go, so that people living with disability take their rightful place as … valued active members of Australian community life and the economy.

National Disability Services:

> The principles on which the NDIS is founded remain compelling and inspiring.

Australian Federation of Disability Organisations:

> We want to begin … by emphasising our unwavering support for the NDIS. AFDO and its members regularly hear from people with disability and their families about the difference the NDIS is making to their lives. People who now have the dignity of appropriate and timely support, the opportunity to be more involved in their communities, the chance to move out of home, the economic freedom of a new job. These are the kinds of differences the NDIS is making.

Anglicare Australia:

> Anglicare Australia strongly believes that the establishment of the NDIS is a major achievement. Our member agencies are already witnessing the transformative power of the scheme for participants, and finding that reconfiguring services to reflect their needs and aspirations is creating opportunities to reimagine and create better outcomes in people's lives.

Health Services Union:

> The HSU has always been a strong supporter of the NDIS and our longstanding position has been that quality disability services depend on a quality workforce.

New South Wales Government:

> The NSW Government is a strong advocate of the National Disability Insurance Scheme (NDIS). The improvement in the lives of people with disability, as outlined by the Productivity Commission (PC) in its 2011 inquiry report into Disability Care and Support, is a goal embraced by NSW.

A highly ambitious rollout schedule

The NDIS was trialled from 2013 in different jurisdictions across Australia in four trial sites (including two whole-of-state age cohort trial sites). Trials commenced in July 2013 in New South Wales, Victoria, South Australia and Tasmania (table 2).

Table 2 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	Hunter area trial			Transition to full scheme (by region)		Full scheme	
		Early Transition in Nepean Blue Mountains area (children aged 0-17 years)					
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld			Transition to full scheme from July 2016 (by region). Early Transition from January 2016 in Townsville, Charters Towers and Palm Island				Full scheme
SA	Statewide trial (children aged 0-14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15-24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial			Transition to locally-administered NDIS		Full scheme
		MyWay trial					

[a] The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17 the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. [b] In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally administered, NDIS.

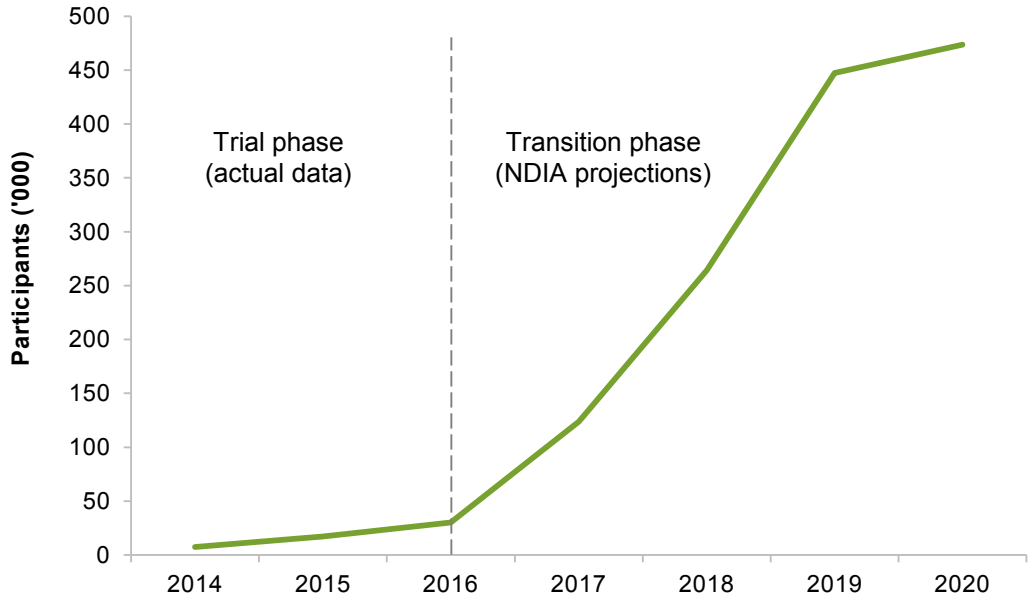
The Bilateral Agreements between the Commonwealth and the States and Territories set out the timeframes, and the estimated number of people who will become participants in the scheme, for the transition to full scheme in each jurisdiction. The transition to the full scheme began in all states and territories in July 2016, with the exception of Western Australia (which will transition from July 2017). The full scheme is scheduled to be rolled out by 2019-20, but some jurisdictions will move to full scheme earlier.

The Commission's 2011 report recommended that the trials start a year later than they did and also that they operate in only two geographic locations. According to the NDIA, the changed timing and breadth of the trial compromised what the NDIA could achieve in the short term and as a consequence, some aspects of the scheme were being built and tested over the trial period. For example, the NDIA started the trial without an assessment tool to determine reasonable and necessary supports, and had to build one over the first three months of operation. And the ICT system used during trial was an interim system which would not scale up to full scheme.

An independent review of the capabilities of the NDIA described the Agency as 'a plane that took off before it had been fully built and is being completed while it is in the air'.

The NDIA has been given an extremely difficult task — the rollout schedule is highly ambitious given the magnitude of the reform. To reach the estimated 475 000 participants at full scheme by 2019-20 (figure 4), the NDIA will need to approve hundreds of plans a day. In the March 2017 quarter, the NDIA approved about 14 000 plans, or roughly 160 plans a day. In 2018-19 (the final year of transition), the NDIA's modelling indicates that about 500 plans a day will need to be approved, while reviewing hundreds more.

Figure 4 **Participant numbers will increase substantially over the next three years[a]**



[a] The projections of scheme participants were prepared by the Scheme Actuary for the NDIA's 2015-16 Annual Financial Sustainability Report using data at 30 June 2016. They do not incorporate actual participant numbers beyond June 2016.

Given the size, speed and complexity of the reform, it is inevitable that there will be transitional issues with the rollout of the NDIS that require careful risk management. It needs to be recognised that the scheme is still in its infancy and it will take time to get things right.

But already there are signs that the rollout schedule is compromising the NDIA's ability to implement the NDIS as intended and putting the financial sustainability of the scheme at risk — and the number of participants entering the scheme is only now just starting to ramp up. At the end of March 2017, around 78 000 participants had approved plans. This is just 82 per cent of the bilateral estimate.

Many of the concerns raised in this study were about the rollout schedule, including concerns around market and provider readiness, the capacity of the NDIA systems to function at full scheme, and the quality of plans (box 3).

The NDIA is aware of the risks of focusing on participant numbers, noting that:

> … bilateral estimates can and do impact upon the way in which the Scheme is delivered. This can put sustainability at risk and impact on the way in which early intervention and investment initiatives are implemented in the short term. It may also have adversely impacted the quality of plans.

The rollout schedule is compromising the integrity of the planning process, and the quality of participant plans. While the NDIA has been set a challenging task of completing high numbers of plans in a short period of time, it is important that it also undertakes the planning process in a way that achieves the objectives of the scheme and financial sustainability. A focus on participant numbers can compromise the depth and quality of the planning process, with the result that some participants are allocated resources without meaningful consultation and are sometimes unable to manage their plans. Quality plans are critical not only for participant outcomes but for containing long-term costs of the scheme (section 6).

The rollout schedule has also meant that parts of the supporting infrastructure that are essential to the objectives of the scheme are not operating as intended. For example, Local Area Coordinators (LACs), who play a key role in delivering information and linking participants to disability services, were supposed to be 'on the ground' in rollout areas six months before participants joined the scheme. Some areas were without LACs after they had joined the scheme.

One option to address these concerns is to slow down the timetable for the rollout. Further discussion of this option is in section 11.

Box 3 **Risks from the rollout schedule are highlighted**

Community Mental Health Australia:

> If the focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost.

JFA Purple Orange said:

> The NDIS transition arrangements, as set out in the bilateral agreements, mean a tsunami of new participants will be processed into the scheme over the next two years. During this time, any fledgling design features intended to advance what we understand to be the NDIS's underlying values — choice and control, and participation in community life and economy — are at risk, due to the provisions in the various bilateral agreements where a specific volume of people are to enter the NDIS in a specific timeframe and with an associated transfer of specific costs.

Maurice Blackburn Lawyers said:

> We believe the roll-out timeline of the NDIS is highly ambitious and increases the serious risk of inadequate delivery of services to participants. It also poses significant financial risks to the scheme as a whole.

Blind Citizens Australia:

> While we understand that the agency is under intense pressure to meet the targets that have been agreed upon under the bilateral agreements between state and territory governments, meeting these targets should not come at the expense of the basic rights and freedoms of people with disability.

Australian Federation of Disability Organisations:

> The need to bring in a large number of participants into the scheme to meet bilateral targets has during transition led to practices which have not always been consistent the original vision of the scheme.

House with No Steps:

> … the Scheme has aggressive ramp-up targets. These are putting pressure on the NDIA's capacity to develop quality plans for participants. Unfortunately, the need to achieve high growth in participant numbers appears to be outweighing considerations of plan quality and consistency.

Department of Social Services:

> … there are risks arising from the scale and pace of roll-out that has potential to place strain on the NDIA, and on agreed transition timeframes.

Victorian Government:

> Victoria recognises the NDIA has been set the task of completing a very large number of plans in a relatively short period of time and it is important the NDIA perform its planning function adequately. Too great an emphasis on cost containment at this early stage of the NDIS rollout risks undermining the effectiveness of the scheme in meeting the reasonable support needs of participants with adverse implications for longer term costs both to the NDIS and to mainstream services.

4 Key insights from trial and transition data

Costs in the trial phase aligned with expectations

Given the uncertainties around the costings of the scheme before it commenced, an important rationale for trial sites was to inform more reliable estimates of full scheme costs (and for testing and refining the scheme). At the end of the trial phase:

- the number of participants with an approved plan (30 821) was 83 per cent of bilateral estimates (36 307) (there were 35 695 people who had been determined eligible but who did not yet have an approved plan)
- the average annualised package cost was $36 049.

The scheme, at the end of the trial, also came in under budget — there was a surplus of around 1.5 per cent of the funding envelope over the three years. However, this was in large part because not all committed supports were used — in 2015-16, 74 per cent of committed supports were used.

Transition — the latest data

The Commission have data for the first three quarters of transition (July 2016 to March 2017). More data are expected after the release of the position paper.

At the end of March 2017, an additional 63 000 people were eligible for the scheme, taking the total number of participants to 99 092. Around 75 000 participants are currently active (they have not exited the scheme) and have an approved plan. Some insights from the transition data are that:

- autism and intellectual disability are the largest primary disability groups (accounting for almost two-thirds of scheme participants). Psychosocial disability is the next most common disability, accounting for about 6 per cent of scheme participants
- most scheme participants at the end of 2016 were children aged 14 years and under (around 43 000 or 44 per cent of participants). Around 45 per cent of the children in the scheme have autism, while 34 per cent have an intellectual disability (including developmental delay)
- while only 18 per cent of packages approved from 1 July 2016 are more than $100 000, they account for 56 per cent of scheme costs.

Emerging cost pressures

The Commission compared trial and transition data on participant numbers and package costs with the assumptions in the NDIA's modelling to better understand how the scheme

is tracking in terms of costs. Noting the limitations of the data, scheme costs are broadly in line with expectations.

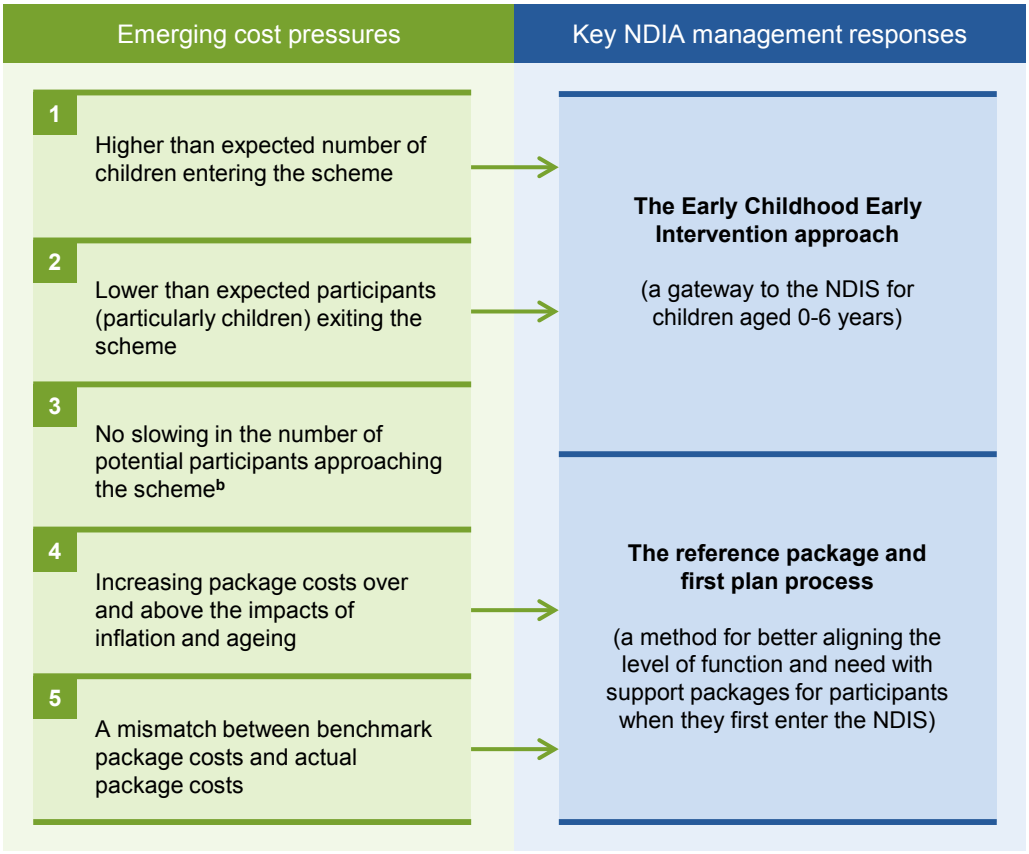
- For most disabilities, participant numbers broadly match the modelling assumptions for all but the largest disability groups — there are more children with autism and intellectual disability than expected.
- Average package costs (for plans effective from 1 July 2016) are higher than the modelling assumptions (after accounting for disability, age and level of function). Breaking this down further:
  - the average package provided to participants with low levels of function is less than expected ($120 000 compared to $150 000)
  - the average package for participants with medium levels of function is higher than the modelling assumptions ($56 000 compared to $41 000)
  - participants with high levels of function are receiving higher packages on average than the modelling assumes ($29 000 compared to $11 000).
- Utilisation rates are lower than expected. Underutilisation is currently offsetting the increase in scheme costs attributable to higher prevalence rates for children and higher than expected package costs.

The NDIA is tasked with ensuring the NDIS is financially sustainable. This involves identifying and managing emerging cost pressures. The NDIA has identified five early cost pressures that need to be managed for the full scheme going forward (figure 5).

- The number of children entering the scheme is higher than expected.
- The number of people approaching the scheme in trial sites that have been operating the longest (since 2013) is higher than would be expected if only people with newly acquired conditions were approaching the scheme.
- The number of participants exiting the scheme has been lower than expected (particularly for children entering under the early intervention requirements).
- Levels of committed support tend to increase as participants move to their second and third plans (over and above the impacts of inflation and ageing).
- There is greater than expected variability in package costs for participants with similar conditions and levels of function (suggesting inconsistencies in planners' decisions).

The NDIA has not updated its baseline cost projections to reflect these cost pressures. But it has put in place initiatives to address these cost pressures, including the Early Childhood Early Intervention (ECEI) approach for children aged 0-6 years (section 5, box 4), and the first plan process to reduce variability in the level of support provided to participants (section 6, box 5). As discussed below, while these initiatives appear appropriate, it is too early to tell whether they will be effective at containing costs.

Figure 5 **The NDIA's responses to emerging cost pressures**[a]



[a] The NDIA's two main responses to emerging cost pressures. The NDIA has also initiated several smaller projects to address emerging cost pressures, such as an analysis of reasonable and necessary costs across the lifespan of participants. Box 4 provides details on the Early Childhood Early Intervention approach and box 5 outlines the first plan process. [b] Potential participants continuing to approach the scheme is not a cost pressure that can easily be addressed by the NDIA.

Benefits are already being realised

Realising the benefits of the scheme is critical for the wellbeing of people with disability and for ensuring that the community continues to be willing to pay for the scheme. However, at this early stage, only some of the benefits are being realised.

The NDIS Outcomes Framework and a National Institute of Labour Studies evaluation of the NDIS provide some insights into the scheme's benefits. Both find that the NDIS has:

- increased supports — more hours of support, a wider range of supports and greater access to equipment — than under the previous system
- on average, improved wellbeing of NDIS participants and their families and carers
- given people more choice and control over their supports
- increased social participation for some scheme participants and their carers.

The Commission also received numerous submissions supporting these findings. As one disability advocate said:

> … I have seen the life changes in people with disability who now have the NDIS funding. They are now accessing community, have a good life and have hope for their futures. The burdens are off the family, some aged carers, and there is job creation. Broken wheelchairs are now being replaced and people who never had wheelchairs, now have and can access the community. I now see happy people.

However, not all people with disability report improved outcomes under the NDIS. The National Institute of Labour Studies evaluation found that:

- some people with disability are experiencing poorer outcomes under the NDIS and receiving fewer services than previously. Often these are people who cannot effectively advocate for themselves, particularly people with psychosocial disability, and those who find it difficult to navigate NDIS processes
- many NDIS participants are experiencing difficulties accessing supports (due to lengthy waiting lists for some providers and types of supports, the absence of local providers and concerns about quality). Also, unmet demand is more common for participants living in rural and remote areas and for older participants
- about 15 per cent of participants feel they have less choice and control, while about one quarter of participants are accessing fewer distinct supports. Qualitative data suggests that those who are unable to navigate the NDIA website to find service providers, and those less able to articulate support needs, are less likely to feel that they have more choice and control.

There has also been a significant fall in participant satisfaction with the scheme since the scheme entered the transition phase — participants reporting that they were satisfied or very satisfied fell from an average of 95 per cent to 85 per cent between 2015-16 and 2016-17 (the first three quarters). This could be linked to the speed of the rollout, and changes to the planning process (discussed below).

The remainder of this overview discusses the longer-term issues that affect financial sustainability and highlights where the major risks lie.

5 Scheme eligibility

The eligibility criteria are the main instrument available to influence how many people will be eligible for individualised support through the NDIS. It is important that these criteria are clear, aligned with the objectives of the scheme, and rigorously upheld.

When the Commission designed the national disability insurance scheme, it recommended that the eligibility for the scheme for individualised supports uphold the following principles:

- individuals should have a disability that is or is likely to be permanent, reflecting the irreversible nature of disabilities

- individuals would meet one of the following conditions:
  - have significantly reduced functioning in self-care, communication, mobility or self-management and require significant ongoing support
  - be in an early intervention group, comprising of individuals for whom there is good evidence that the intervention is safe, significantly improves outcomes and is cost effective
- individuals would meet residence and age requirements.

The eligibility criteria for the NDIS are broadly in line with what the Commission recommended in 2011, with two exceptions:

- the inclusion of supports to undertake activities of *learning or social interaction*
- the inclusion of developmental delay in the early intervention criteria (table 3).

Both these criteria allow more people to qualify for individualised supports under the NDIS than the Commission included when costing the scheme.

Adding learning or social interaction — what effect?

The Commission was unable to assess the effect of adding learning or social interaction to the eligibility criteria, because the NDIA does not collect data on which (or how many) of the six activity domains are relevant to each participant when they enter the NDIS (table 3). Speech Pathology Australia, however, said that their members who are NDIS providers are not providing services to children whose *only* disability relates to learning and literacy.

Collecting data at entry on the domains would provide information on the impact of each part of the eligibility criteria on participant numbers (and therefore scheme costs). Such information would also allow for more granular analysis of who is in the scheme and what their needs are likely to be (which could also be useful to the NDIA in its monitoring and forecasting roles). The NDIA should collect this information.

Adding developmental delay — what effect?

The evidence suggests that providing individualised supports for children with developmental delay can improve outcomes for individuals and reduce costs. It is therefore consistent with the early intervention principles of the scheme.

A review undertaken for the Department of Social Services (DSS) estimated that around 11 600 children with developmental delay or global developmental delay would be eligible for support under the scheme at a cost of $155 million each year. While no definitive data are available to test this estimate, trial site data (which may not be reflective of full scheme prevalence rates) suggest higher prevalence rates than the estimate provided to the DSS.

Table 3 **A summary of the NDIS eligibility requirements**

Age requirements	Residence requirements
Aged under 65	• Australian citizen • Permanent resident • Hold a protected special category visa
And meet either:	
Disability requirements	**Early intervention requirements**
Disability attributable to one or more: • intellectual • cognitive • neurological • sensory • physical impairments; or • an impairment attributable to a psychiatric condition; and	• Has one or more identified intellectual, cognitive, neurological, sensory or physical impairments, and likely to be **permanent**; or • Has one or more identified psychiatric conditions, and likely to be **permanent**; or • Is a child who has developmental delay; and
The impairments are, or are likely to be, **permanent**; and	The early intervention support is likely to benefit the person by **reducing the person's future needs** for supports in relation to disability; and
Impairments substantially reduce **functional capacity** or **psychosocial functioning** to undertake one or more of the following activities: • communication • social interaction • learning • mobility • self-care • self-management.	The early intervention support is likely to benefit the person by: • **mitigating or alleviating** the impact of the person's impairment on their functional capacity • **preventing the deterioration** of such functional capacity • **improving** functional capacity • strengthening the **sustainability of informal supports** available to the person, including through building the capacity of the person's carer.

For children to be eligible for individualised supports, they need to have a delay across multiple domains. This suggests that the eligibility criteria set an appropriately high hurdle. However, assessment of the functional capacity of children in the scheme suggests that the entry pathway may not be sufficiently robust, as 40 per cent of children in the scheme do not have any identified deficits compared to the normal range for their age. This points to a problem with eligibility screening, and underscores the importance of rigorous entry and exit pathways in moderating scheme costs. The development of the ECEI pathway for children to enter the scheme seeks to tighten the entry pathway for children aged 0-6 years (box 4).

Box 4 **Early Childhood Early Intervention (ECEI)**

The ECEI approach is designed to be a 'gateway' to the NDIS for children aged 0 to 6 years. It aims to ensure that only those children who meet the eligibility criteria of the NDIS become participants of the scheme. Under the ECEI approach, families meet with an early childhood intervention service provider to discuss the needs of their child. The provider then identifies appropriate supports for the child and family, and whether the supports should be provided through the NDIS or through mainstream services. As the NDIA put it, 'the ECEI approach aims to ensure children are provided with the right level of support at the right time for the right length of time'.

The ECEI approach is also aimed at ensuring early intervention supports are effective and result in the exits expected in the 0-6 years cohort. The NDIA plots a child's progress against development milestones and supports the child to access mainstream supports when NDIS supports are no longer required.

Effective entry and exit pathways?

Effective entry pathways uphold the eligibility criteria of the NDIS and allow only individuals who meet the criteria to qualify for supports. The two entry pathways for people to receive individualised supports under the NDIS are the ECEI pathway for children aged 0-6 years (box 4), and a more general pathway for people aged 7-65 years.

The ECEI approach was put in place in response to the higher than expected number of children entering the scheme in the trials.[2] The approach is designed so that children in the 0-6 years cohort requiring early intervention supports will have their needs met either through the NDIS or by other support systems.

It is too early to gauge the success of the ECEI in upholding the eligibility criteria of the NDIS and to assess its effectiveness in supporting children who are not eligible for individualised supports. However, given that children receiving early intervention supports are one of the largest participant groups in the scheme, it is critical that the NDIA builds an evidence base on early intervention to inform the types of intervention that are most beneficial and should be funded. The NDIA has developed an evaluation and monitoring framework for the ECEI approach.

Streamlined entry for early intervention

The NDIA maintains a list (List D in the latest NDIA operational guidelines) that allows for streamlined entry into early intervention supports for children who have a condition on this list. List D contains about 130 conditions, including Global Developmental Delay.

2 The NDIA is also developing an early intervention approach for the 7-14 years cohort.

Maintaining such a list represents a trade-off. The appeal of such a list is that it places less onus on families to demonstrate eligibility, reduces the administrative burden on the NDIA and provides a degree of certainty for the families of children with these conditions. However, the list can also affect incentives, and can represent an overly-generous entry gateway if set too expansively. A list can also stifle exits from the scheme. If diagnosis forms the basis of early intervention, a child would remain eligible for early intervention supports so long as their condition is present, even if the expected benefits from early intervention have been realised (or are unlikely to be realised).

The Commission is seeking feedback on the advantages and disadvantages of List D, with a view to determining whether it should continue to be a pathway for children to enter the scheme under the early intervention requirements.

Scheme exits

The NDIA has identified lower than expected exit rates as an early cost pressure. At the end of March 2017, while just under 700 participants had exited the scheme, only 10 per cent were people with early intervention plans. The NDIA should address trends in exit rates that appear inconsistent with scheme objectives.

Psychosocial disability and the NDIS

In 2011, the Commission recommended that people with psychosocial disability be supported through the NDIS. This was on the basis that:

- the day-to-day support needs for people with significant and enduring psychiatric disability are often the same as people who have an intellectual disability or an acquired brain injury
- some important parts of the care requirements of people with psychosocial disability — namely community supports — are best met through the NDIS
- providing supports to people with psychosocial disability through the NDIS provides them with the wider benefits of the scheme, including personalisation of supports to meet the needs of the individual, more choice in what supports are provided, when and by who, and greater access to early intervention supports.

These points remain salient, and lend support to people with psychosocial disability being supported through the NDIS. And, while the Commission heard a range of views about whether the NDIS is the 'right' vehicle to provide support to people with psychosocial disability, the majority of submissions to this study were supportive of its inclusion.

Concerns were also raised about the need for permanency under the NDIS Act being incompatible with the recovery models used in supporting people with psychosocial disability. However, the investment approach to the NDIS and the recovery model of mental health are both about building capacity, and appear to be well aligned.

Scheme participant numbers suggest that people with psychosocial disability are able to demonstrate that their condition is, or is likely to be, permanent. At the end of March 2017, about 5000 people with psychosocial disability received individualised supports through the NDIS. Data also indicated that 81 per cent of people with psychosocial disability who lodged an access request to the NDIS were eligible for the scheme.

The Commission does not support changing the eligibility criteria to relax the definition of permanency and how it relates to psychosocial disability.

Estimating the number of participants with psychosocial disability is difficult because a robust and comprehensive database from which to draw is lacking. However, given that a range of estimates have been prepared by a number of stakeholders and agencies, it would be beneficial for the methodology used to be made fully transparent, so that each could be assessed and considered in relation to projections of numbers of participants with psychosocial disability at full scheme.

Concerns about gaps in support for people with psychosocial disability not eligible for the NDIS are discussed in section 7.

6 Supports and plans

Scope of supports

The NDIS is designed to cover specialist disability supports that are 'reasonable and necessary'. This includes supports that help people with disability to:

- pursue their goals and maximise their independence
- live independently and be included in the community as fully participating citizens
- participate in the community and in employment.

The concept of 'reasonable and necessary supports' is not specifically defined in the NDIS Act, nor does it provide direct guidance on how to determine whether a support is a reasonable and necessary support. There is good reason for this — flexibility around what is reasonable and necessary allows participants to exercise choice and control, and to be innovative about supports.

However, what is 'reasonable and necessary' will ultimately be shaped by court and tribunal decisions over time, having regard to the legislation, rules and operational guidelines. Such decisions will affect what supports are funded and scheme costs. This is one policy lever that is outside the control of the NDIA. The Commission is seeking feedback on whether greater legislative clarity is required around whether and how the test of 'reasonable and necessary' should be applied.

About plans and the planning process

The planning process is about matching scheme participants with support packages. It involves conversations between the participant and the NDIA to ascertain, for each participant: their goals and aspirations, their level of function and an appropriate support package. The NDIS Act requires the development of a plan to, where possible, be individualised, directed by the participant, and maximise participant choice and control.

Good planning processes are essential for the long-term sustainability of the NDIS. Poor planning processes can:

- be unreliable and contribute to underutilisation of supports, undermining the predictability of scheme costs and the ability of governments to plan for the future of the scheme
- mean that participants are allocated supports that are not right for them, with the result that the benefits of the NDIS (such as increased quality of life, greater social and economic participation, and reduced need for other or future supports) are not realised
- result in greater variability in plans and outcomes for participants with similar needs, compromising equity within the scheme
- place greater stress on review processes, adding to the workload of planners and the NDIA.

Planning processes were changed in response to trial experience

In July 2016, the NDIA introduced a 'first plan process' for determining participants' support packages (box 5). The first plan process has resulted in more plans being in line with benchmark costs (compared to the trial period).

The move to transition also saw a shift from face to face to phone planning conversations (although face to face meetings can be requested). This was a decision by the NDIA to allow people to enter the scheme as quickly as possible. The decision was based on trial experience which suggested that people want to join the scheme as soon as they can, and want time to think about their goals, supports and how to use them. The NDIA's approach is that the first planning conversation is the start of a lifetime journey and plans can be adjusted and improved over time.

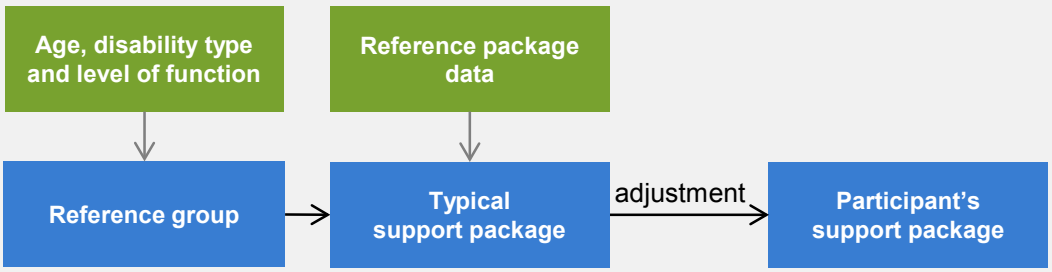
There is a lot of dissatisfaction with phone planning (box 6). The Commission heard (on numerous occasions) that participants had been called with no forewarning of the planning conversation, so the person was not prepared and could not have an advocate present. Others said that they had not known that the conversation they were having with the Agency was a planning conversation until they had received their plan.

A number of participants also said they felt rushed during their planning meetings. As one study participant put it:

… the transition time pressures appear to have resulted in a reduction in the time available to assist people to resolve their plan; in some cases this is reported to have reduced to a 30 minute phone call. This could not be further removed from the feature of a 'person centred model of care and support' that is meant to distinguish the NDIS from previous approaches.

Box 5 How does the first plan process work in practice?

Participants are first allocated a 'typical support package', based on their reference group (which is determined by their age, disability type and level of function). The typical support package may include funding across the following eight core domains: daily activities; social participation; consumables; transport; home modifications; assistive technology; capacity building; and support coordination.



For each participant, the level of funding is adjusted according to the participant's circumstances. This is done using a questionnaire, which asks the participant about each of the domains, including what supports they already have in place, and whether these are sufficient and sustainable. For example, where it is reasonable that sustainable informal, community or mainstream supports continue to assist the participant, or where the participant believes that other informal, community or mainstream supports may provide a better outcome, funding is adjusted in the participant's support package.

The speed of transition has placed a lot of pressure on the NDIA to finalise plans quickly and phone planning conversations are seen as part of the solution. The NDIA said:

> The current process is designed to balance the need to gather sufficient information for a decision-maker to make a valid decision under the NDIS legislation, with making the process non-intrusive and convenient for the participant.

An individualised approach to planning is a key feature of the NDIS and sufficient time is required to match participants with the supports that are right for them. Phone planning conversations can mean that planners do not 'get the full picture'. For example, the living environment of participants may not be adequately reviewed (which means issues such as accessibility, safety and appropriate assistive technology can be difficult to identify).

Phone planning conversations are not appropriate for some participants, including some participants with particular accessibility requirements, mental illness, cognitive impairment and neurodegenerative diseases or people of culturally and linguistically diverse backgrounds. However, they may be adequate for others, particularly if there has been adequate pre-planning.

Box 6 Dissatisfaction with phone planning

Social Support & Precarious Workforce Research Discussion Group:

> … some participants are not fully aware that the phone conversation occurring with the NDIS staff member is actually their planning process occurring. This confusion is also evident in the NDIS marketing of phone-planning as a 'planning conversation', where the suggestion is you will 'talk-about' the plan whereas the reality is that it is a full and structured assessment and plan procedure.

The Disability Services Commissioner:

> Planners are not providing clear and accessible information about the planning process including when and how planning will take place. A sister of a participant said that someone from NDIA had rang her while she was in the car. They advised that they were 'only collecting answers' and it would 'only take a minute'. Following that conversation, her sister received a plan for approval from the NDIA, with less funds than she had previously received.

Alzheimer's Australia:

> Annie called the Parkinson's 1800 support line as she worried about an over the phone NDIS planning session that had taken place earlier that day. Annie's volume and quality of speech has been impaired due to Parkinson's and she also requires longer to respond to questions. She felt rushed and because her response is delayed she felt that the assessor didn't get a clear indication of her needs. Annie and a Parkinson's Nurse Specialist were able to take the time [to] put information together in order to apply for a review for Annie's plan.

Ethnic Communities' Council of Victoria:

> … anecdotal evidence from advocates and providers in the North Eastern Melbourne Region indicates that some participants are not being adequately informed about the purpose of phone contact by the NDIA or their LAC. These participants are having plans being completed without realising that they are engaging in the process or providing informed consent.

Blind Citizens Australia:

> [Phone planning] severely compromises the ability of people who are blind or vision impaired to demonstrate the difficulties they may face with completing tasks like reading, navigating the environment or household chores.

But the Commission considers that the pre-planning phase of the planning process has not received the attention that it requires and many participants are ill-prepared for planning conversations (which is affecting the quality of plans). The NDIA acknowledges that there has been some dissatisfaction with the way the planning process has been operating and because of the speed of the transition, it was not able to engage LAC partners in time to provide participant and community development during the pre-planning stages (and this has made the first plan process more difficult to implement).

A greater focus on pre-planning should mean that phone planning conversations will be suitable for a larger pool of participants. LACs need to be in place six months in advance in the areas in transition to assist participants with pre-planning. The Commission considers this to be a better (and likely less costly) option than trying to 'fix' plans twelve months after they are first put in place. It will also mean that participants are not only in the scheme, but are also more likely to be exercising choice and control (and this is more likely to induce a provider response).

Participants need to understand the planning process

The planning process has changed a lot since the NDIS commenced in 2013. As with all insurance-based schemes, the tools and processes for handling claims and assessing entitlements are a matter of ongoing refinement. This is necessary to ensure that the insurance scheme remains 'on track' and is viable in the long term. Dynamic processes are also important to allow the scheme to adapt to changing circumstances or incorporate information that becomes available over time.

In light of this, it is important that stakeholders can access accurate and up-to-date information about planning processes. Clear messaging about how and why things are changing is also important to maintain the credibility of evolving planning practices.

At present, the planning process is complex and confusing, and often lacks clarity and transparency. Study participants found it difficult to access information about what assessment tools the NDIA uses (including tools used for measuring level of function), and many were unsure or unaware of how the first plan process operated. In addition, limited information is publicly available to help scheme participants and their families, carers and advocates to navigate the planning system. Scheme participants are often not aware of their rights and options, such as their entitlement to request a face-to-face meeting, or have an advocate present during the planning meeting.

For many scheme participants, pre-planning support can assist them in navigating a confusing and complex system. But demand for pre-planning support services is partly driven by how accessible and complex planning processes are. There is considerable scope for the NDIA to improve transparency and clarity around planning processes. This includes providing clear and up-to-date information about what to expect during the planning conversation, when it will occur, and how the information gathered during that conversation will be used.

Planners need more disability knowledge

Planners' limited disability knowledge is an issue of real concern (box 7). Many advocacy groups said that planners do not have sufficient knowledge of particular disabilities or the impact that particular conditions have on people's lives, and they often did not know what supports would be most effective for the participant's disability. Alzheimer's Australia, for example, reported that a person with Multiple Sclerosis (MS) was asked by the LAC at a planning meeting 'How long will MS last?'

Box 7 Concerns about planners' and LACs' lack of knowledge about disabilities

MND Australia:

> LAC's do not have the expertise to support people with [motor neurone disease]. … They have no understanding of MND and the disability it creates. They attempt to plan via a telephone conversation, when speech and communication can be one of the early losses created by MND.

Alzheimer's Australia:

> Peter, the carer of a woman with younger onset dementia, felt unprepared when he and his wife attended their first NDIS planning session. … The NDIS planner had no understanding of dementia and the needs of people living with dementia and as a result the planning session focused on physical needs and solutions. As a result their first NDIS plan provided funded supports totalling $600 … Feedback from people with progressive neurodegenerative diseases has revealed that Local Area Coordinators (LACs) have also shown insufficient knowledge of their disease, the impact of that condition on their lives, the most effective service interventions and the degenerative and fatal nature of their disease.

Amaze:

> We are also concerned that participants appear to be receiving very inconsistent and at times, misleading advice, from planners and NDIA staff. The NDIA must support planners with clear policy and guidelines to provide consistent advice to participants about the planning process, criteria for supports and how plans may be implemented … Amaze's 2017 survey found: 65% of respondents rated their planner's knowledge and understanding of autism as none to moderate a level (with the remainder rating the planner's knowledge as high). … given 30% of participants identify autism as their primary diagnosis, a high level of ongoing training in autism will be a necessity to developing and maintaining their capacity to reliably develop plans.

New South Wales Government:

> … planner knowledge and capability is highly varied, as is their interpretation of reasonable and necessary supports and understanding of interim working arrangement with mainstream services. Approved supports are less likely to be based on a participant's needs and more on a planner's knowledge of the disability and / or how effectively the participant or their carer advocate for certain supports.

Planners should, at a minimum, have a general understanding about different types of disability. The Commission recommends specialised planning teams for some types of disability, such as psychosocial disability.

An alternative (or complementary) approach would involve leveraging expertise from within the industry, and getting specialist disability organisations or service providers more involved in the planning process. While this could give rise to potential conflicts of interest, these can be managed or mitigated by ensuring that such organisations have an advisory role, with final decision-making powers being exercised by an impartial planner. This approach would also mean that the NDIA would not need to compete with others in an already thin market to recruit planners with specialist qualifications or experience.

7 Boundaries and interfaces — the NDIS and services outside the scheme

People with disability, their families and carers rely on a wide range of services — including mainstream services, specialist disability services and community supports. For the NDIS to work efficiently and effectively, the interface of the scheme with these other services on which people rely must be as seamless as possible.

While the level of funding provided to the NDIS recognised that the aggregate level of funding available to people with disability was inadequate, it is also the case that the NDIS was not expected to fill *all* the service gaps that predated the scheme. The responsibility to provide services to people with disability remains a shared responsibility between all levels of government.

The interface between supports for people with disability will take time to determine at the coalface, but until those interfaces and the associated boundaries are settled it is important that governments do not withdraw from services too quickly, as any gaps that emerge will place added burdens on people with disability and their families. As the interface issues become more defined, it is essential to understand and manage the incentives that are set up where boundaries exist. Most critically, it is important that people with disability do not see the NDIS as an oasis of support, surrounded by a desert, where little or nothing is available. Should such a dynamic develop, the financial pressures on the NDIS could be unsustainable, particularly if people feel the need to test their ability to qualify for the scheme, or remain in the scheme for as long as possible, for fear of not gaining access again should the need arise.

This contrasts to the more sustainable situation where supports within the NDIS are well tailored, so that those with high needs will receive substantially more than those with low needs. The gap between participants with the lowest needs, and hence with the lowest level of supports, and those outside the scheme, should be such that there is not a large difference between the two. In such a system, people will not have an incentive to enter the scheme as their needs will be adequately met outside it, and those inside the scheme who are assisted sufficiently to no longer need individualised supports will have little incentive to stay in the scheme longer than necessary.

Clearly there is much detail yet to be worked through. Nevertheless, establishing clear and robust boundaries (and appropriately tailored supports) is an essential element to the fiscal sustainability of the NDIS, and for the surrounding network of supports. When people are accessing the services they need, the system as a whole should be providing supports at the most efficient and cost effective level.

Linking people to the right services

The Commission's 2011 report recommended a bridging and capacity building service for any person with, or affected by, a disability. The ILC program is a key component of the NDIS and has been set up to provide information, linkages and referrals to people with disability, their families and carers, with the appropriate community and mainstream supports (box 8). The focus of ILC is on community inclusion.

ILC will be important for scheme sustainability because it is expected to reduce reliance on NDIS funded support and costs over time, by reducing the demand for individualised packages and the need for supports within funded packages, as well as making supports more effective at helping people achieve their goals. Therefore, it is important that ILC is adequately funded.

ILC is still to be implemented and the funding for ILC will gradually increase over transition (from $33 million in 2016-17 to $131 million in 2019-20). The timing of ILC funding (starting with a small budget that increases over time) has prevented the NDIA investing in ILC activities and the rollout of initiatives that would allow the infrastructure of a national ILC framework. Withdrawal of existing ILC-type activities by State and Territory Governments may also have affected the supports available.

Box 8 **What role for ILC?**

In July 2015, COAG members endorsed the ILC Policy Framework. The framework describes five streams to achieve the objectives of ILC.

- Information, Linkages and Referrals — connect people with disability, their families and carers with appropriate disability, community and mainstream supports.
- Capacity building for mainstream services — ensure people with disability connect with and access mainstream supports.
- Community awareness and capacity building — support organisations (such as not-for-profit organisations, local councils, businesses) and communities to be inclusive of people with disability, and understand the needs of families and carers.
- Individual capacity building — foster the principle of choice and control, improving outcomes for people with disability, their families and carers.
- Local Area Coordination (LAC) — the development of relationships between the NDIS; people with disability; their families and carers; and the local community. The LAC's role connects across each of the streams of ILC, which include information and linkages and individual capacity building, as well as working with mainstream services and communities to better enable access and participation. Twenty per cent of LACs annual funding is for ILC activities.

It is a false economy to have too few resources for ILC activities in the transition period when it is critical to have structures in place to ensure that people eligible for the NDIS can access the scheme, and that those who are not eligible can access supports and services outside the NDIS.

Although directing additional funds to ILC in transition could crowd out state and territory 'ILC-like' activities, the grants process by which organisations receive ILC funding means that these activities can be targeted to where they are most needed. There may also be a risk of duplicating services, but the risk of service gaps appears much more likely under current arrangements, particularly as determining precisely what ILC should cover is unclear at the operational level.

It is the Commission's view that ILC funding should be increased to the full scheme amount for each year during the transition to allow for an accelerated national rollout of ILC activities. The additional funding should come from the NDIA's program delivery budget.

The effectiveness of the ILC program in improving the outcomes for people with disability and its impact on the sustainability of the NDIS should be reviewed as part of the 2023 review of NDIS costs when data on ILC activities is available. In the interim, there should be much greater transparency about the specific programs that are being funded as ILC activities by each jurisdiction over the transition and at full scheme. The ILC budget should be maintained at a minimum of the full scheme amount each year until results from this review are available.

Interface with mainstream services is not clear at an operational level

The Australian Government has entered into Bilateral Agreements with State and Territory Governments to delineate the types of services to be provided and funded by the NDIS and mainstream services. Schedule 1 of the *National Disability Insurance Scheme Rules (Supports for Participants) 2013* (Cwlth) sets out the rules to determine whether the scheme or another system is more appropriate to fund the specific supports for individuals.

COAG has accountability for the NDIS and the *National Disability Strategy,* and through its Disability Reform Council (DRC), receives reports and advice on progress and risks. While the principles agreed to by COAG on the boundaries between the NDIS and mainstream services are relatively clear, greater clarity is required at the operational level.

The boundary issues are yet to be tested. However, the NDIA reports some instances of possible cost-shifting, scope creep and service gaps, including:

- providers trying to extend the amount of therapeutic (health) interventions through use of NDIS funding
- reports that mainstream services are refusing entry to people who are likely to be eligible for the NDIS
- issues around a lack of accessible public transport options, particularly in regional, rural and remote areas, which means NDIS participants seek transport funding through the NDIS despite having the capacity to travel independently.

The current arrangements under the *National Disability Strategy* should be strengthened to include more detail around boundaries (based on challenges faced when seeking to operationalise boundaries), and greater accountability. This could be achieved through review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreements by setting out specific commitments, key performance targets and outcomes. As the DSS said:

> Translating the National Disability Strategy into tangible results for people with disability, their families and carers is a major factor in successful implementation of the NDIS.

Adding a standing item to the agenda of each COAG council that is responsible for any services which interface with the NDIS to discuss any gaps in service provision would also help build clarity around what services governments will provide and ensure ongoing monitoring and solutions for potential future gaps.

Concerns that some people with disability may be left without services

Many are concerned that, as disability support programs are rolled into the NDIS, people using these services (including those not eligible for the NDIS) may no longer receive continuity in support. This is a key risk to the financial sustainability of the NDIS — and one that the NDIA has little control over.

Mental health services are an area of particular concern. The National Mental Health Commission's report on Mental Health Programs and Services estimated that about 700 000 Australians experience a severe mental illness in any one year. However, according to the NDIA, only around 64 000 people with psychosocial disability are expected to be eligible for individual packages in the NDIS.

Clearly, there needs to be support for people with mental health illnesses outside of the scheme — a responsibility that remains (largely) with State and Territory Governments. However, governments have been withdrawing their funding for a number of mental health support programs in their jurisdictions and using this funding to offset part of their contribution to the NDIS. At this stage, it is unclear what supports will be available for people with a mental illness who do not meet the NDIS eligibility criteria and this should be clarified as a matter of urgency.

The implications of this are significant. Not only is this uncertainty distressing for those with mental illness, any gap in support would place an additional call on the generosity of informal support. Gaps could place another pressure on the financial sustainability of the NDIS should it encourage scope creep, or force those who are unlikely to meet the eligibility criteria to test their access for fear of having few supports should they not qualify for the scheme. Mental health and psychosocial disability have been made a key priority of the DRC, but more clarity is required.

While the Australian and State and Territory Governments have agreed to provide continuity of support for disability services outside the NDIS, in practice there is confusion

and uncertainty about what services will continue to be provided and/or funded. Governments need to be clearer about how they will approach continuity of care, and in particular about what disability services they will continue to provide for people who are not eligible for the NDIS.

Gaps in disability services need to be quickly identified (possibly with the assistance of ILC and LACs) and managed, to ensure the sustainability of the overall scheme. The NDIA should report, as part of the quarterly COAG DRC report, on boundary issues. There should also be mandatory public reporting by all governments on the number of people covered by disability programs pre- and post-NDIS, and it should cover all disability services — that is, those within and outside the responsibility of the NDIS.

The National Injury Insurance Scheme

In 2011, the Commission recommended a National Injury Insurance Scheme (NIIS) that would operate in parallel to the NDIS. The scheme was to cover the care costs of people who acquired severe disabilities through catastrophic accidents. The Commission also recommended that the NIIS be in full operation before the full rollout of the NDIS.

The NIIS is only partially implemented, with the motor vehicle and workplace accident streams effectively operating, but the medical and general accident streams still to be implemented. This means that some people who would be expected to have their needs met through NIIS will instead need to have them met by the NDIS.

In principle, states and territories should bear the consequential NDIS costs if the NIIS remains only partially implemented for an extended period. The Commission is seeking feedback on a mechanism to ensure that the States and Territories bear the cost of NDIS participants who were intended to be covered by the NIIS.

8 Market readiness

The market-based approach of the NDIS means that there will be significant changes in the way that supports are demanded by and provided to, participants. This disruption of the disability services market is designed to maximise the choice and control of participants, while also providing incentives to providers to efficiently and effectively deliver the supports that participants want and need (table 4).

While efficiencies are likely to be driven by the scheme, the increase in funding and considerable unmet need in the disability support sector means that the number of workers and providers will need to grow quickly over the transition period. For example, the NDIS workforce will need to more than double from 2014-15 to 2019-20, and the number of NDIS providers will need to increase by between four- and ten-fold.

Table 4 **Intended effects of the NDIS in the disability services market**

Features of Disability Services Market pre-NDIS	*Features of a Mature Disability Services Market*
• Largely 'block funded', with funding provided in advance of service delivery and little freedom to innovate.[a]	• Predominantly fee-for-service paid on invoice. In principle, prices for services are set by the competitive market, and there is innovation by service providers seeking to attract and retain consumers.
• Services often limited and priorities for families in immediate crisis, rather than for early intervention. Consumers have little control over the services they receive and limited choice of provider.	• Funding to meet the reasonable and necessary support needs of each NDIS participant. Consumers have choice and control regarding the services received and providers used.
• The primary relationship is between the service provider and the funder, with consumers often described as 'passive' recipients of services.	• The primary relationship is between the consumer and service provider. Intermediaries and access to information about provider quality, performance and pricing help consumers exercise choice.
• Providers are subject to various statutory provisions (at all levels of government) regarding quality. The system is complex, difficult to navigate and not well integrated nationally.	• Compliance with a national quality framework. A nationally consistent and navigable system.
• High transaction costs for both consumers and service providers.	• Lower transaction costs for consumers and service providers. There is adequate depth and resilience in the market to underpin financial sustainability.

[a] Block funding refers to the process where governments purchase a 'block' of services from a provider, which is to be delivered to clients who meet certain criteria, or are referred to those providers as part of an individualised plan.

As the success of the NDIS relies on the timely provision of the right supports to participants, the readiness of the market will affect the trend in costs during transition and beyond. The following sections look at the readiness of disability support providers, the workforce, and participants.

Providers face challenges to be ready for the NDIS

To meet the needs of NDIS participants, there needs to be an increase in the quantity, quality, range and responsiveness of disability supports supplied. But as noted by House With No Steps, the disability support market is not a typical market.

> The disability support 'market' is not a normal or 'perfect' market in classical economic terms. It is about providing a range of customised supports, human and technological, paid and unpaid, to meet complex and often poorly-defined human needs and wants. Outcomes are often hard to measure and report. Information is unbalanced. Regional, rural and remote markets are 'thin'. The 'buyers' of services and their local situations are diverse and heterogeneous, not homogeneous. Many are vulnerable.

In making the transition to a market-based system for disability support services, providers are facing the prospect of workforce shortages and coming to grips with operating in a

market that will, for some time, be characterised by price caps. The best ways to service thin markets will also need to be considered in the new environment.

Prices are important for market development and participant outcomes

In a mature market, the choice and control that participants exercise will increasingly drive the price of disability supports. In turn, these prices will drive providers to supply the supports that participants most value, and encourage competition and innovation among providers to efficiently deliver those supports. Allowing the market to determine the price of supports is an important tenet of the NDIS, as it will contribute to both participant outcomes and the financial sustainability of the scheme.

However, prices are currently regulated (box 9). The NDIA currently sets maximum prices ('price caps') for many of the supports provided by NDIA-registered providers to:

- ensure value for money for participants — as the price of supports may be bid up too quickly before the sector grows sufficiently to meet the increased demand
- encourage the market supply of disability supports.

Box 9 Why regulate the price of disability supports?

Governments have historically regulated the price of human services, including disability care and support services, on the grounds of equity and efficiency. Without appropriate price regulation, the provision and use of disability services may be below socially optimal levels for a number of reasons, including abuse of market power arising from a lack of competition.

The simplest example is that there may be too few providers in a market for there to be competition. This is a real risk in the market for disability supports. For example, early data indicate a market concentration of more than 80 per cent in some disability service sub-markets. If prices are not regulated, this may result in limited access to services for some disadvantaged groups over the transition period.

This was recognised by the Commission in 2011, who recommended that an early — but temporary — task for the NDIA was to set efficient prices to allow providers to recover the costs of service provision (including adequate returns for capital investment), and in turn, ensure the supply of disability supports. But price regulation should not persist unnecessarily, have excessive scope, nor shape the market — such as by benefiting some providers or participants over others.

In practice, the NDIA must balance these two objectives. Setting prices too high may induce greater supply in the market, but reduce the purchasing power of participants. Setting prices too low may ensure lower costs, but may lead to shortages of particular supports. Striking the right balance is difficult.

Some existing providers — who would benefit from an increase in price caps — argued that some price caps are too low to provide quality supports. In turn, the NDIA stated that existing providers — many of whom relied on block funding previously — may be finding

it difficult to adjust to the fee-for-service model. Given that the NDIA's most recent price review has only just concluded (with new prices to take effect on 1 July 2017), the Commission has made no findings or recommendations about the adequacy of those prices.

However, there is a potential conflict of interest with the NDIA setting prices and also being responsible for the financial sustainability of the scheme. This is a structural issue in the design of the scheme that needs to be addressed, as the mere perception of a conflict is sufficient to disrupt the transition to price deregulation.

Mindful of the immediate and significant challenges being managed by the NDIA, the Commission proposes moving towards the deregulation of prices in three stages. The first stage is to immediately introduce an independent price monitor with responsibilities including to:

- examine how the market is responding to prices set by the NDIA
- review the NDIA's price caps based on the available evidence, including comparing NDIA's price caps to other care sectors (such as aged care)
- report publicly on its assessment of the NDIA's price controls with regard to market development and participant outcomes.

The independent price monitor would improve transparency around how price caps are set, and in turn, lead to greater accountability and thereby confidence to participants, providers and the wider community. It should be put in place immediately to serve as a 'check and balance' on the NDIA's pricing over the crucial transition period.

The second stage is to shift the NDIA's price-setting powers to a regulator that is an independent statutory authority — an approach consistent with the evolution of other markets for consumer-directed care, such as the aged care sector. Such a move would allow the NDIA to focus on its core responsibilities of delivering and administering the NDIS, remove the potential conflict of interest, and provide ongoing independence and transparency of price regulation.

The body tasked with price regulation (including the NDIA while it remains the price regulator) should, among other things:

- collect data and publicly report on providers' characteristics and costs
- communicate with disability support providers, participants and the NDIA to transparently set prices at regular intervals, with sufficient time for providers to phase in price changes
- periodically review its price model for transitional and efficient prices in a transparent and comprehensive manner
- send more granular and targeted price signals — that is, provide prices by supports at the state and territory level, with an expectation that price signals could be set at a more disaggregated regional level where possible

- assess and recommend — on the basis of transparent consultation and evidence — when prices for particular NDIS supports in each region should be deregulated, and evaluate whether there remains a need for price controls. To enable efficiencies to be driven by the market wherever possible, the price regulator should presume that it is appropriate for prices to be deregulated — that is, to only have price controls when there is clear evidence that unregulated prices are likely to lead to inflation that would harm participants.

At this time, the Commission envisions that the independent price monitor would be best placed to take over these pricing powers, as it would have developed the knowledge and expertise necessary to understand the disability support market.

The third and final stage of deregulation occurs when the price of a given disability support has been deregulated, but is still subject to subsequent monitoring. The independent price monitor would maintain an ongoing watch on pricing, collect data, and publicly report on emerging market issues that affect the purchasing power of scheme participants.

A key question is when the NDIA's pricing powers should be transferred to an independent price regulator. There appears to be broad consensus among many (including the NDIA, the DSS and the Australian National Audit Office) that price controls are likely to be needed for the foreseeable future. Given the potential conflict of interest that the NDIA faces in setting prices, the need for price regulation to persist over coming years, and the imminent significant increase in participants, the Commission's view is that the price regulation powers should be transferred to the independent body by 1 July 2019.

Thin markets need more attention

When creating a new market for disability supports, there is a risk that, in some areas, or for some types of supports, the market (the number of providers or participants) will be too small to support the competitive provision of services ('thin market'). Thin markets are not new — they have been, and will continue to be, a persistent feature of the disability sector, even under the NDIS.

In the absence of government intervention, there may be greater shortages, less competition, and poorer outcomes for participants in thin markets. Participants at most risk are those who:

- live in outer regional, remote or very remote areas
- have complex, specialised or high intensity needs, or very challenging behaviours
- are from culturally and linguistically diverse backgrounds
- are Aboriginal and Torres Strait Islander Australians
- have an acute and immediate need (crisis care and accommodation).

A more considered and timely approach is needed to address access issues in thin markets. More flexible funding, service delivery and other measures tailored to the specific circumstances are needed. Block-funding may continue to play a role, as well as provider of last resort arrangements. Regardless of the approach chosen, there is a need for: transparent reporting and evaluation of thin market arrangements; strong market stewardship; and collaboration between the Commonwealth and the State and Territory Governments.

The Commission is seeking feedback on when particular measures should be used to provide services in thin markets, when provider of last resort arrangements should be used, and any other information on ways to address thin markets.

The workforce is not growing fast enough

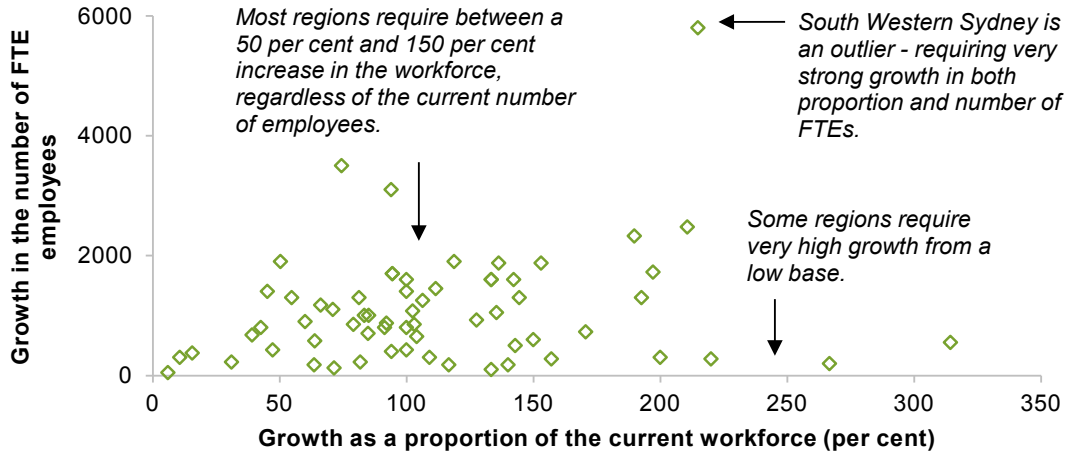
As the NDIS provides more individualised supports for people with disability, the workforce needed to provide those supports will not only need to increase, but also become more diverse. While precise estimates of the size of the necessary workforce differ, there is broad consensus that the number of full-time equivalent positions will need to roughly double over the three year transition period. At a more local level, some regions will need to expand their workforce only marginally, while others will need to more than double (figure 6).

Three policy changes are recommended to mitigate the potential workforce shortage over the short term:

- Meeting the desires of many existing workers — who are more qualified and experienced, and usually work part-time — to work additional hours. While in some cases this may not expand the *effective* workforce (especially given that many participants need care at particular hours of the day), this approach will provide more scope for 'on-the-job' training and mentoring of new staff to expand the overall workforce more quickly.
- Temporarily relaxing the restrictions on NDIA payments to informal carers to encourage them to provide more care over the transition period. This involves removing the restriction that paid informal carers must not live at the same residence as the participant, which is an obstacle to providing care for those in rural and remote areas. Such payments will need to be monitored closely, and their scope reduced as the workforce develops.
- Allowing for skilled migration where residual shortages remain persistent — especially in the case where allied health professionals may be lacking in particular regions. It remains to be seen how recently announced changes to skilled migration visas will affect labour supply for the NDIS.

Figure 6 **Variation in growth required in different regions[a]**

Each dot represents the growth in the amount of full-time equivalent (FTE) employees needed relative to the current situation, both in terms of the number and proportion, between 2015-16 and 2019-20.



[a] The NDIA's market position statements provide 'low and high' estimates for the number of FTE disability workers at present and what will be needed in the future. To derive these estimates for growth, the midpoints of each range are used. No data available for Western Australia. Regions are areas consisting of several local government areas.

Building the workforce is a long-term exercise

While these measures will help to address workforce shortages in the transition period, more attention also needs to be paid to the longer-term development of the workforce.

The responsibility for workforce development is currently shared jointly between the DSS and the NDIA — with the former having 'oversight' of workforce development and the NDIA allocated the task of 'market steward'. The COAG DRC also plays a role in workforce development issues, along with the relevant State and Territory Government departments.

The fragmented landscape of roles and responsibilities is understandable given the breadth and reach of the scheme, and the speed of implementation. The risk is that a fragmented workforce policy may lead to duplication or unnecessary programs at a time when the scheme can least afford it.

The Commission considers that a 'big tent' approach to workforce development remains appropriate, but that the roles and responsibilities of different parties should be clarified further and made public.

- State and Territory governments should have more responsibility for workforce development issues over the transition period, as they have the best experience of

where there has been historically unmet need and which approaches may be best suited to solve such issues in particular jurisdictions.

- The Australian Government should retain oversight of the scheme and focus on areas such as tertiary education and immigration, and how increased demand affects and interacts with other caring sectors, in particular aged care.
- The NDIA is best placed to provide more information to Australian Governments in the form of actuarial and scheme data collected to provide more granular detail on where supply gaps are emerging, or likely to emerge.
- Providers should also have a means to have a greater say in emerging workforce policy issues, such as where the incentives of the scheme may interact with other laws and regulations, like minimum standards, conditions of State and Commonwealth awards, and training and development.

Over the long term, the workforce development responsibilities of State and Territory Governments will diminish as the NDIS fully rolls out and supplants their existing disability support programs. However, State and Territory Governments should remain 'in the tent' when it comes to workforce policymaking given the interaction between the NDIS and other mainstream services.

Building the evidence base is also important

Existing data on the size and scope of disability care workers and the organisations they are employed by are poor, and not commensurate with the importance of the NDIS. This was acknowledged by many study participants, including the DSS (the agency currently tasked with market development oversight), who said that 'a significant limitation to assessing the NDIS market readiness is the availability of market and workforce data'.

Given the size of the scheme, and its importance to participants, the NDIS needs an evidence base about the providers and workforce who deliver supports. To remedy this deficiency, the Australian Government should fund the collection of more fit-for-purpose data by the Australian Bureau of Statistics and the university sector.

Participants need help to make the most of the NDIS

The NDIS is about giving participants more choice and control over their supports. While some participants will be ready to manage and work with the NDIS to implement their plans, others will be less so, and may find it difficult to get the most out of the scheme. This in turn will reduce the overall benefits and financial sustainability of the scheme.

How ready participants are to make the most of their plan will depend on a number of factors, including: an individual's capacity; their network of informal carers and peers; the assistance provided under the NDIS; how ready the market is to provide supports; and the

complexity of the scheme. As participants spend more time in the NDIS, there will also be some degree of 'learning by doing'.

However, some scheme participants are finding the NDIS hard to understand and interact with, particularly because the scheme is a new way of allocating and supplying disability supports. Some transitional issues are also making it harder for participants.

The NDIS provides some assistance to participants to implement their plans, including through support coordination (the key means to bolster the readiness of participants with complex needs). The Commission is seeking feedback on possible improvements to support coordination and complementary actions that may make support coordination more efficient.

Other groups can also help participants navigate the NDIS and access the supports that they need, such as:

- peer support groups and disability support organisations, who can provide participants and their families with information on how best to find and secure disability supports
- advocacy groups, who may be able to help participants find supports. They can also provide systemic feedback to the NDIA and Governments about the difficulties that participants may face in accessing supports within their plans.
- intermediaries, who can provide tailored supports to participants, including helping to pay providers and hiring workers.

Each of these groups play an important role in helping participants and their families to be ready for the NDIS. Intermediaries, in particular, can assist those who may struggle to deal with the administrative burden of managing their own affairs (while allowing participants to retain choice and control), and reduce scheme costs by aggregating participants' purchases of common supports. The Commission is seeking feedback on the role of intermediaries and disability support organisations within the NDIS.

While finding ways to bolster readiness is important, a complementary approach is to reduce the complexity of the scheme. One way is for the NDIA to implement its proposed eMarketPlace — an online platform that, among other things, is designed to provide participants with timely information on the number, quality and past performance of providers. This would make it easier for participants to find the supports that they need at a time when many are finding it difficult to identify and engage with providers.

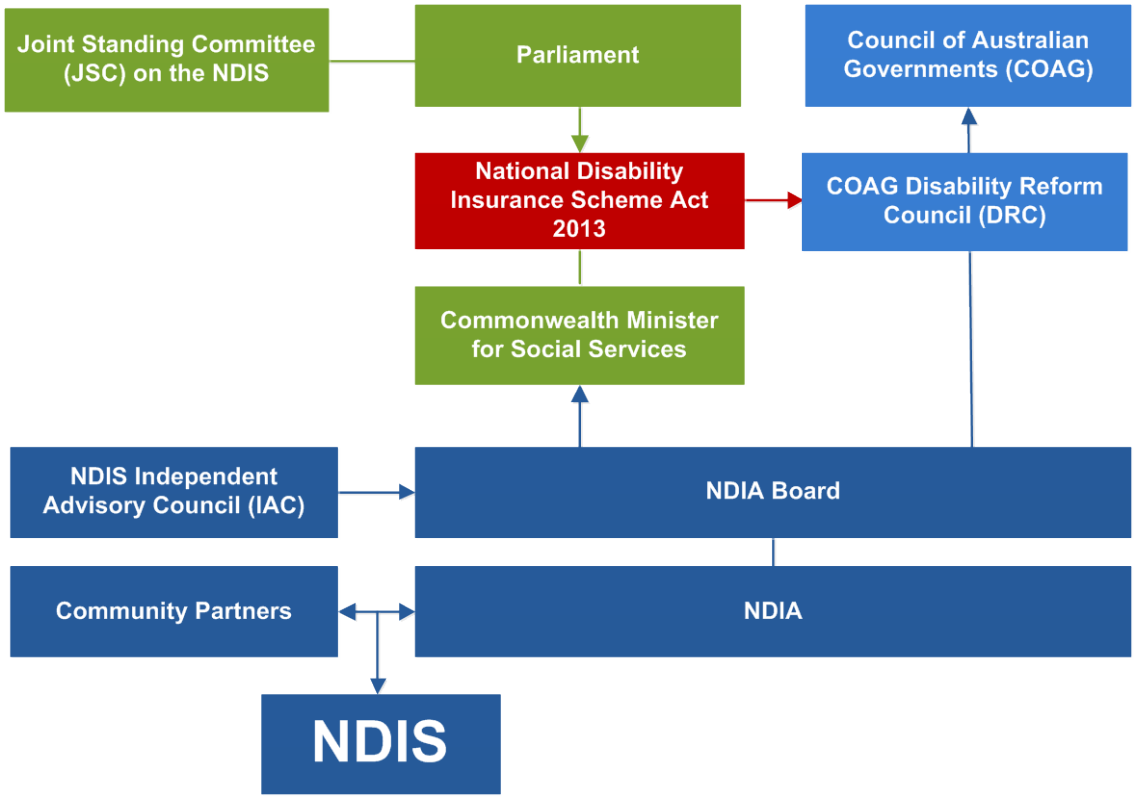
9 Governance

The governance arrangements for the NDIS are complex and reflect the shared responsibility of the scheme between the Australian and State and Territory Governments (figure 7). While the NDIS is administered by an Australian Government Authority (the NDIA) under Commonwealth legislation and under the direction of an Australian

Government Minister, it is designed and funded by the Australian, State and Territory Governments.

The NDIA is governed by a Board, which is appointed by the Minister for Social Services in consultation with State and Territory Governments. The Board is responsible for managing risk and setting the strategic direction of the NDIA. It is also responsible for monitoring and reporting on the performance of the Agency. The NDIA Board was expanded from 1 January 2017 by the Australian Government with the aim to ensure it has the disability service, financial management, corporate governance and insurance-based expertise needed to guide it through its critical three year expansion to 2019-20.

Figure 7 **Summary of NDIS governance arrangements**



In 2011, the Commission recommended a single national scheme, and a single national agency, to provide disability care and support. All states and territories, except Western Australia, joined the national scheme. In 2017, the Australian Government and Western Australian Government signed a bilateral agreement for the implementation of the WA NDIS. Under the agreement, the WA NDIS (intended to be consistent with the NDIS) will be administered by the Western Australian Government, not the NDIA. The Commission considers Western Australia should be in the national NDIS. That said, given the concerns about the transition timetable, Western Australia could delay joining the national scheme until after 2019-20.

Lack of transparency and clarity

Clear and transparent governance arrangements for the NDIS are crucial, especially given the scale and complexity of this reform. Effective governance is also essential for ensuring accountability and trust in the scheme.

The high-level governance arrangements generally provide a strong foundation for the development of the NDIS, including in relation to managing scheme costs and sustainability, but they lack clarity and transparency in some key areas. This includes, for example, confusion over the role of LACs, how the NDIS interfaces with mainstream services, the continuity of care arrangements of State and Territory Governments, and the planning process.

It is important that governments and the NDIA work to strengthen the clarity and transparency of governance arrangements and processes. The Commission has made recommendations with this aim.

Australian Government responsibility for NDIS

In 2011, the Commission recommended that the Australian Government Treasurer should be responsible for the NDIS because of the proposed commercial focus of the NDIA, and the need to ensure strong cost controls, insurance characteristics, long-run sustainability and appropriate management of funds. The Commission also envisaged other ministers, such as the Minister for Social Services, playing a prominent role in disability policy.

However, primary responsibility for the NDIS was given to the Minister for Social Services. While the Commission does not recommend a change to the current arrangements (given that stability is important amidst the pace and extent of reform), it is important that the governance supporting the NDIS is akin to that of an insurance scheme and it is not managed as a welfare program.

NDIS rules

Under the current governance arrangements, the states and territories play a significant role in setting NDIS policy. For example, while the Minister for Social Services is responsible for creating NDIS Rules, in many cases these rules require unanimous agreement from the Australian Government and each host jurisdiction.

There have been cases where NDIS rules have taken considerable time to implement, including the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth), which is reported to have taken at least eight months. This is a significant period of time in a transition period of three years.

The benefits of requiring agreement from all jurisdictions to implement many NDIS rules needs to be balanced against the need for the NDIS to be agile and able to adapt to emerging risks, especially during the transition, to ensure the financial sustainability of the scheme. The requirement for unanimous agreement from the Australian Government and all host jurisdictions for changes to some rules should be relaxed. There is also a need to align the governance and risk-sharing arrangements (discussed below).

Review processes

There are review processes both internal and external to the NDIA. Concerns were raised about the review processes, including that: there is confusion about the distinction between a plan review and a review of a decision; the information provided about the review processes is inadequate and the review processes are not accessible; and the time taken for reviews can vary drastically and can be significant.

The NDIA and governments are taking steps to improve review processes. However, publicly reporting on reviews, including on the numbers of reviews, review timeframes, outcomes of reviews, and participant satisfaction with the review process, would improve clarity, transparency and accountability around the effectiveness of the review process.

Review processes can also influence costs, both by the number of internal reviews undertaken and external reviews resulting in changes to eligibility or supports provided. For internal reviews, it is important that issues with the planning process that are resulting in increased numbers of plan reviews are addressed. The NDIA should adopt a process for amending or adjusting plans without triggering a full plan review to reduce costs and time delays associated with plan reviews.

For external reviews, it is essential that where such reviews lead to significant impacts on scheme sustainability that mechanisms are available to swiftly respond. The Commission is seeking more information on what is required in this regard.

Monitoring the performance of the NDIS

Performance reporting is important for ensuring outcomes are realised and that there is accountability when they are not. It is also an important component of the insurance approach. Effective performance reporting involves timely and transparent reporting of output and outcome indicators that measure performance against the objectives of the scheme.

The performance of the NDIS is currently monitored and reported through a number of mechanisms and reports, the main one being the *Integrated National Disability Insurance Scheme Performance Reporting Framework*. This framework includes the measures and indicators of scheme performance that the NDIA is required to report against to the COAG DRC and information the NDIA is required to provide to jurisdictions.

While the NDIA is still developing its performance reporting (which makes it too early to determine whether the performance reporting is sufficient to shed light on scheme objectives), the Commission has identified some gaps in the framework and the performance reporting against this framework. There is limited reporting against the outcomes indicators. And, there are few indicators for mainstream services, ILC and LACs. Given the importance of understanding the interaction between the NDIS and mainstream services, and the critical role that ILC and LACs play in the scheme, data on these activities should be an important component of reporting on the NDIS performance.

The performance reporting framework also does not have a strong enough focus on reporting on quality, including the quality of participants' plans. Over time, as reporting on outcomes under the reporting framework develops, evidence of good outcomes will be evidence of good quality plans, processes and experiences. However, it could be many years until this outcomes reporting is of a sufficient standard. Until then, reporting on quality is needed.

10 Funding

To ensure that the integrity of the NDIS' objectives are maintained, the scheme needs to be funded so that it operates in a way that is consistent with an insurance scheme, rather than a welfare program. It is also important that the way the funding mechanisms are designed create good incentives for appropriate allocation of responsibility between the Australian and State and Territory Governments to act in the long-term best interests of Australians with disability requiring services provided by the NDIS, and by mainstream and other disability services.

In 2011, the Commission recommended that the Australian Government fully fund the NDIS from general revenue (because of an absence of reliable growth in taxes at the State and Territory level). However, the scheme has been implemented with funding from Australian, State and Territory Governments governed by a range of Bilateral Agreements that are to be revisited every five years.

Escalation parameters

People covered by insurance schemes are generally required to contribute premiums in exchange for having their risk covered. For the NDIS, the Australian and State and Territory Governments make these contributions using taxation revenue.

At full scheme, the State and Territory Governments will contribute a combined $10.3 billion each year to the NDIS (the transition period has separate funding arrangements). The current Bilateral Agreements between the Australian Government and the States and Territory Governments require that these contributions increase by

3.5 per cent each year (the 'escalation parameters') until 2023, subject to the outcomes from this study.

The current escalation parameters are based on the long-term annual projections of the consumer price index of 2.5 per cent and a net population growth rate of 1 per cent. If the objective of the escalation parameters is to maintain the real per capita contributions to the NDIS from the States and Territories, they should be based on the best available estimates of inflation and population growth for the period of the agreement, at the time of making the agreement. The 3.5 per cent currently specified in Bilateral Agreements is at the lower bound of a range that would be expected to keep real per capita contributions from the states and territories constant over time.

However, if scheme costs were to rise faster than the current escalation parameters (for example, because of greater than expected increases in wages or prevalence rates of disability), the proportion of funding by the Australian Government would increase relative to that of the states and territories over time (in the absence of any other mechanisms being applied).

An alternative way to set escalation parameters would be to explicitly link them to scheme costs so that the proportion of funding allocated to the Australian Government and the State and Territory Governments is maintained over time. The Commission seeks further views on the appropriate role of escalation parameters.

Flexibility of funding

For the NDIS to operate as an insurance scheme, the NDIA needs to have the capacity to manage the lifetime risk of participant costs — for example, by making large upfront investments to yield future cost savings. This requires more funding flexibility than is allowed under the existing 'pay as you go' approach (which effectively operates on a cash reimbursement basis, much like a welfare program).

The NDIA will have a capped operational budget of 7 per cent of total package costs each year at full scheme. While acknowledging the need to constrain administrative expenditure, the Commission considers that a target range of 7 to 10 per cent of package costs would be more appropriate given the insurance approach, as constraining the operating budget within a particular year could undermine the objectives of the scheme.

The NDIA called for increased flexibility around the use of funding currently exclusively allocated to program delivery to better manage risks in accordance with insurance principles. However, the Commission's preferred option, in the longer-term, is to provide the NDIA with a pool of reserves (as recommended by the Commission in 2011). A pool of reserves would enable the NDIA to operate the scheme more like an insurance scheme, which could facilitate a cultural and operational shift within the Agency. It could also result in improved lifetime outcomes for participants and provide assurance to the community that the scheme is insulated (to some extent) from the vagaries of the budget

cycle. The Commission is seeking feedback on how this could be achieved, and what level of reserves would be required.

Creating the right incentives

The allocation of funding responsibility between the Australian and State and Territory Governments needs to be designed to create the right incentives. Importantly, funding cost overruns should be based on good risk management principles — that is, risks should be allocated based on who is best able to manage them. Under the funding arrangements during the transition, the Australian Government is responsible for all cost overruns of the NDIS, but there are a number of potential cost drivers that are in the control of the State and Territory Governments. For example:

- State and Territory Governments' funding and management of mainstream services can impact on scheme costs
- State and Territory Governments provide the majority of 'in-kind' contributions, which can drive up scheme costs and limit participant choice
- State and Territory Governments have a key governance role in the scheme — unanimous support is needed to change the NDIA Board or many of the NDIS Rules, or to direct the NDIA to take specific action, which gives them leverage over cost mitigation tools.

This creates a disconnect between the Australian Government's ability to control costs and the liability for cost overruns. There are two options available to address this at full scheme.

- The responsibility for funding cost overruns could be reallocated between the Australian and State and Territory Governments based on their ability to manage cost overruns. Determining what these should be is not straightforward (allocations of between 25 and 50 per cent of the cost overruns to the State and Territory Governments were suggested to the Commission by some stakeholders. The Bilateral Agreements currently state that the Commonwealth will accept at least 75 per cent of the cost overruns at full scheme.)
- Adjust the governance arrangements to allow the Australian Government to manage a greater proportion of the risk of the cost overruns in line with their greater responsibility for funding these overruns.

More information is requested given that these options are not necessarily mutually exclusive.

In-kind services

The Australian, State and Territory Governments are also able to provide in-kind services (that is, they can transfer already funded disability services to be used by NDIS participants) to the NDIA in lieu of cash contributions towards their NDIS funding commitments. In practice, what this means is that supports in individual participant's plans are described specifically as having to be provided by a particular provider (that is, the provider engaged through the in-kind arrangement).

In-kind contributions are estimated to account for about 19 per cent of total NDIS package costs during transition, and are expected to fall to about 10 per cent in 2020-21. While all governments are reviewing their in-kind contributions on an ongoing basis (with the intention of minimising in-kind contributions in full scheme), there is still some uncertainty around the quantum and scope of in-kind contributions at full scheme. The Commission recommends that all in-kind funding of supports be phased out by the end of the transition. Governments should not continue to make such costly contributions without any requirement to provide additional resources to balance the adverse impacts that such contributions have on financial sustainability, and participant choice and control.

11 Summing it all up

While the issues described above may seem considerable, it is important to consider them in the context of the scale, pace and complexity of the NDIS reform. It will take time to get things right. It is this need for more time that makes the roll out timetable such a key focus for addressing the many and considerable risks identified in this report.

The rollout timetable

As highlighted throughout this position paper, the ambitious timetable for the rollout presents an immediate risk to the success and financial sustainability of the scheme. The speed of the rollout has:

- compromised the quality of plans
- implications for the development of other parts of the scheme, especially the disability care workforce, which is unlikely to be sufficiently developed by 2020 to deliver the supports the NDIA is expected to allocate
- imposed challenging timeframes on the development of important structural elements of the scheme — including details around responsibilities at the coalface in services like health and transport, and instituting the new Quality and Safeguarding Framework.

Some study participants argued that the scheme rollout should be slowed down (box 10). For example, the Mental Health Community Coalition of the ACT argued that slowing

down the implementation of the NDIS would mean that you could 'replace costly mistakes with getting it right in the first place'.

Box 10 Some argued for a slowdown of the transition timetable

Cerebral Palsy Alliance:

> We would strongly recommend that the Commonwealth and States revise the transition timetable to support a realistic and manageable change management process for all stakeholders — as per NSW Bilateral Agreement Management of Risk Clauses 48-51 — if the risk of market, sector and system readiness to transition emerges — changes to the participant phasing schedule may be considered by both parties.

David Parkin:

> The rollout to new areas needs to be slowed. Get the current system as right as it can be. There are enough participants now … who are actually using the system to understand where the effort needs to be applied. The NDIS has to listen to people and Providers.

Australian Lawyers Alliance:

> One important response to the challenges ought in our view to be a reconsideration of the rollout schedule. As at the date of this submission, the rollout is less than nine months old, yet the level of dissatisfaction with the scheme, and the clarity with which problems are being identified, are both rapidly escalating.

Australian Physiotherapy Association:

> Our members are concerned that the balance between the speed of the roll-out and its effectiveness needs to be changed, and the roll-out slowed so that the NDIS can properly train its team, manage its workload and provide consistent support to the regions in which the roll-out is occurring.
>
> Alternatively, the financing of the Scheme needs to be adjusted to address the substantial implementation costs.

Maurice Blackburn Lawyers:

> A prudent approach would be to consider a slower roll-out schedule to help minimise the risks associated with the introduction of the scheme. … A revised rollout schedule could involve a complete cessation of the rollout on a regional basis for a specified period, to enable the remedial work to be undertaken, and a fresh analysis of readiness after that period.
>
> Aside from managing financial risks, a roll-out over an extended period would avoid significant frustration and distress for those living with disabilities and their families, and allow lessons learned from the early results to be incorporated into the scheme's final design.

However, others argued that the rollout schedule should not be changed. For example, the Australian Federation of Disability Organisations said:

> Some in the sector have responded by arguing for a slow down [to] the roll out and to lengthen the transition period. To AFDO and its members, this would be completely unacceptable. For many people with disability, the wait has already been too long. For people who have had little or no support for many years, the NDIS cannot come quickly enough. Slowing down the roll out is therefore not an option.

The Commission acknowledges the hardship that has been imposed on some people with disability under the pre-NDIS arrangements. Given the problems under the current rollout schedule, however, it may be in the interests of people with disability to slow down the

rollout timetable with the objective of securing for them the NDIS's ultimate success and sustainability.

The rollout timetable is tied to the schedules set out in the Bilateral Agreements. Given that the numbers of scheme participants in the Bilateral Agreements are estimates and not hard targets, there may already exist some flexibility for the NDIA to slow down the pace of the rollout should that be required. However, any slowdown would have implications for scheme funding arrangements and the disability services provided by the states and territories. These matters would need to be careful addressed should a slowdown be implemented.

The NDIA is aware of the current problems …

The NDIA acknowledges that the scale of the participant intake has affected the quality of participants' and providers' experiences. The NDIA has been working with participants, providers, peak disability bodies and other stakeholders to identify changes or improvements required to achieve:

- the intake of participants at the rate required by the Bilateral Agreements
- plans that maximise choice and control for participants, and contribute to improved participant outcomes
- plans that are of a high quality
- plans that are financially sustainable so that the aggregate value of all plans remains within the funding envelope.

While the NDIA's proposed new approach is yet to be tested with participants and providers, at this stage the Agency plans to have a greater focus on outcomes, more active involvement with communities, more face-to-face communications, and improved interaction with providers and disability organisations. The NDIA also plans to make improvements to its call centre and portal to make it easier to navigate.

The Commission appreciates that it will take time to implement the changes and for the changes to be reflected in the performance reporting data. On the information received to date about the changes proposed by the Agency, the Commission is unable to form a judgment about whether the much needed focus on participant and provider experiences (and ultimately participant outcomes) can be achieved while also meeting the rollout timetable. A slowdown in the rollout of the scheme may be required. The Commission is seeking feedback on how a slowdown, if required, could be operationalised, and what the implications of a slowdown would be.

… but scheme success and financial sustainability are about more than the rollout

The Commission has identified several other key risks to the success and sustainability of the scheme beyond the rollout, including decisions by the Administrative Appeals Tribunal or courts about what are 'reasonable and necessary' supports, changes to NDIS rules, market readiness, and State and Territory Government responsibility for disability care and mainstream services.

A significant challenge is the need to develop the disability supports market, so that there are enough providers and workers to meet the increased demand for services from scheme participants. Without a sufficient supply of disability supports, the NDIS cannot function as intended.

And all governments need to work together to better manage the integration of the NDIS and other services. As noted earlier, there is evidence of service gaps opening up and an apparent reluctance in some instances to find ready solutions. In these circumstances, it is critical that all governments take greater care when withdrawing from services to ensure that there is genuine continuity of supports for people with disability. Without such care, families and informal carers can be left bearing the burden of unintended gaps, which would be contrary to the objectives of the scheme.

Only an integrated and holistic system, supported by the ongoing and shared commitment and goodwill of people with disability and their families and carers, providers of disability services, governments and the community more broadly, will bring about the expected benefits from the seismic shift in the delivery of supports to those that need them the most. There is enormous goodwill behind the NDIS — and it is needed now more than ever.

Draft recommendations, findings and information requests

How is the scheme tracking?

DRAFT FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious. It risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

DRAFT FINDING 2.2

While a different methodology is used, the National Disability Insurance Agency projections of scheme costs are broadly consistent with the Productivity Commission's modelling of the scheme in 2011, after accounting for sector-specific wage increases, population changes, and costs associated with participants aged over 65 years (who were not included in the Commission's estimates).

DRAFT FINDING 2.3

The National Disability Insurance Scheme, at the end of trial, came in under budget. This was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 74 per cent).

Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children and higher than expected package costs) have been offset by lower than expected levels of utilisation.

The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.

DRAFT FINDING 2.4

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report more choice and control over the supports they receive and an increase in the amount of support provided.

However, not all participants are benefiting from the scheme. Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes.

Scheme eligibility

DRAFT RECOMMENDATION 3.1

When determining that an individual is eligible for individualised support through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* (Cwlth) are relevant for each individual when they enter the scheme.

INFORMATION REQUEST 3.1

The Commission is seeking feedback on the advantages and disadvantages of maintaining 'List D — Permanent Impairment/Early Intervention, Under 7 years — No Further Assessment Required' *in the National Disability Insurance Agency's operational guidelines on access. Feedback is sought on the extent to which the list:*

- *reduces the burden on families to demonstrate that their child will benefit from early intervention and/or provides certainty that support will be provided*
- *reduces the burden on the National Disability Insurance Agency of assessing whether children are eligible for early intervention support under the* National Disability Insurance Scheme Act 2013 *(Cwlth)*
- *may be contributing to supports being provided to children who are unlikely to benefit from such supports*
- *may be discouraging or inhibiting exit from the scheme.*

INFORMATION REQUEST 3.2

The Commission is seeking feedback on the benefits and risks of maintaining 'List A — Conditions which are Likely to Meet the Disability Requirements in section 24 of the NDIS Act'. *In particular:*

- *to what extent does List A reduce the burden for people with permanent and significant disability of entering the National Disability Insurance Scheme under the disability requirements?*
- *is there any evidence that people who do not meet the disability requirements are entering the scheme under List A?*

Scheme supports

INFORMATION REQUEST 4.1

Is the National Disability Insurance Scheme Act 2013 *(Cwlth) sufficiently clear about how or whether the 'reasonable and necessary' criterion should be applied? Is there sufficient clarity around how the section 34(1) criteria relate to the consideration of what is reasonable and necessary?*

Is better legislative direction about what is reasonable and necessary required? If so, what improvements should be made? What would be the implications of these changes for the financial sustainability of the scheme?

INFORMATION REQUEST 4.2

Should the National Disability Insurance Agency have the ability to delegate plan approval functions to Local Area Coordinators? What are the costs, benefits and risks of doing so? How can these be managed?

DRAFT RECOMMENDATION 4.1

The National Disability Insurance Agency should:

- implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review
- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

DRAFT RECOMMENDATION 4.2

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

Boundaries and interfaces with the NDIS

DRAFT FINDING 5.1

It is a false economy to have too few resources for Information Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

DRAFT RECOMMENDATION 5.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount (of $131 million) for each year during the transition. The funds that are required beyond the amounts already allocated to ILC to reach $131 million should be made available from the National Disability Insurance Agency's program delivery budget.

The effectiveness of the ILC program in improving outcomes for people with disability and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed five-yearly review of scheme costs. The ILC budget should be maintained at a minimum of $131 million per annum until results from this review are available.

DRAFT RECOMMENDATION 5.2

The Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. These arrangements for services should be reflected in the upcoming bilateral agreements for the full scheme.

The National Disability Insurance Agency should report, in its quarterly COAG Disability Reform Council report, on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.

DRAFT RECOMMENDATION 5.3

Each COAG Council that has responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address the provision of those services and how they interface with NDIS services. This item should cover service gaps, duplications and other boundary issues.

Through the review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreement, parties should include specific commitments and reporting obligations consistent with the National Disability Strategy. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

INFORMATION REQUEST 5.1

The Commission is seeking feedback on a mechanism to ensure that the States and Territories bear the cost of participants who were intended to be covered by the National Injury Insurance Scheme.

Provider readiness

DRAFT RECOMMENDATION 6.1

The Australian Government should:

- immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)
- transfer the NDIA's power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.

The body tasked with price regulation for scheme supports should:

- collect data on providers' characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University
- determine transitional and efficient prices for supports at a state and territory level
- comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives
- assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.

DRAFT FINDING 6.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure is likely to result in greater shortages, less competition and poorer participant outcomes.

INFORMATION REQUEST 6.1

In what circumstances are measures such as:

- *cross-government collaboration*
- *leveraging established community organisations*
- *using hub and spoke (scaffolding) models*
- *relying on other mainstream providers*

appropriate to meet the needs of participants in thin markets? What effects do each have on scheme costs and participant outcomes? Are there barriers to adopting these approaches?

Under what conditions should block-funding or direct commissioning of disability supports (including under 'provider of last resort' arrangements) occur in thin markets, and how should these conditions be measured?

Are there any other measures to address thin markets?

INFORMATION REQUEST 6.2

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

Workforce readiness

DRAFT FINDING 7.1

It is unlikely that the disability care workforce will be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.

DRAFT RECOMMENDATION 7.1

The roles and responsibilities of different parties to develop the National Disability Insurance Scheme workforce should be clarified and made public.

- State and Territory Governments should make use of their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.
- The Australian Government should retain oversight of workforce development, including how tertiary education, immigration and aged care policy interact and affect the development of the workforce. In doing so, the Australian Government should pay particular attention to immigration policy to mitigate workforce shortages over the transition period.
- The National Disability Insurance Agency should provide State and Territory Governments with data held by the Agency to enable those jurisdictions to make effective workforce development policy.
- Providers of disability supports should have access to a clear and consistent mechanism to alert those tasked with market development about emerging and persistent workforce gaps.

INFORMATION REQUEST 7.1

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

DRAFT RECOMMENDATION 7.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports, existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

DRAFT RECOMMENDATION 7.3

The National Disability Insurance Agency's (NDIA) guidelines on paying informal carers who live at the same residence as a participant should be relaxed for core supports for the period of the National Disability Insurance Scheme (NDIS) transition. Such payments should be:

- accessible under clearly defined and public guidelines, which make reference to worker shortages in the relevant market using the NDIA's information about providers and supports in the participant's region
- set at a single rate determined by the NDIS price regulator in a transparent manner
- reviewed by the NDIA as part of plan reviews.

INFORMATION REQUEST 7.2

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

Participant readiness

INFORMATION REQUEST 8.1

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

DRAFT RECOMMENDATION 8.1

The National Disability Insurance Agency should implement the eMarketPlace discussed in the *Integrated Market Sector and Workforce Strategy* as a matter of priority.

INFORMATION REQUEST 8.2

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

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

Governance

DRAFT RECOMMENDATION 9.1

The requirement that changes to National Disability Insurance Scheme Category A Rules have unanimous agreement from the Australian Government and all host jurisdictions should be relaxed.

DRAFT RECOMMENDATION 9.2

The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.

DRAFT RECOMMENDATION 9.3

The National Disability Insurance Agency should publicly report on the number of unexpected plan reviews and reviews of decisions, review timeframes and the outcomes of reviews.

DRAFT RECOMMENDATION 9.4

The performance of the National Disability Insurance Scheme (NDIS) should be monitored and reported on by the National Disability Insurance Agency (NDIA) with improved and comprehensive output and outcome performance indicators that directly measure performance against the scheme's objectives.

The NDIA should continue to develop and expand its performance reporting, particularly on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities. The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews).

The *Integrated NDIS Performance Reporting Framework* should be regularly reviewed by the NDIA and the COAG Disability Reform Council and refined as needed.

DRAFT RECOMMENDATION 9.5

In undertaking its role in delivering the National Disability Insurance Scheme, the National Disability Insurance Agency needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.

INFORMATION REQUEST 9.1

The Commission is seeking feedback on the most effective way to operationalise slowing down the rollout of the National Disability Insurance Scheme in the event it is required. Possible options include:

- *prioritising potential participants with more urgent and complex needs*
- *delaying the transition in some areas*
- *an across-the-board slowdown in the rate that participants are added to the scheme.*

The Commission is also seeking feedback on the implications of slowing down the rollout.

Funding arrangements

DRAFT FINDING 10.1

The objective of the escalation parameters is not specified in the Bilateral Agreements between the Australian Government and the State and Territory Governments at full scheme.

The existing escalation parameters are unlikely to reflect the full increase in National Disability Insurance Scheme (NDIS) costs over time, which would result in the Australian Government bearing a higher share of NDIS costs over time.

INFORMATION REQUEST 10.1

The Commission is seeking views on the role of the escalation parameters in the Bilateral Agreements between the Australian Government and the State and Territory Governments.

Should escalation parameters be set on the basis of maintaining a constant real per capita contribution to the National Disability Insurance Scheme by State and Territory Governments; or should they be more explicitly tied to scheme costs so that the proportion of funding allocated to the Australian Government and the State and Territory Governments is maintained over time?

DRAFT FINDING 10.2

Responsibility for funding National Disability Insurance Scheme (NDIS) cost overruns should be apportioned according to the parties best able to manage the risk. This is not the case in the transition period, as the Australian Government bears all the risk of any cost overruns, but not all the control.

The governance arrangements for the NDIS do not allow the National Disability Insurance Agency to respond swiftly when factors outside its control threaten to impose cost overruns.

INFORMATION REQUEST 10.2

The Commission is seeking information on the best way to align the ability to control cost overruns with the liability to fund cost overruns. Possible options include:

- *estimating the proportion of cost overruns that the Australian and State and Territory Governments are responsible for and allocating funding responsibility accordingly*
- *altering the governance arrangements of the National Disability Insurance Scheme to give the Australian Government greater authority to manage the risk of cost overruns, to better reflect their funding liability.*

DRAFT RECOMMENDATION 10.1

At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7-10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.

The National Disability Insurance Agency should be required, in its annual report, to state reasons why it has not met this target in any given year.

DRAFT RECOMMENDATION 10.2

The Australian Government should reconsider the staffing cap on the National Disability Insurance Agency, given the importance of developing internal capability and expertise.

INFORMATION REQUEST 10.3

The Commission seeks feedback on the level of a future contingency reserve that would enable the National Disability Insurance Agency to operate like an insurance scheme, and how this would best be implemented, including any transitional arrangements.

DRAFT RECOMMENDATION 10.3

In-kind funding arrangements should be phased out by the end of transition and should not form part of the intergovernmental agreements for full scheme funding. Should in-kind funding persist beyond transition, jurisdictions should face a financial penalty for doing so.

1 About this study

The National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way that support and care are provided to people with permanent and significant disability. It is currently being rolled out across Australia and is expected to be fully implemented in all states and territories by mid-2019.

This study is a review of NDIS costs. It looks at the sustainability of scheme costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally. The study will help inform the final design of the full scheme.

Some background to the study

In 2011, a Productivity Commission inquiry into *Disability Care and Support* found that Australia's system of disability supports was inequitable, underfunded, fragmented, inefficient and gave people with disability little choice and no certainty of access to appropriate supports (PC 2011). The Commission recommended that a national disability insurance scheme be established to change the way that support and care are provided to people with significant disability, and to provide insurance cover to all Australians in the event of such a disability. The recommendation was based on the finding that such a scheme would generate substantial community-wide benefits, including improving the lives of people with disability and their families and carers.

The Commission's recommendation was accepted by Australian Governments and on 7 December 2012, COAG signed an Intergovernmental Agreement for the launch of the NDIS (COAG 2012b). In the Heads of Agreement between the Commonwealth and the States and Territories, it was established that the Productivity Commission would review NDIS costs in 2017, to inform the final design of the scheme ahead of its full rollout. The terms of reference for this study were received on 20 January 2017.

1.1 About the NDIS

The NDIS is based on the premise that individuals' support needs are different, and those participating in the scheme should be able to exercise choice and control over the services and support they receive. The objectives of the NDIS (as outlined in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act)) are to:

- support the independence and social and economic participation of people with disability

- provide reasonable and necessary supports, including intervention supports
- enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports
- facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability
- promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community
- raise community awareness of issues that affect people with disability.

The NDIS operates under the NDIS Act, and is administered by the National Disability Insurance Agency (NDIA). Funding for the NDIS is shared by the Australian and State and Territory Governments.

The NDIS provides individualised supports to assist people with permanent and significant disability to participate in economic and social life.[3] This paper refers to people who are eligible for individualised supports as 'participants' of the scheme.

For each participant, the NDIS funds 'reasonable and necessary' supports related to their disability. Reasonable and necessary supports are those that help participants live as ordinary a life as possible, including care and support to build skills and capabilities, so that they can engage in education, employment and community activities.

Supports are also available to those who meet early intervention criteria. This covers cases where early intervention can significantly improve outcomes and is cost effective. The focus on early intervention reflects the lifetime, insurance-based approach of the scheme.

Individuals eligible for the scheme are assessed, and individual support packages are developed and funded. Access, planning and payments are managed by the NDIA. (In Western Australia, arrangements will be different to reflect a recently announced bilateral agreement with the Commonwealth, but are intended to be consistent with the NDIS (Porter, Barnett and Faragher 2017)).

The individualised supports provided to participants account for the vast majority of scheme costs and therefore references to 'the scheme' (including in this paper) often refer to these supports.

However, the NDIS is broader than just supports for eligible participants. Information, linkages and capacity building (ILC) services will also be provided under the NDIS from July 2017 to help all people with disability (not just scheme participants), and their families and carers, with information and referrals to community and mainstream services (including health, education, employment, justice, transport and housing) (NDIA 2016g).

3 Permanent and significant disability is defined in this paper as a disability that substantially reduces a person's functional capacity or psychosocial functioning. This is in line with the eligibility criteria contained in the Act.

ILC will also facilitate greater social cohesion by promoting awareness and acceptance of disability in the wider community.

More detail on the scheme, including eligibility criteria, planning processes and governance arrangements, is provided throughout this paper.

The NDIS is part of a broader system of support

The NDIS is part of a wider disability system. It is one component of the broader *National Disability Strategy 2010–2020*, which was endorsed by the Council of Australian Governments in February 2011 and provides a ten-year national policy framework for improving life for Australians with disability, their families and carers (COAG 2011b).

Only a proportion of people with disability will become participants and receive individualised supports. There are approximately 4.3 million people with disability in Australia (figure 1.1). Once fully implemented, the NDIS will provide individual packages to about 475 000[4] people — those people with a 'permanent and significant' disability.

Supports for people with disability (both NDIS participants and non-NDIS participants) are also provided through other Australian and State and Territory Government funded disability services, and mainstream services, such as health and education.

1.2 The benefits of the NDIS

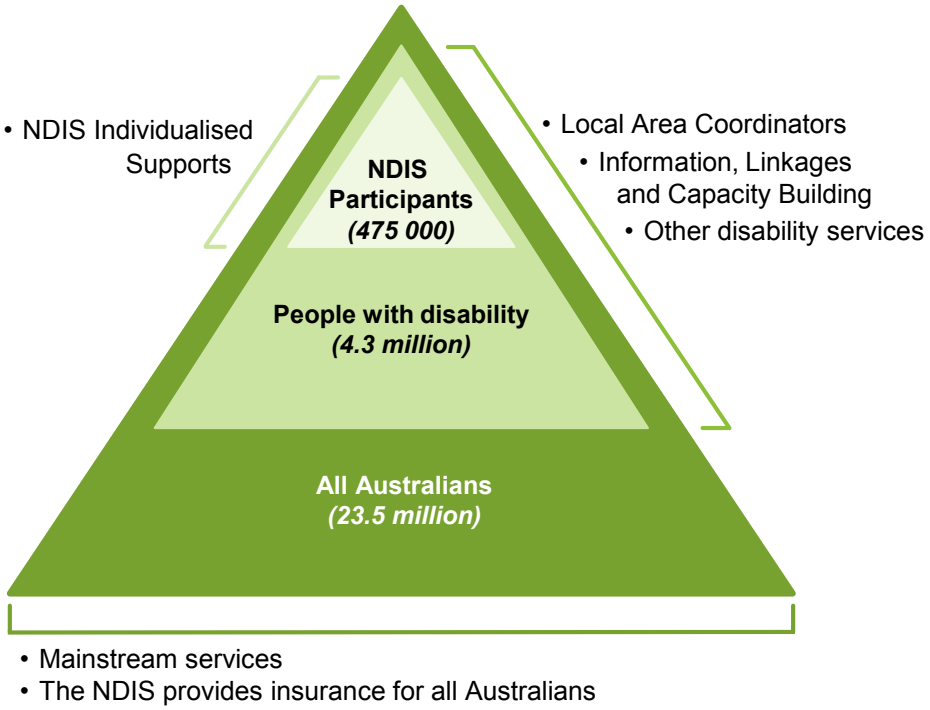
The Commission recommended a national disability insurance scheme in 2011 on the basis of the substantial net benefits it would generate in the long term from:

- improved lives for people with disability and their families and carers through increased care and support and more choice and control over the supports they receive. This was identified as the area of largest benefit with more, and better targeted, support for participants leading to greater social participation and independence
- efficiency gains in the disability sector — through increased competition and innovation, and better value for money
- savings to other government services — by better supporting people with disability and reducing their reliance on mainstream services
- increased economic participation for people with disability — by overcoming obstacles to employment for those with disability through direct interventions, like school to work transition programs, and through changes to community attitudes. The Commission estimated that employment of people with mild to profound disabilities could increase by 100 000 by 2050 (catching up to OECD levels) resulting in $8 billion in additional gross domestic product in that year alone

4 460 000 participants under the age of 65 and 15 000 aged 65 years and over (chapter 2).

- increased economic participation for informal carers — the Commission estimated that an additional 7500 carers could re-enter the workforce (PC 2011).

Figure 1.1 **The NDIS is part of a broader system of supports**[a]



[a] Number of Australians and those with a disability are based on 2015 data. NDIS participants are the projected number of people eligible in 2020.

Sources: Commission estimates based on unpublished NDIA data and ABS *(Disability, Ageing and Carers, Australia: Summary Findings, 2015, Cat. no. 4430.0)*.

A new approach to disability care and support

The scheme is designed to change the way that participants and disability support providers interact, and the way that supports are funded. Two of the key changes from previous approaches include a more market-based, person-centred approach to care and support, and a scheme based on insurance principles.

A market-based approach aims to create incentives that better provide participants with the quantity, quality and variety of services they desire in an efficient way. It is expected to overcome many of the previous system's shortcomings (table 1.1), including by providing participants more choice and control over their supports and services, and encouraging innovation by service providers through increased competition.

Table 1.1 **Intended effects of the NDIS in the disability services market**

Features of Disability Service Markets pre-NDIS	*Features of Mature Disability Service Markets*
• Largely 'block funded', with funding provided in advance of service delivery and little freedom to innovate.[a]	• Predominantly fee-for-service paid on invoice. In principle, prices for services are set by the competitive market, and there is innovation by service providers attracting and retaining consumers.
• Services often limited and priorities for families in immediate crisis, rather than for early intervention. Consumers have little control over the services they receive and limited choice of provider.	• Funding to meet the reasonable and necessary support needs for each NDIS participant. Consumers have choice and control regarding the services received and providers used.
• The primary relationship is between the service provider and the funder, with consumers often described as 'passive' recipients of services.	• The primary relationship is between the consumer and service provider. Intermediaries and access to information about provider quality, performance and pricing help consumers exercise choice.
• Providers are subject to various statutory provisions (at all levels of government) regarding quality. The system is complex, difficult to navigate and not well integrated nationally.	• Compliance with a national quality framework. A nationally consistent and navigable system.
• High transaction costs for both consumers and providers.	• Lower transaction costs for consumers and service providers. There is adequate depth and resilience in the market to underpin financial sustainability.

[a] Block funding refers to the process where governments purchase a 'block' of services from a provider, which is to be delivered to clients who meet certain criteria, or are referred to those providers as part of an individualised plan.

Sources: Adapted from ANAO (2016, p. 20), which is based on analysis of PC (2011); DRC (2015a) and NDIA presentations on the market transition.

As an insurance-based scheme, the NDIS takes a lifetime approach to a participant's support needs and life goals (box 1.1). It is intended to provide assurance to both those with a permanent and significant disability, and those who may acquire such a disability in the future, that they will receive the support they require. In other words, there is essentially no cap on funding — anyone who meets the eligibility criteria is guaranteed to get funding for supports and services. It also focuses on early intervention investment in people with disability so that their outcomes can be improved later in life, and so that costs can be minimised over the long term, even if that involves more spending upfront.

This contrasts with the previous system which operated on an annual capped amount and did not tailor supports to individuals, leading to short-term planning, limited choice, higher long-term support needs, unmet demand and adverse outcomes for some (PC 2011).

Box 1.1 **The NDIS is an insurance-based scheme**

The insurance approach of the NDIS takes a long-term view of the total cost of disability in order to improve participant outcomes and meet the future costs of the scheme. Key elements of the approach include:

- universal coverage by pooling risk across all Australians and taking the risk of disability support costs away from individuals
- creating an innovative and competitive market for disability support, through which participants can exercise choice and control over the planning and delivery of their supports
- a long-term view of the total future social cost of disability for all people who are insured and yet to be insured
- the NDIA — in its role as the social insurance manager — managing the total cost of disability over a participant's lifetime and incentivising short-term investment in participants to reduce long-term costs.

The NDIA identifies four principles for the way that the insurance approach is operationalised:

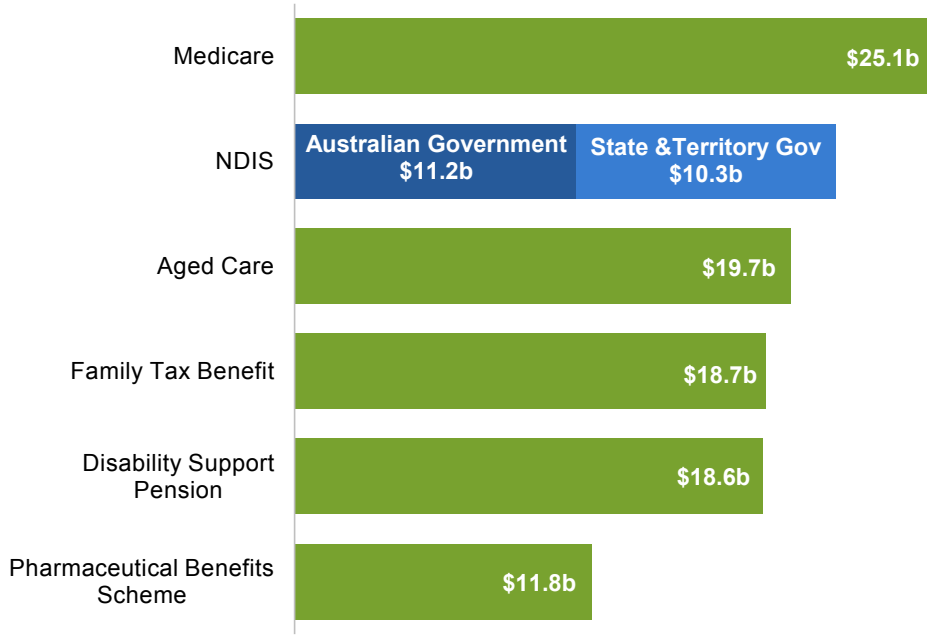
1. Actuarial estimate of long-term costs — updated to reflect the experience of the scheme, and used to help ensure the scheme is financially sustainable and that the scheme is continuously improved.
2. A long-term view of funding requirements — takes a lifetime view of participant needs and seeks early investment and intervention for people in order to maximise their independence, and social and economic participation, and reduce their support requirements in the long term.
3. Investment in research and innovation — to encourage and build the capacity and capability for innovation, outcome analysis and evidence-based decisions on early interventions.
4. Investment in community participation and building social capital — to make the community accessible and inclusive for people with disability, and provide participants and non-participants with necessary supports outside of the NDIS, through mainstream services, ILC initiatives and education programs.

Source: NDIA (sub. 161, pp. 23–26).

1.3 The NDIS is a major reform

The NDIS is a major reform. As the NDIA said, the scheme is 'on a scale not previously contemplated in Australia and is designed to address un-met need' (NDIA 2016k, p. 7). The NDIS will be the largest social reform since the introduction of Medicare. At a currently estimated annual cost of about $22 billion when fully implemented, government expenditure on the NDIS will exceed that on Aged Care and will be almost double that spent on the Pharmaceutical Benefits Scheme (figure 1.2).

Figure 1.2 **Projected NDIS expenditure compared with other Australian Government programs, 2019–20**



Source: Adapted from Department of Parliamentary Services (2017), which is based on Australian Treasury (2016a, 2016b).

At full rollout, the NDIS is expected to cover 475 000 people with disability. This is almost 200 000 more people than were covered under the previous system (NDIA 2016k, p. 8). To meet this increased demand, the disability workforce will need to more than double.

Introducing a scheme of this scale and nature is a challenging task and it is inevitable that it will take many years before the scheme is fully established and operating smoothly. The enormity and significance of the task was acknowledged by many participants to the study. For example, the ACT Disability Aged Carer and Advocacy Service said:

> The NDIS is monumental reform for Australia: a grand scheme (akin to the introduction of Medicare) that has the potential to make vast differences in the life experiences of an array of people with disability, their families and carers both now and in decades to come. (sub. 87, p. 1)

Richard Madden, from the Centre for Disability Research and Policy at University of Sydney, said:

> The NDIS has been introduced quickly, and involves a large increase in public expenditure, and inevitably some uncertainty as long standing support arrangements change. The change effort has been huge for all involved. Inevitably, there have been issues to be addressed, and some delay in ambitious timetables. These issues, while important, must not detract from the achievements made and the opportunities that exist. (sub. 101, p. 3)

There is overwhelming support for the scheme

While many submissions to this study commented on the scale and complexity of the reform, there is an extraordinary level of commitment to the success and sustainability of the NDIS (and to preserving the core principles of the scheme as set out by the Commission). This commitment is shared by governments, people with disability and their families and carers, providers of disability services and disability advocates (box 1.2). For example, Every Australian Counts said:

> The Scheme is a once-in-a-lifetime change to the way disability support is delivered in Australia. It is going to affect millions of Australians. Because of the relative unfamiliarity of this model, there are issues that need ironing out. A reform of this size will take time to get right. Long-term, the NDIS will give back to the economy. Indeed, it would cost far more not to implement it. (sub 92, p. 2)

It is also acknowledged that 'making the scheme work' is not just the responsibility of the NDIA, but also of governments, providers, participants (and their families and carers). As the Australian Disability Discrimination Commissioner said:

> Yes — the NDIS is big, it is complex, and it changes everything, but it is the change that we need. And when we think about what life might be like for people with disability without the NDIS, I think it becomes clear that it is the change we cannot afford to prevent. … ensuring the sustainability and success of the NDIS is not only the responsibility of the NDIA or its board — it is the responsibility of all governments, service providers, participants, their families and carers. If we want real and lasting change for people with disability, we cannot absolve ourselves of our responsibility to make the NDIS work. (McEwin 2017)

Box 1.2 There is overwhelming support for the NDIS

Australian Federation of Disability Organisations:

> We want to begin … by emphasising our unwavering support for the NDIS. AFDO and its members regularly hear from people with disability and their families about the difference the NDIS is making to their lives. People who now have the dignity of appropriate and timely support, the opportunity to be more involved in their communities, the chance to move out of home, the economic freedom of a new job. These are the kinds of differences the NDIS is making. (sub. 180, p. 6)

Anglicare Australia:

> Anglicare Australia strongly believes that the establishment of the NDIS is a major achievement. Our member agencies are already witnessing the transformative power of the scheme for participants, and finding that reconfiguring services to reflect their needs and aspirations is creating opportunities to reimagine and create better outcomes in people's lives. (sub. 157, p. 4)

NSW Council for Intellectual Disability:

> … we have been strong supporters of the development of the NDIS and we continue to see the scheme as having a fundamental capacity to improve the lives of people with disability around Australia. (sub. 193, p. 2)

Flourish Australia:

> Flourish Australia strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support. … However, we are also mindful that, as with any reform of such a substantial scale, there can be unintended consequences, implementation issues and uncertainty, especially during the transition phase. We are particularly mindful of the impact of this on the people we support. (sub. 74, p. 1)

JFA Purple Orange:

> … the NDIS is a major, once-in-many-generations opportunity to invest in the life chances of people living with disability, to achieve a fair go, so that people living with disability take their rightful place as valued active members of Australian community life and the economy. (sub. 186, p. 4)

National Disability Services:

> The principles on which the NDIS is founded remain compelling and inspiring. Doubling the funding for disability support to rectify the chronic under-supply of services, choice and control for people with disability and their families, an insurance approach that focuses on early intervention and building the capacity of individuals and families and increased equity across Australia. (NDS 2016, p. 3)

Scope Australia:

> Scope is fully committed to the implementation of the National Disability Insurance Scheme. The Scheme creates a paradigm shift in social policy and recognises the rights of all Australians to live an ordinary life. It has enhanced the lives of more than 60,000 participants and their families and for the first time fully recognises the rights of people with a disability to live their lives as empowered and equal citizens. (sub. 72, p. 29)

Health Services Union:

> The HSU has always been a strong supporter of the NDIS and our longstanding position has been that quality disability services depend on a quality workforce. (sub. 132, p. 5)

New South Wales Government:

> The NSW Government is a strong advocate of the National Disability Insurance Scheme (NDIS). The improvement in the lives of people with disability, as outlined by the Productivity Commission (PC) in its 2011 inquiry report into Disability Care and Support, is a goal embraced by NSW. (sub. 60, p. 2)

1.4 The Commission's approach to the study

This study is a review of NDIS costs. The Commission has been asked to look at:

- the sustainability of scheme costs, including current and future cost pressures, and how to manage any potential cost overruns
- whether jurisdictions have the capacity to deliver disability care and support services as the scheme expands
- how the NDIS impacts on, and interacts with, mainstream services
- whether efficiencies have been achieved within the scheme
- whether there are any issues with scheme design, including the application of market and insurance principles, in ensuring the best possible outcomes for people with permanent and significant disability
- funding and governance arrangements, including financial contributions, risk-sharing, and the 'escalation parameters', which define the annual increase in funding required by different jurisdictions.

A number of stakeholders expressed concern that the Commission would focus on costs and not take into account the intent of the scheme and the potential impact that it could have on the lives of people with disability (box 1.3). As the Australian Federation of Disability Organisations said:

> A focus on costs should not be at the expense of a focus on outcomes for the very people the scheme is intended to support. Any decisions made in the interests of ensuring sustainability should also be consistent with improving outcomes for people with disability. (sub. 180, p. 6)

And while the focus of this study is on scheme costs, the Commission's approach (consistent with the *Productivity Commission Act 1998* (Cwlth)), is to examine costs in light of the benefits and impacts of the scheme on the lives of people with disability, and Australians more generally, using a wellbeing framework (see figure 1.5 below). This is also consistent with the insurance approach of the NDIS, which is about 'maximising outcomes for participants and their families/carers at the lowest possible sustainable cost' (NDIA, sub. 161, p. 26).

The objectives of the NDIS (choice and control, independence, social and economic participation, reasonable and necessary support) are seen by the Commission as an integral part of the analysis of the scheme costs. Costs cannot be considered in isolation of the benefits they provide.

Box 1.3 **Stakeholders said the focus should not be solely on costs**

Anglicare Australia:

> … measures of the financial sustainability of the NDIS should not be narrowly held and applied solely within the scheme itself. Although such measures are of course essential, questions regarding the overall worth of the scheme that capture the cost and benefit to Australian society should be included … (sub. 157, p. 21)

Community Mental Health Australia:

> … CMHA … believes that the Commission in assessing whether or not the NDIS is financially sustainable must investigate how the scheme is being implemented and how this is being managed. (sub. 11, p. 2)

Australian Blindness Forum:

> The financial sustainability of the NDIS should be defined and measured by the standard that all people with disability can access and participate in the community. (sub. 48, p. 17)

NSW Government:

> Any review of costs and sustainability isn't necessarily about minimising short term costs. Costs must be considered in relation to the objectives of the NDIS (reasonable and necessary support; choice and control; increased social and economic participation). (sub. 60, p. 9)

SDN Children's Services:

> SDN believes that a drive for financial sustainability must not be disconnected from a drive for quality, effective practices. (sub. 73, p. 2)

Autism Aspergers Advocacy Australia:

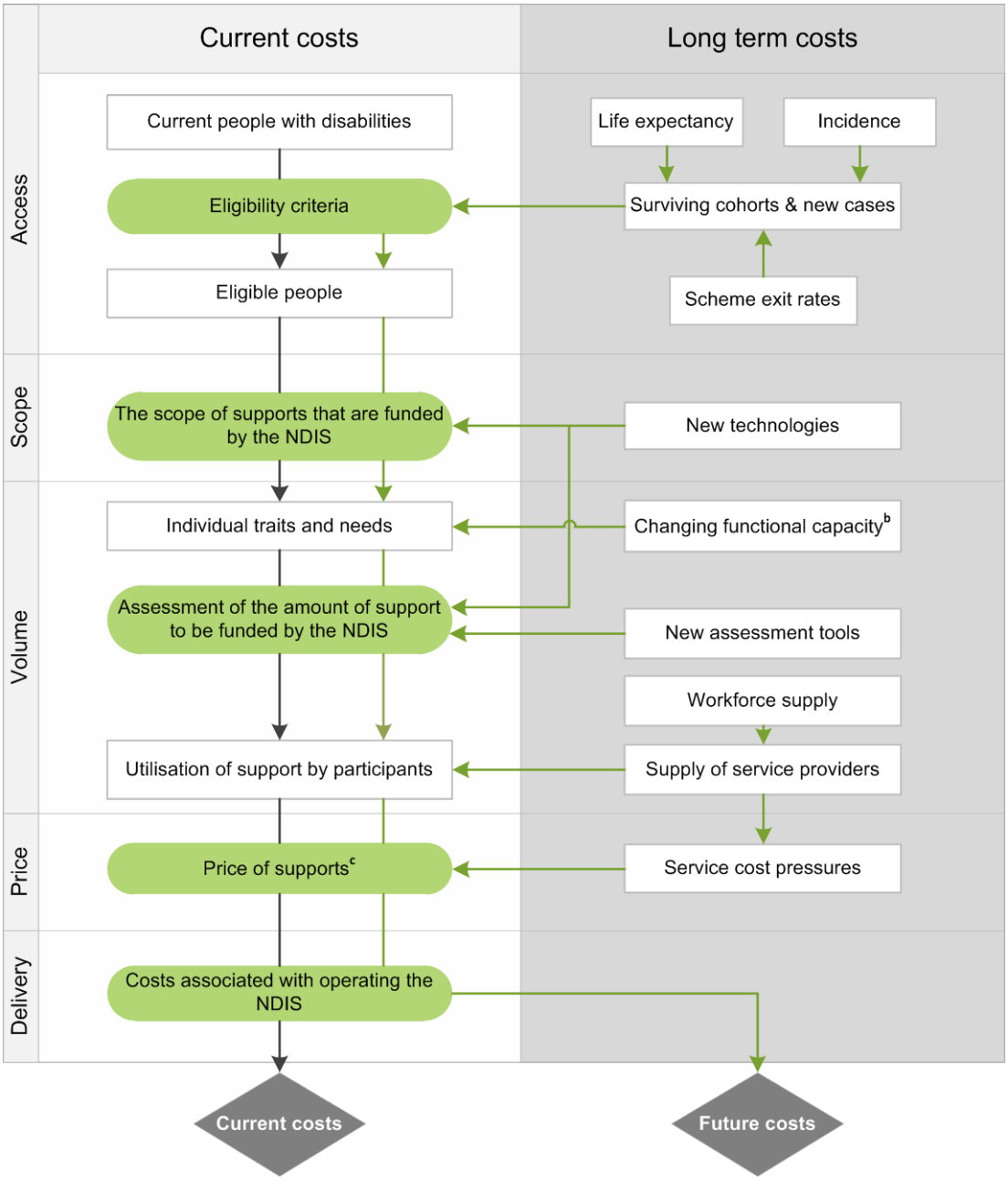
> Maybe 'sustainability' is the wrong notion. It is more about benefit versus cost, and people having a reasonable standard of living in our community. (sub. 178, p. 36)

What are the factors driving scheme costs?

Assessing the sustainability of scheme costs, including current and future cost pressures, involves examining the factors that drive scheme costs. Key factors driving scheme costs include:

- access — the number and profile (age, sex, disability type, disability severity) of participants in the scheme
- scope — the scope of supports provided to participants in the scheme
- volume — the quantity of supports in a participant's plan and the proportion of supports in a plan that are utilised by a participant
- price — the price paid for supports under the scheme
- delivery — the costs associated with operating the scheme (figure 1.3).

Figure 1.3 **What drives scheme costs?**[a]



[a] Green cells denote cost drivers that the NDIA and/or governments have direct control over. Grey cells are cost drivers that can only be *indirectly* influenced by governments. [b] This includes changes in participants' functional capacity attributable to early intervention. [c] Prices of disability supports are currently set by the NDIA. The NDIA intends to deregulate prices as the market matures (NDIA 2016h, p. 11).

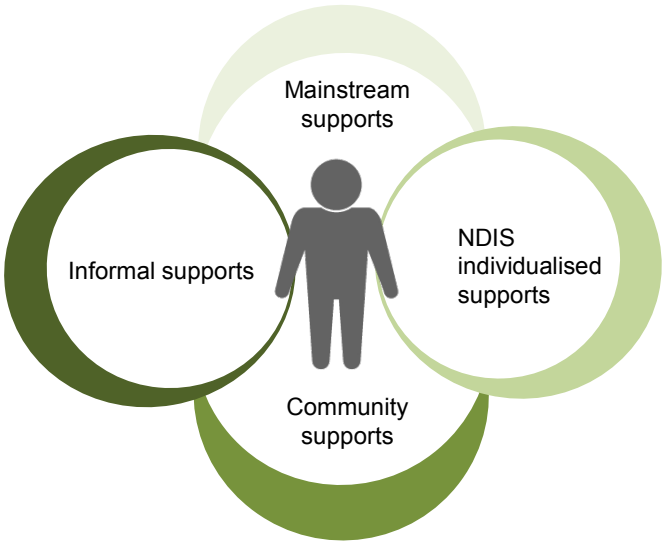
Scheme culture will also be an important driver of costs. Moving away from the welfare culture of current disability systems to one of seeking reasonable and necessary supports and managing down the total cost of disability over a participant's lifetime (in line with an

insurance approach) will be critical for the financial sustainability of the scheme. As noted by Bruce Bonyhady, the former Chair of the NDIA Board:

> Importantly, the NDIS cannot be allowed to be turned into a Centrelink-type entitlement model, because under this approach costs would continually escalate. (sub. 100, p. 2)

Other support systems can also affect scheme costs. The NDIS, as a person-centred approach to providing disability supports, relies on supports and services outside of the NDIS (including informal, community and mainstream supports) to be in place to help people with disability to live ordinary lives (figure 1.4). If these supports are not available, people with disability could seek NDIS funding to fill the gap, and this could pose risks to scheme costs.

Figure 1.4 **A person-centred approach relies on supports outside the NDIS**



Source: Adapted from NDIA (sub. 161, p. 22).

Sustainability — interpreted as financial sustainability

The Commission has interpreted scheme sustainability to mean 'financial sustainability'. This is in line with the NDIS Act. Under the Act, the NDIA manages, advises and reports on the financial sustainability of the NDIS. While financial sustainability is not defined or listed as one of the explicit objectives of the Act, the Act (s. 3) does state that 'regard is to be had to … the need to ensure the financial sustainability of the National Disability Insurance Scheme'.

The insurance approach to the scheme and financial sustainability are inextricably linked. For a commercial insurer, financial sustainability is about balance sheet adequacy — there needs to be enough capital to meet some proportion of future expected liabilities by way of

cash claims (as set out in prudential standards set by the Australian Prudential Regulation Authority) (NDIA 2016j).

However, the financial risks inherent in the NDIS are unique. The NDIS is funded on a cash-flow basis — annual contributions meet the cash claims expense — so a balance sheet approach to financial sustainability is not appropriate. And because there is no annual capped amount (as there was in previous disability support systems), the financial risk associated with satisfying all valid claims for reasonable and necessary support needs to be managed. As the NDIA explained:

> … unlike traditional disability systems, it is not open to the NDIA to refuse to fund reasonable and necessary supports for a participant who has been found to be eligible on the basis that the 'budget has been exhausted'. The NDIS, therefore, faces significant financial risks in the same way that an insurer does and these risks must be managed. Indeed, the NDIS Act explicitly requires the Agency to manage the financial risk that goes with a regime under which any valid claim has to be satisfied. However, the NDIS is still concerned with people rather than claims, and outcomes as well as financial result. (2016j, p. 6)

In light of this, the NDIA defines financial sustainability for the NDIS as:

- the scheme is successful on the balance of objective measures and projections of economic [and] social participation and independence, and on participants' views that they are getting enough money to buy enough goods and services to allow them reasonable access to life opportunities — that is, reasonable and necessary support; and
- contributors think that the cost is and will continue to be affordable, under control, represents value for money and, therefore, remain willing to contribute. (2016j, p. 18)

Based on the NDIA's definition, achieving financial sustainability requires continuous monitoring of both participants' outcomes and costs. It is not about minimising costs or maximising benefits, but rather balancing the two in a way that ensures there is a net benefit over time. As the NDIA put it:

> … while cost efficiency will be of prime importance to an insurer it will not be the sole focus of the NDIS. Rather, good participant outcomes will be an ongoing objective and, so, finding the right balance between participant outcomes and cost will be critical. (2016j, p. 12)

And as pointed out by the New South Wales Government, financial sustainability must be considered against a long term (not a short term) view of costs:

> The lifetime costs for supporting participants must be considered and an investment approach taken. Early intervention principles are appropriate (including beyond just early childhood), and may increase costs in the short term before delivering lower lifetime costs. The alternative is immediate cost reductions that deliver worse social or economic outcomes for participants or the need for acute responses later in life: this is not an improvement to financial sustainability.
>
> … Financial sustainability must be considered with reference to a suite of indicators, with a long-term view, and with consideration of broader impacts elsewhere. (sub. 60, pp. 9–10)

The Department of Social Services (sub. 146, p. 17) said it supported the NDIA's definition of financial sustainability, and noted that 'considerations of NDIS sustainability

need to weigh the success of the Scheme in improving economic and social outcomes and the value-for-money proposition for contributors'.

As outlined above, financial sustainability is a difficult concept to define in a unique scheme like the NDIS, but the Commission supports the definition used by the NDIA. The definition provides a clear link between scheme costs and benefits and support from taxpayers.

A wellbeing framework for considering costs and benefits

The Commission has examined scheme costs and the financial sustainability of the scheme in light of the benefits to people with disability and Australians more generally using a wellbeing framework (figure 1.5).

The NDIS aims to improve the lives not only of current scheme participants, but also future participants. This will only be the case if the scheme is financially sustainable. Financial sustainability is also essential if scheme participants are to consistently receive reasonable and necessary care while they remain in the scheme. Cost overruns could jeopardise the level of care and support participants receive, or result in a return to some of the less desirable features of the previous system (including, for example, an inequitable rationing of support services).

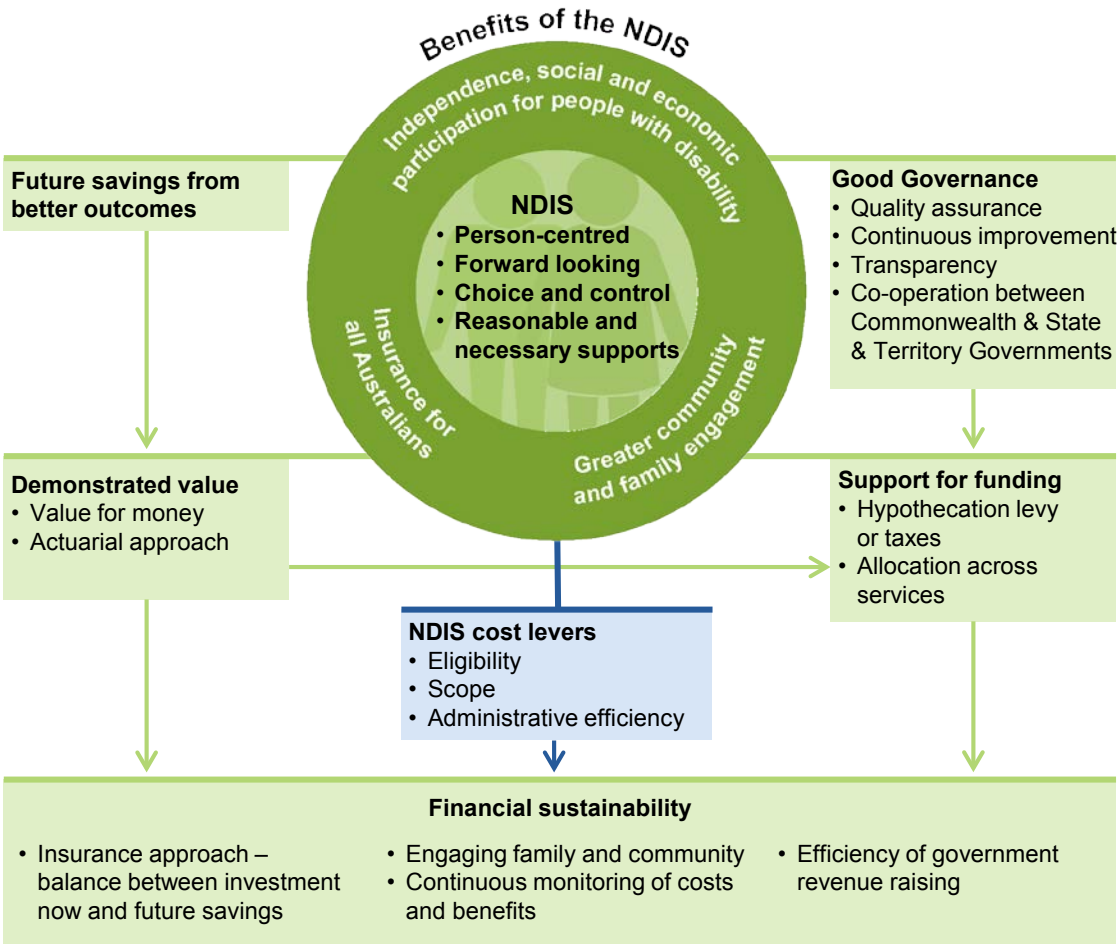
And, unlike other insurance schemes that rely on premiums to fund costs, the NDIS will only be funded as long as taxpayers consider it is a good use of taxes.

Taxpayers' willingness to fund the NDIS will depend on their perception of value for money in terms of:

- people with disability experiencing better lives as a result of the scheme
- the scheme making it easier for families and carers to play a supporting role
- the way the scheme invests in people with disability
- the supports that are funded (and the evidence base to support what is funded)
- efficiency gains and cost savings in the disability support system and other government services.

While the NDIS is sometimes described as an 'uncapped scheme', the ultimate cap — and test of financial sustainability — is taxpayers' continuing willingness to pay for it. Cost overruns could lead to pressure to reduce the scope and certainty of care and supports provided under the NDIS, or require governments to provide more funding at the expense of other programs.

Figure 1.5 **Wellbeing framework for considering costs and benefits**



The NDIA's actuarial estimates of long-term costs (which reflect the experience of the scheme and management responses to cost pressures) play an important role in demonstrating to the Australian community that the scheme represents value for money.

Perceptions about the effectiveness of governance arrangements for the NDIS are also important. For example, the community expects planning processes to be in line with the objectives of the scheme and services to meet quality standards. Governments also need to demonstrate that the funds for the NDIS are dollars well spent from a limited tax revenue bucket and funding the scheme is not to the detriment of other important expenditures.

Assessing the financial sustainability of the NDIS also involves looking at interrelated systems. This includes, but is not limited to, the efficiency and effectiveness of the NDIA, the readiness of participants, the readiness of providers, and the integration of the NDIS with mainstream services. Only a system that is integrated and holistic in its focus will bring the benefits to people with disability that the scheme is expected to deliver.

Transitional issues can become entrenched problems

It is no surprise that, given the size, speed and complexity of the reform as noted above, there have been considerable transitional issues with the rollout of the NDIS. All major reforms are followed by a (sometimes protracted) period of disruption and adjustment.

Many of these transitional issues are expected to be ironed out as the scheme rollout is completed and the scheme matures. It is evident to the Commission through consultation with the NDIA, and from its submission to this study, that the Agency is devoting resources to addressing implementation issues. The NDIA said:

> The NDIS is still in its infancy and delivering the Scheme will evolve and improve over time. The NDIA is intent on learning from experience and improving systems, processes and practices as quickly as possible to ensure the success of the Scheme. (sub. 161, p. 14)

However, if transitional issues are not dealt with quickly and effectively, they can become entrenched problems that endure in the longer term and affect the success and sustainability of the scheme.

It is still early days

The Commission is mindful that, while significant benefits are expected to result from the new approach to providing disability care and support, like any major reform it will be many years before the full extent of the benefits are realised or reflected in objective measures.

Even once the scheme is fully implemented by mid-2019, the transition to a mature market will be gradual, and participants, carers and providers will need time to adjust to the new system. According to an Australian National Audit Office report, the disability services market under the NDIS is expected to take up to ten years to develop, and perhaps longer in some market segments (ANAO 2016, p. 19). The NDIA, in its Market Approach Statement 2016–2019, said that:

> Developing a strong, contestable marketplace for disability supports is a long term project. All stakeholders in the marketplace will require time to build capability, confidence and systems to support the market mechanisms. Participants, possessing greater consumer power, are learning to make choices and explore different service options. Providers are building an understanding of their customer base and preferences, positioning service offers and transforming their operations. (2016k, p. 12)

The Commission is also mindful that, because the scheme is not yet fully rolled out and there are some transitional issues, the experience to date may not be reflective of the underlying long-term outlook (chapter 2 discusses in more detail the limitations of the trial and transition data).

1.5 A guide to this paper

This position paper outlines the Commission's early thinking on the sustainability of NDIS costs. The purpose of this position paper is to seek feedback on the Commission's preliminary conclusions, and on any additional issues that should be considered before the public release of the final study report in September 2017. The Commission welcomes written comment on this paper, and will undertake further consultation to facilitate feedback from participants to inform the preparation of the final study report.

The Commission is aware that more data and information will be available before the study's final report is released. As such, the draft recommendations in this paper should be viewed as indicative.

In conducting this study, the Commission has drawn on a range of evidence. It consulted widely, including with NDIS participants, advocacy groups, peak bodies, service providers, disability care and support workers and academics. It also met with Australian and State and Territory Government departments and agencies, including extensive liaison with the NDIA and the Department of Social Services. There have also been a number of other reviews of various aspects of the NDIS since the trial began and the Commission has drawn on these where relevant.

The Commission has used the information and evidence provided in the 206 submissions it received in response to the issue paper released in February 2017 (a full list of submissions and consultations is provided in appendix A). The Commission wishes to thank study participants for their input.

Submissions on this paper are due by 12 July 2017.

Structure of this paper

Chapter 2 looks at how the scheme is tracking based on scheme experience to date. Two of the key drivers of cost are then discussed in more detail in chapters 3 and 4 — the scheme eligibility (which determines the number of participants in the scheme), and the supports NDIS participants receive (as determined by the planning process). These components essentially form the demand for NDIS services.

Chapter 5 looks at how the NDIS interfaces with non-NDIS disability services and mainstream services and the ways in which this impacts on the financial sustainability of the scheme.

Chapters 6 and 7 look at the supply side of the equation. Chapter 6 assesses whether providers will be capable of meeting demand for disability services and chapter 7 analyses workforce readiness. Chapter 8 looks at whether participants have the knowledge and skills to successfully engage with the scheme. Governance arrangements are discussed in chapter 9 and chapter 10 looks at funding arrangements.

2 How is the scheme tracking?

Key points

- Tracking scheme costs and participant outcomes (and making adjustments in response to scheme experience) is critical to ensuring that the National Disability Insurance Scheme (NDIS) achieves its objectives and is financially sustainable.
- The NDIS was launched a year earlier than recommended by the Commission in 2011 and the scope of the trials was broadened. The changed timing and scope of the planning phase meant that some aspects of the scheme were being built and tested over the trial period, including assessment tools and ICT systems.
- The rollout schedule of the NDIS is highly ambitious. To reach the estimated 475 000 participants at full scheme, the National Disability Insurance Agency (NDIA) will need to approve hundreds of plans a day — in 2018-19, about 500 plans a day will need to be approved and hundreds more reviewed.
- It is inevitable that there will be transitional issues with the rollout of the NDIS given the size, speed and complexity of the reform, but already there are signs that the rollout schedule risks the NDIA not being able to implement the NDIS as intended.
  - The focus on getting participants into the scheme has come at the expense of the quality of plans. Some key planning supports for participants have not been in place and this has affected participant readiness. And the supply side of the market has had very little time to adjust.
- The NDIA's projection of full scheme costs ($22 billion) is broadly consistent with the Commission's 2011 modelling. The Commission has not updated its own projection of scheme costs. Early scheme data have too many limitations to update assumptions on prevalence rates and package costs.
- Based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling. While there are more children entering the scheme than expected and higher than expected package costs, these factors are offset by lower levels of utilisation than expected.
- The NDIA has put in place initiatives to address emerging cost pressures, including the Early Childhood Early Intervention approach and the first plan process to reduce variability in the level of support provided to participants.
- The benefits of the NDIS are becoming apparent. The early evidence suggests that many (but not all) scheme participants are receiving more disability supports than previously, and they have more choice and control. There is also evidence that the NDIS is improving the wellbeing of participants and their families and carers.

Tracking scheme costs and participant outcomes is critical to ensuring that the National Disability Insurance Scheme (NDIS) achieves its stated objectives and is financially sustainable over the longer term. In 2011, when the Commission estimated full scheme

costs for a national insurance scheme, it noted that insights from the early experience of the scheme should be used to provide a more precise estimate of the long-term scheme costs, given the uncertainties at the time around the costings of the scheme (PC 2011, p. 932).

The National Disability Insurance Agency (NDIA) estimates that at full scheme about 475 000 participants will have individualised supports and the scheme will cost $22 billion in the first year of full operation (NDIA 2017o, p. 5, 2016b, p. 18). The number of participants is higher than what is reported in the NDIA's publications because the NDIA only reports the number of scheme participants under the age of 65 years.[5]

These estimates are consistent with the Commission's 2011 estimates of scheme costs (discussed further below). The Commission has not calculated its own estimate of long-term scheme costs for this position paper. There are too many limitations with the early scheme data to update the modelling assumptions. That said, early scheme data can be used to assess where cost pressures may be emerging.

The first section (section 2.1) of this chapter looks at the NDIS rollout schedule. Section 2.2 looks at the assumptions that drive the NDIA's long-term estimates of scheme costs. Section 2.3 provides an overview of scheme participants and costs to date, and looks at how they compare with the NDIA's assumptions. Section 2.4 looks at the early evidence on the benefits of the scheme to participants and their families and carers.

2.1 The rollout of the scheme so far

The NDIS was trialled from 2013 in different jurisdictions across Australia. Trials commenced in July 2013 in New South Wales, Victoria, South Australia and Tasmania (table 2.1). The trial sites varied in size and scope. For example, the trial sites in:

- South Australia and Tasmania covered the whole jurisdiction but were restricted to certain age groups (children aged 0-14 years for South Australia and 15-24 years in Tasmania)
- Victoria and New South Wales were limited geographically (the Barwon and Hunter regions) but had no age restrictions (apart from the NDIS-wide restriction that participants must be aged under 65 years to enter the scheme).

The transition to full scheme began in all states and territories in July 2016, with the exception of Western Australia (which will transition from July 2017). The Bilateral Agreements between the Australian and State and Territory Governments set out the timeframes for the transition in each jurisdiction, including quarterly estimates of the number of participants who will enter the scheme. Jurisdiction-specific Heads of Agreements signed by the Australian and the State and Territory Governments outline that

5 The NDIA project that in 2019-20, the NDIS will include 460 000 participants under the age of 65 years and 15 000 participants aged 65 years and over. The NDIA reports 460 000 participants in its publications.

the full scheme is scheduled to be rolled out nationally by 2019-20, with the timeframes for the transition to differ across jurisdictions (NDIA ndb) (table 2.1).[6]

Table 2.1 **NDIS transition arrangements by jurisdiction**

	Trial period			Transition to full scheme			Full scheme
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
NSW	Hunter area trial		Early Transition in Nepean Blue Mountains area (children aged 0-17 years)	Transition to full scheme (by region)		Full scheme	
Vic	Barwon area trial			Transition to full scheme (by region)			Full scheme
Qld			Transition to full scheme from July 2016 (by region). Early Transition from January 2016 in Townsville, Charters Towers and Palm Island				Full scheme
SA	Statewide trial (children aged 0-14 years)			Transition to full scheme (by age and region)		Full scheme	
Tas	Statewide trial (people aged 15-24 years)			Transition to full scheme (by age)			Full scheme
NT		Barkly region trial		Transition to full scheme (by region)			Full scheme
ACT[a]		Territorywide trial		Full scheme			
WA[b]		Perth Hills area trial MyWay trial			Transition to locally-administered NDIS		Full scheme

a The Bilateral Agreement for the NDIS launch between the Australian Government and the ACT Government notes that from 2016-17 the ACT will be in 'transition to full scheme'. This transition has been categorised as 'full scheme' because all residents who meet the eligibility criteria will have access to the scheme. **b** In February 2017, the Australian Government and Western Australian Government signed a Bilateral Agreement for a nationally consistent, but locally-administered, NDIS.

Sources: Adapted from ANAO (2016, p. 79); NDIA (ndb); Porter, Barnett and Faragher (2017).

The speed of the rollout is creating problems

In 2011, the Commission recommended that the NDIS commence in July 2014 in two geographic regions (PC 2011, p. 938).[7] But the scheme was launched a year earlier, and

6 The Bilateral Agreements covering the trial phase (signed between 2012 and 2014) included the planned intake of participants and the balance of cash and in-kind contributions to the scheme. A second set of Bilateral Agreements cover the arrangements for transitioning the NDIS to full scheme. These were signed in 2015 and 2016. The ACT reached full scheme at the completion of the trial period so a second bilateral agreement was not required.

the scope of the trials was broadened significantly. The changed timing and scope of the trials compressed the planning phase for the scheme. Some aspects of the scheme were being built and tested over the trial, for example:

- the NDIS commenced without an assessment tool to help determine reasonable and necessary supports and had to build one over the first three months of operation (in 2011 (NDIA, sub. 161. p. 3). The Commission acknowledged that there was no ideal assessment tool to use in the NDIS, but also said that the scheme should not be delayed in the absence of 'perfect' tools (PC 2011, pp. 338–339)
- the ICT system used during trial was an interim system that would not scale to full scheme (a new system was put in place in 2016 for full scheme) (NDIA, sub. 161. p. 3).

A review of the capabilities of the NDIA described the Agency as being 'like a plane that took off before it had been fully built and is being completed while it is in the air' (Whelan, J., Acton, P. and Harmer, J. 2014, p. 7).

The rollout schedule is highly ambitious given the magnitude of the reform. To reach the estimated 475 000 participants at full scheme by 2019-20, the NDIA will need to approve hundreds of plans a day (figure 2.1). In the March 2017 quarter, the NDIA approved about 14 000 plans, or roughly 160 plans a day (NDIA 2017o, p. 12). In 2018-19 (the final year of transition), NDIA modelling indicates that about 500 plans a day will need to be approved, and hundreds more reviewed.

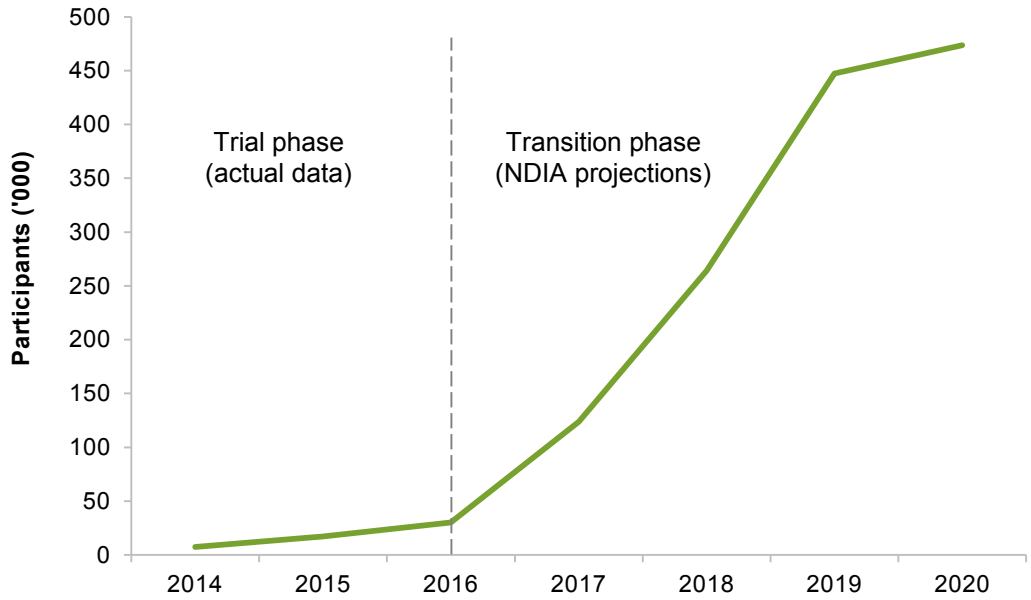
As JFA Purple Orange said (sub. 186, p. 7), the NDIS transition arrangements 'mean a tsunami of new participants will be processed into the scheme over the next two years'. Associate Professor Helen Dickinson of the Public Service Research Group at the University of New South Wales (2017) also recently commented that 'this vast reform is being implemented at break-neck speed'.

The NDIA is already struggling to keep up with the participant numbers included in the Bilateral Agreements — at the end of March 2017, there were 78 000 participants with approved plans, which was just 82 per cent of the bilateral estimates (table 2.2).[8] If the number of people approved to enter the scheme but awaiting a plan (23 000) are added to scheme participant numbers, then the bilateral estimates have just been reached.

7 The Commission also recommended that the scheme would be national by July 2015 and reach full scheme by 2018-19.

8 The 78 000 participants with an approved plan reported by the NDIA includes children who have entered the Early Childhood Early Intervention pathway but who *do not* have an approved plan.

Figure 2.1 **Growth in number of participants in the scheme[a]**



[a] The projections of scheme participants were prepared by the Scheme Actuary for the NDIA's 2015-16 Annual Financial Sustainability Report using data at 30 June 2016. They do not incorporate actual participant numbers beyond June 2016.

Source: NDIA (2016b).

Table 2.2 **NDIS participants and bilateral estimates**

	Participant cohort with approved plans				*Bilateral estimate*	*Per cent of estimate*
	Existing disability service clients	*New*	*ECEI[a]*	*Total*		
End of 2015-16	16 112	14 169		30 281	36 307	83
End of 2016-17 Q1	21 473	16 395		37 868	56 573	67
End of 2016-17 Q2	38 516	22 694	2 267	63 477	74 833	85
End of 2016-17 Q3	48 391	27 176	2 439	78 006	95 148	82

[a] 'ECEI' denotes the number of children who have entered the Early Childhood Early Intervention pathway but who *do not* have an approved plan.

Source: NDIA (2017o, p. 16).

The NDIA, commenting on the bilateral estimates, said:

> The transition to full scheme commenced on 1 July 2016 and immediately there were problems. The new systems and process, coupled with the scale of intake and issues with the ICT portals saw the NDIA fall behind both in terms of the bilateral estimates and the quality of the participant and provider experience.

> The NDIA was able to recover against the bilateral estimates, but problems emerged during this time with the quality of plans and concerns were expressed about aspects of the planning process and the impact on the participant experience. These are matters that the NDIA is now actively addressing. (sub. 161, p. 4)

The NDIA indicated that there appear to be fewer clients in existing programs than the national minimum dataset suggested, and compared to the estimated number of transitioning participants in Bilateral Agreements (noting that the numbers in the Bilateral Agreements are estimates, not hard targets). And while this is expected to affect the mix of transitioning and new participants, at this stage the NDIA has not revised the overall expected number of participants in full scheme (sub. 161, p. 76).

Given the size, speed and complexity of the reform, it is inevitable that there will be transitional issues with the rollout of the NDIS. It needs to be recognised that the scheme is still in its infancy and it will take time to get it right. As the Australian Federation of Disability Organisations (AFDO) said:

> We acknowledge that there have been many issues during trial and the transition to full scheme implementation. But we also recognise that this is a unique period in the life of the NDIS. Never again will the scheme have to grapple with the multiple challenges posed by bringing in a large number of participants in such a short period of time. Once this period of transition is over, growth will be limited to a small number of new participants. AFDO understands that there are significant operational challenges in ensuring hundreds of thousands of people enter the scheme in a short period of time. (sub. 180, p. 5)

But already there are signs that the rollout schedule is compromising the NDIA's ability to implement the NDIS as intended, and risking the financial sustainability of the scheme — and the number of participants entering the scheme is only just starting to ramp up. Many of the concerns raised with the Commission in this study relate to the rollout schedule and the risks of focusing on participant numbers (box 2.1). The NDIA is also aware of the risks, noting that:

> … bilateral estimates can and do impact upon the way in which the Scheme is delivered. This can put sustainability at risk and impact on the way in which early intervention and investment initiatives are implemented in the short term. It may also have adversely impacted the quality of plans. (sub. 161, p. 109)

While the NDIA has been set a challenging task of generating plans for tens of thousands of participants each quarter, it is important that it also undertakes the planning process in a way that achieves the objectives of the scheme (chapter 4).

Box 2.1 **Risks from the rollout schedule are highlighted**

House with No Steps:

> … the Scheme has aggressive ramp-up targets. These are putting pressure on the NDIA's capacity to develop quality plans for participants. Unfortunately, the need to achieve high growth in participant numbers appears to be outweighing considerations of plan quality and consistency. (sub. 104, p. 5)

Community Mental Health Australia:

> If the focus purely becomes about signing as many people up as quickly as possible and preventing cost-overruns, then the intent of what the NDIS was actually meant to deliver starts to become lost. (sub. 11, p. 2)

Maurice Blackburn Lawyers:

> We believe the roll-out timeline of the NDIS is highly ambitious and increases the serious risk of inadequate delivery of services to participants. It also poses significant financial risks to the scheme as a whole. (sub. 58. p. 6)

Blind Citizens Australia:

> While we understand the agency is under intense pressure to meet the targets that have been agreed upon under the bilateral agreements between state and territory governments, meeting these targets should not come at the expense of the basic rights and freedoms of people with disability. (sub. 130, pp. 2–3)

Australian Federation of Disability Organisations:

> The need to bring in a large number of participants into the scheme to meet bilateral targets has during transition led to practices which have not always been consistent the original vision of the scheme. (sub. 180, p. 5)

Young People in Nursing Homes Alliance:

> Trying to meet the very demanding targets in the bi-lateral agreements has been torturous for both the scheme and for its partners. The NDIS has had to divert resources away from core commitments to manage these urgent imperatives … (sub. 187, pp. 26–27)

Plan Management Partners:

> … the volume of plans to be completed in order for the scheme to achieve its milestone rollout targets is ultimately generating more work for LACs and plan reviewers due to the variability in quality of resultant plans. (sub. 126, p. 11)

Catholic Social Services Australia:

> The speed of the NDIS rollout will put considerable pressure on processing participants' eligibility, assessment and planning. This pressure will be exacerbated by annual plan reviews that are required for those already in the scheme (sub. 166, p. 7)

The Department of Social Services:

> … there are risks arising from the scale and pace of roll-out that has potential to place strain on the NDIA, and on agreed transition timeframes. (sub. 146, p. 24)

A further problem resulting from the rollout schedule is that parts of the supporting infrastructure that are essential to the objectives of the scheme are not operating as intended. For example, Local Area Coordinators (LACs), which play a key role in delivering information and linking individuals to disability services, were supposed to be 'on the ground' in rollout areas six months before participants joined the scheme (chapter 5). But this did not occur and some areas were still without a LAC months after

they joined the scheme. The need to meet bilateral targets has also resulted in LACs being asked to divert resources away from Information, Linkages and Capacity Building (ILC) tasks to undertake planning-related activities. ILC is important for containing scheme costs and reducing reliance on individualised supports (chapter 5).

The NDIA (sub. 161, p. 16) acknowledges that its 'systems and processes are not at peak efficiency and are not ideal in terms of dealing with the speed and scale of the intake challenge'. Also that:

> While the NDIA remains committed to meeting the bilateral estimates, it recognises that the systems and processes that underpin delivery must continue to improve to meet the scale of the challenge while delivering appropriate high quality individual outcomes. The achievement of the bilateral estimates must be done in a manner that maintains the commitment in all jurisdictions to quality, safety, improved outcomes and sustainability. (sub. 161, p. 16)

The rollout schedule has also meant that the market for disability care and support (including providers, workers and participants and their families) has had very little time to adjust to the new scheme (chapters 6–8). As One Door Mental Health said:

> The speed with which the roll-out has occurred has placed significant financial strain on providers, particularly small providers, as a result of needing to move from the relative stability of block-funding arrangements to the uncertainty of unknown revenue through fee-for-service. (sub. 179, p. 11)

Without time to allow for the demand side to become better informed and active, and for the supply side to adjust and grow, there is a risk that participants will be unable to utilise their supports, either because the services are simply not there, or because participants are not sufficiently well equipped to navigate the scheme.

Chapter 9 explores the issue of whether a slowdown in the rollout schedule is required.

DRAFT FINDING 2.1

The scale and pace of the National Disability Insurance Scheme (NDIS) rollout to full scheme is highly ambitious. It risks the National Disability Insurance Agency (NDIA) not being able to implement the NDIS as intended and it poses risks to the financial sustainability of the scheme. The NDIA is cognisant of these risks.

2.2 Projections of scheme costs

One of the NDIA's insurance principles is to develop actuarial estimates of long-term costs (chapter 1). Actuarial estimates are compared with the actual scheme experience, so that the NDIA can identify cost pressures, and track and monitor responses put in place to address those pressures.

However, estimating future scheme costs presents a number of challenges. For example, while there is information on the number of potential participants who are currently receiving support from existing State and Territory Government programs, there is only survey data (which is subject to sampling error) on the number of potential participants not receiving support from government programs.

There is also uncertainty about the support needs of potential participants. While there is comprehensive data on the catastrophic injuries that are covered by compensation schemes (mostly spinal cord, brain and burn injuries), for most disabilities, comprehensive data on the level of funding required to achieve good long-term outcomes are not available. The NDIA has constructed reference packages for different disabilities with the help of expert reference groups (chapter 4). These packages will be refined over time as data are collected from the NDIS on the effectiveness of different supports and their cost.

In 2011, the Commission estimated a national disability insurance scheme would cover 411 000 participants at a gross cost of $13.6 billion at full scheme (PC 2011) (box 2.2).

The NDIA (2017o, p. 5) projects that by 2019-20 the NDIS will cover 475 000 participants and cost about $22 billion each year.[9] These estimates are broadly consistent with the Commission's 2011 modelling after taking into account inflation (including the effects of pay rises awarded to social and community services workers by the Fair Work Commission in 2012), population changes, and costs associated with participants aged over 65 years (who enter the scheme prior to 65 years) (box 2.3).

The NDIA's methodology is more refined than that used by the Commission in 2011 (the Commission has been supplied with the long-term cost projection model developed by the NDIA to produce the 2015-16 Annual Financial Sustainability Report). The key differences are:

- participant numbers are modelled for 14 separate disability groups (apart from psychosocial disability, there was no distinction between disabilities in the Commission's 2011 modelling)
- average package costs assumptions are based on reference package data developed by expert reference groups (the Commission in 2011 used data from injury and accident schemes that operate in Australia)
- epidemiological data on incidence and mortality rates for different disabilities were used to model participant numbers over time (the Commission did not explicitly model entry and exit rates in 2011).

9 Both the Commission's and the NDIA's projections of scheme costs include Western Australia. While the gross cost of the NDIS is estimated to be $22 billion in 2019-20, the scheme is expected to reduce the funding required for a range of government programs. A review by the Australian Government Actuary in 2011 estimated these offsets to be about $11 billion (NDIA, sub. 161, p. 29).

Box 2.2 The Commission's modelling approach in 2011

In its 2011 report on *Disability Care and Support*, the Commission estimated that the National Disability Insurance Scheme would cover 411 000 participants and would have a gross cost of $13.6 billion (and a net cost of $6.5 billion) at full scheme. The costings were based on three calculations:

- the number of people who would be eligible for the scheme
- the level of support that these people would require
- the average per person cost associated with each level of support — four types of support were costed: care and support, aids and appliances, home modifications and transport.

No single data source contained all the information required.

- The primary data source for numbers of people and level of support was the 2009 ABS Survey of Disability, Ageing and Carers. The number of participants entering with psychosocial disabilities was calculated by consulting with experts who had previously examined the prevalence of enduring psychiatric disability.
- A variety of sources were used to estimate the average per person costs for different types of support, including data from the Victorian Transport Accident Commission, the NSW Lifetime Care and Support Scheme, and the Multiple Sclerosis Longitudinal Study.

The Commission also estimated that when the National Disability Insurance Scheme matures (around 2050), the *net* cost would be $4.4 billion. The long-term savings were attributable to assumptions regarding early interventions and community capacity building (for example, more people with disability are able to live in the community with intensive supports rather than in supported accommodation).

A further offset of about $720 million was assumed when the National Injury Insurance Scheme matured.

The Commission recognised that there were significant uncertainties about the cost estimates because of the nature and quality of the data, and undertook a number of sensitivity analyses to explore these uncertainties.

Source: PC (2011, pp. 748–780).

The NDIA has made some adjustments to their long-term cost projections using some trial data, but have not yet made more extensive changes to cost projections based on all trial and transition data. This is because these data have too many limitations to update assumptions about prevalence and package costs, and reflect a period of the scheme prior to management responses implemented by the NDIA to address early cost pressures (discussed below). As the scheme rolls out, the transition data collected will be used to better inform estimates of full scheme costs, and to assess the effectiveness the NDIA's responses to address cost pressures.

Box 2.3 Comparing NDIA's estimates and the PC's 2011 estimates

While the National Disability Insurance Agency (NDIA) uses a different methodology to that used by the Commission in 2011 to estimate costs, the differences in projected costs are mainly attributable to incorporating population projections, industry-specific wage increases and costs associated with participants aged 65 years and older (table below).

Population

Between 30 June 2012 and 30 June 2020, Australia's residential population aged under 65 years is projected to increase by 12 per cent. Applying this increase to the Commission's estimate of 411 250 scheme participants (aged under 65) results in 461 000 participants aged under 65 years — this in line with the 458 368 participants estimated by the NDIA. Incorporating population projections adds about $1.5 billion to the Commission's estimates of scheme costs.

Wage increases in the disability sector

In February 2012, the Fair Work Commission found that employees in the community and disability sectors were underpaid compared to public service workers doing similar jobs. The subsequent Equal Remuneration Order applies adjustments ranging from 23 per cent (for employees at the lowest level) to 45 per cent (for employees at the highest level) in nine instalments between December 2012 and December 2020. These adjustments are applied on top of increases from the annual wage review undertaken by the Fair Work Commission.

The NDIA's modelling of scheme costs assumes that average cost of care in the disability sector will increase 29 per cent between 30 June 2014 and 30 June 2020. If Australian Government Actuary assumptions regarding cost increases from the Department of Social Services' funding model are applied between 2011-12 and 2013-14, the total increase in average costs to 2020 is 44 per cent. The NDIA assumptions imply an increase in average costs from $31 183 to $45 018 per participant. These cost increases would add about $6.4 billion to the Commission's estimates of scheme costs.

Participants aged 65 and older

The NDIA modelling projects that there will be 15 000 participants aged over 65 in 2019-20 and that they will add an extra $1.09 billion to scheme costs (with an average cost of $71 000 per participant). The Commission's 2011 estimates of costs did not include participants over 65 years on the basis that they did not represent a net increase in costs to the Australian Government (as their support was funded under the aged care system).

Comparing the NDIA's costings and the PC's costings

	Participant numbers	*Scheme costs*
		$b
Productivity Commission estimates 2011[a]	**411 250**	**12.82**
Population projections to 2019-20	49 544	1.54
Inflation in disability sector (wages)	..	6.38
Participants aged 65 years and older	15 285	1.09
Updated Productivity Commission estimates	**476 079**	**21.84**
NDIA projections for participants[b]	**473 653**	**21.76**
Difference (%)	2 426 (0.5%)	0.08 (0.4%)

[a] Excluding operating costs and offsets associated with the National Injury Insurance Scheme and assumed efficiency dividends [b] Excluding operating costs ($1.5b), offsets associated with the National Injury Insurance Scheme (-$0.7b) and assumed efficiency dividends (-$0.3b). .. Not applicable.

Sources: Commission estimates; NDIA unpublished estimates; PC (2011); Fair Work Australia (2012).

DRAFT FINDING 2.2

While a different methodology is used, the National Disability Insurance Agency projections of scheme costs are broadly consistent with the Productivity Commission's modelling of the scheme in 2011, after accounting for sector-specific wage increases, population changes, and costs associated with participants aged over 65 years (who were not included in the Commission's estimates).

Some key assumptions behind the NDIA's cost projections

There are a number of key assumptions that drive the NDIA's long term projections:

- *prevalence and incidence rates* — the estimate of participant numbers at full scheme (prevalence) is derived using the Survey of Disability, Ageing and Carers and epidemiological data. Estimates of entry (incidence) and exit rates used to make long-term projections also use these data.
- *long-term prices* — inflation of 4.3 per cent per year is assumed in the short term based on current wage rates (including the Social, Community, Home Care and Disability Services Award), with a long-term assumption of 4 per cent per year.
- *utilisation* — there is no explicit assumption regarding underutilisation in the NDIA's projections. The projections assume that participants are allocated, and completely spend, a reference package of supports (the expected level of support required by participants given their age, disability and level of function).
- *early intervention and early investment* — the NDIA's projections assume that early investment will reduce costs by 0.35 per cent per year. This assumption was originally developed for the Commission's modelling in 2011.
- *technology* — advances in technology can both increase and decrease costs. The NDIA does not make any assumptions about the effect of technological advances on scheme costs.

No new projections of scheme costs

The Commission has not revised its own projection of scheme costs for this position paper. There are a number of reasons for this.

- The early scheme data have too many limitations to update assumptions about prevalence and package costs (as noted above, the NDIA made a similar assessment)
- The prevalence and package cost estimates made by the Scheme Actuary (and reviewed by the Australian Government Actuary) involved a significant amount of work — assumptions about package costs are directly linked to reference packages, which were developed over many months by expert reference groups including representatives

from industry, government and academia. Any Commission modelling would need to be based on this information which is already incorporated in the NDIA modelling.

In any case, point estimates of total scheme costs do not tell the whole story. Financial sustainability is about both costs and benefits, and risks to financial sustainability cannot always be modelled, or easily identified from scheme data. A long-term focus, both within and outside of the NDIS, is therefore important. While the NDIA is responsible for monitoring scheme costs and responding to the cost pressures that it can control, all governments have a responsibility to ensure the success of the scheme and its financial sustainability.

2.3 Key insights from trial and transition data

This section provides some insights from the early experience of the NDIS (from July 2013 to March 2017). It looks at participant characteristics, package costs, and utilisation of supports. These three factors determine the year to year cost incurred by the NDIA on individualised supports.

The first point to note is that data from the trial and transition phase need to be interpreted with caution. This is because:

- differences in trial sites and phasing schedules mean that the data cannot necessarily be used as a guide to anticipate full scheme experience (for example, the average level of committed support by a jurisdiction will reflect the trial cohorts for each jurisdiction)
- early scheme data are often subject to small sample sizes — minimal weight should be placed on disaggregated results where sample sizes are small
- the number of scheme participants in a region is likely to be an underestimate of the full scheme number because it takes time for potential participants to approach and gain access to the scheme. (Conversely, the number of exits due to successful early intervention are likely to be lower in the first years of the scheme as it can take some years for the benefits of early intervention to accrue.)
- it can be difficult to determine whether observed cost pressures are transitional or whether they are likely to persist
- during transition, about 20 per cent of committed support is expected to be provided in-kind (Commonwealth or State/Territory Government programs delivered under existing block-funding arrangements) (DSS, sub 146, p. 22) and these supports tend to be more expensive than standard supports (NDIA, sub. 161, p. 101).
- there have been some data integrity concerns that may impact upon the analysis, arising in part as a result of the NDIA transitioning to a new ICT system in July 2016, and in part from gradual improvements in the way that scheme data are collected in response to any identified data integrity concerns.

What do the early data tell us about participants?

At the end of the trial phase in June 2016, the number of participants with an approved plan (30 821) was 83 per cent of bilateral estimates (36 307) (NDIA 2016g, p. 42). (There were another 5500 participants who had been determined as eligible, but who did not yet have an approved plan.)

By the end of March 2017 (the most recent quarterly report), an additional 63 000 people had been found eligible for the scheme (this took the total number of scheme participants who had ever been active to 99 092) (NDIA 2017o). About 75 000 participants are currently active (they have not exited the scheme) and have an approved plan (NDIA 2017o, p. 16).

Participants by disability

Almost two-thirds of current scheme participants either have an intellectual disability (37 per cent) or autism (28 per cent) as their primary disability (figure 2.2). Psychosocial disability is the next most common disability, accounting for about 6 per cent of scheme participants.[10]

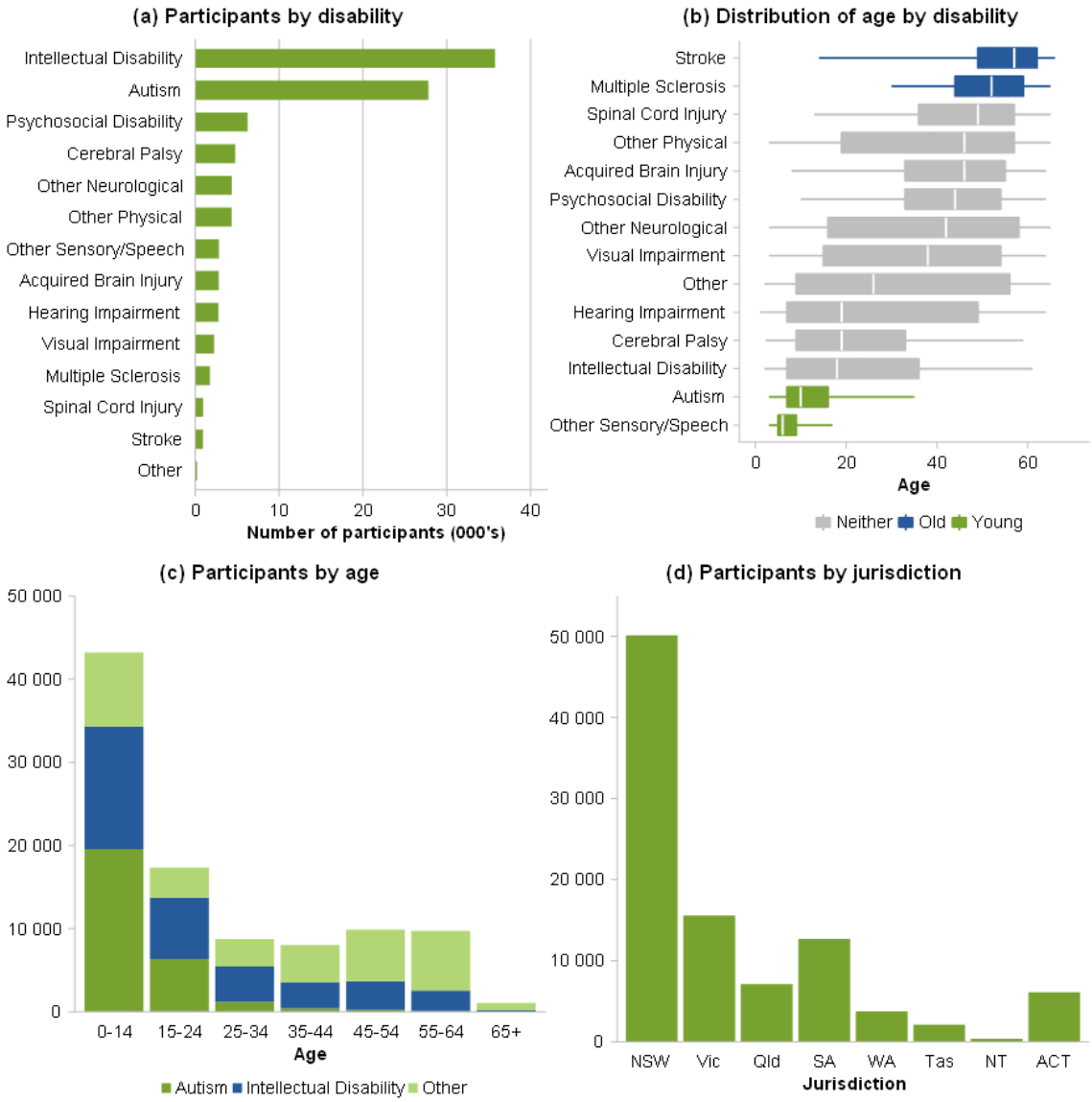
Participants with some disabilities (like stroke and multiple sclerosis) tend to be older, while participants with autism and other sensory/speech disabilities are relatively young (figure 2.2). Most participants with autism enter the scheme under early intervention requirements (and early intervention is most effective at younger ages). In recent years there has been an increase in the number of autism diagnoses — likely in part due to a growing awareness of autism and more sensitive screening tools leading to higher prevalence rates for younger ages (Gothe-Snape, J. 2017).

Disability-specific prevalence rates at the Barwon and Hunter trial sites broadly match those assumed in the NDIA's long-term modelling for all but the largest disability groupings (figure 2.3) (box 2.4). Prevalence rates were higher than the NDIA's long-term modelling assumptions for:

- autism, where prevalence rates were significantly higher in both trial sites (the NDIA has implemented initiatives in response, discussed below)
- intellectual disability, where prevalence rates were much higher in the Barwon region, but not the Hunter region. The higher prevalence rate for intellectual disability in the Barwon region was most pronounced in participants aged under 18 years.

[10] The NDIA (sub. 161, p. 82) noted that, in addition about 4 per cent of participants have a psychosocial disability that is not considered their primary disability.

Figure 2.2 **Some insights: NDIS participants[a,b,c]**



a All figures include data on active eligible participants at 31 March 2017. **b** Figure (b) shows box plots of the distribution of the age of participants for different disability groups. The white dash represents the median and the box shows the interquartile range (quartiles 1 and 3). The box plot tails show the 2.5 and 97.5 percentiles. **c** In figure (d), the number of participants in Western Australia includes the Perth Hills NDIS trial site, but not the WA NDIS MyWay trial.

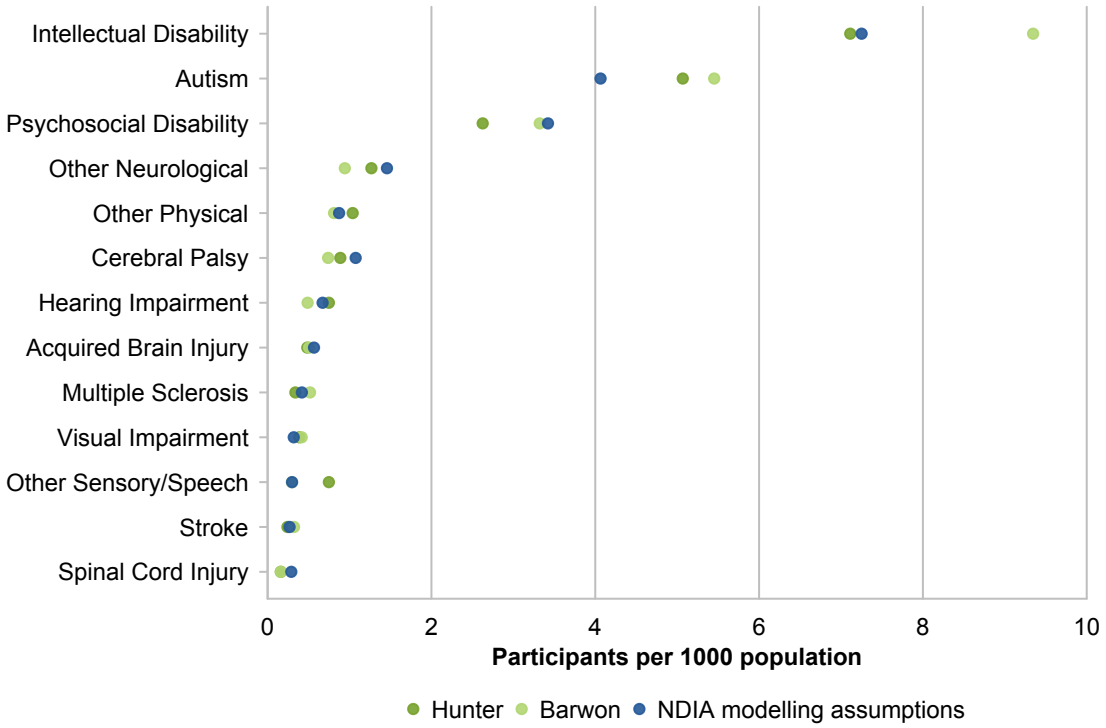
Source: Commission estimates based on unpublished NDIA data.

Box 2.4 Calculating prevalence rates

It is difficult to assess how participant numbers are tracking compared to the National Disability Insurance Agency's long-term modelling assumptions, as it takes time for potential participants to approach and gain access to the scheme. To address this issue, the Commission used data from the Barwon and Hunter trial sites. Both these sites have been in operation since July 2013 and are open to everyone under the age of 65 years.

One significant limitation of this approach is that these trial sites may not be representative of the broader Australian population. Another limitation is that the NDIA have found that participants are continuing to approach the scheme at mature trial sites at a rate that is above that expected if only participants with newly acquired disabilities were approaching the scheme (though this latter factor would suggest prevalence may be even higher relative to the modelling assumptions than the numbers so far collected would indicate). Similarly, the number of exits from the scheme due to successful early intervention is likely to be lower than would be expected at full scheme, as it can take some years for the benefits of early intervention to accrue.

Figure 2.3 Prevalence rates by disability — trial compared to the NDIA's long-term estimates[a]



[a] Prevalence rates for a region are calculated as the number of active eligible participants with the selected disability per 1000 of the population aged 0-64 years at 30 June 2016. Data on the population for the Barwon and Hunter trial regions were sourced from ABS (*Data by Region, 2011–16*, Cat no. 1410.0) with 2015 data projected to 2016 using data from ABS (*Australian Demographic Statistics, Sep 2016*, Cat. no. 3101.0).

Source: Commission estimates based on unpublished NDIA data.

There is a lot of uncertainty around the number of participants with psychosocial disability at full scheme.

- Modelling work undertaken by the Department of Health in 2016, using the National Mental Health Service Planning Framework, estimated that about 92 000 people (18-64 years) have severe and complex psychosocial disorders that would closely align with the NDIS eligibility criteria for individualised supports (sub. 175, p. 4).
- David McGrath Consulting estimated that 'approximately 289 000 people with a severe mental illness will need individualised, intensive 'NDIS-like' community supports in any 12-month period' in work conducted for Mental Health Australia in 2015 (sub. 155, p 10).
- The NDIA (2016g, p. 26) expects that there will be about 64 000 participants with a primary disability of psychosocial disability in the scheme in 2019-20. According to the NDIA, at this stage of the rollout, the number of participants with psychosocial disability is tracking broadly in line with their modelling assumptions in mature trial sites (Scheme Actuary 2016).

The Commission is very aware that estimating the number of participants with psychosocial disability is difficult because a robust and comprehensive data base from which to draw is lacking. However, given that a range of estimates have been prepared by stakeholders and agencies, it would be beneficial if the methodology used was made fully transparent, so that these estimates could be assessed and considered in relation to projections of numbers of participants with psychosocial disability at full scheme.

Participants by age

The largest share of scheme participants at the end of March 2017 were children aged 14 years and under (about 43 000 or 44 per cent of total participants) (figure 2.2). About 45 per cent of children in the scheme have autism, while 34 per cent have an intellectual disability (including development delay).

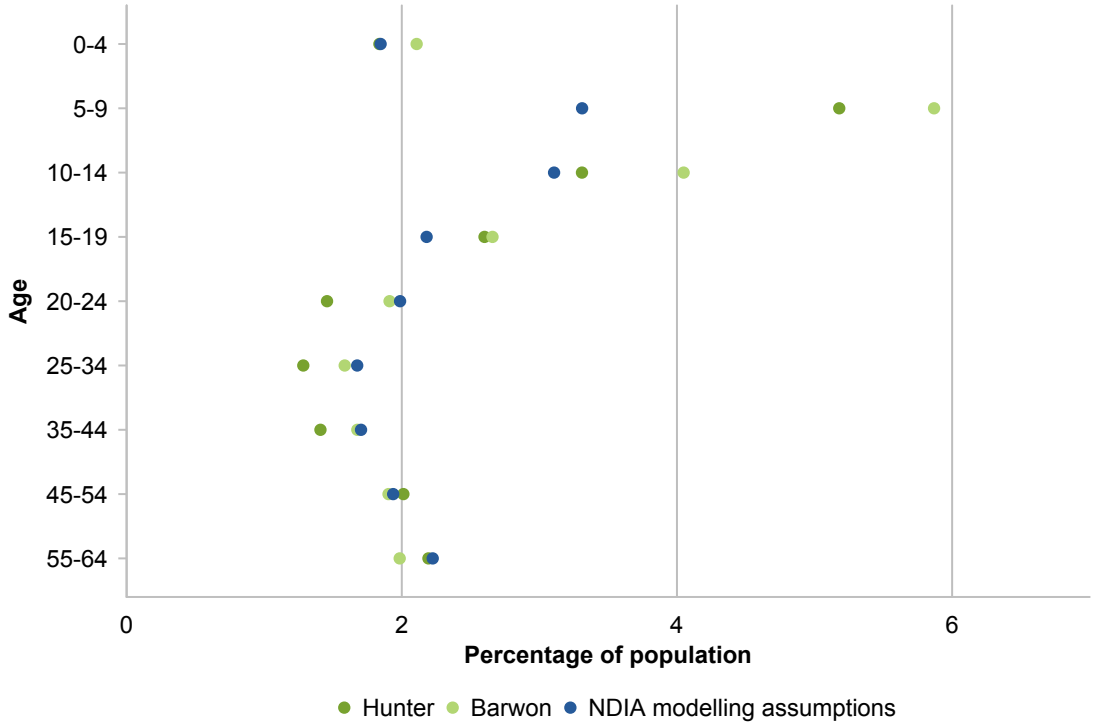
There are more children in the scheme than originally expected — this is even after accounting for the fact the number of children in the scheme is skewed by the South Australian trial site, which only contained children. The NDIA analysed the experience of trial sites and found that the prevalence rates for children aged 0 to 6 years:

- exceeded the Commission's 2011 estimates in South Australia, Barwon and ACT trial sites
- were in line with the Commission's 2011 estimates in Western Australia and the Hunter trial sites (sub 161, p. 78).

Looking at the data from the Barwon and Hunter trials sites, the Commission has reached a similar conclusion. The largest gaps between actual and expected prevalence rates (based on the NDIA's long-term modelling) are for children aged 5 to 9 years followed by

children aged 10 to 14 years. There are larger gaps for the Barwon region than the Hunter region (figure 2.4).

Figure 2.4 **Prevalence rates by age group — trial compared to the NDIA's long-term estimates[a]**



[a] Prevalence rates for a region are calculated as the number of active eligible participants in a given age group per 1000 of the population in the age group at 30 June 2016. Data on the population for the Barwon and Hunter trial regions was sourced from ABS (*Data by Region, 2011–16*, Cat no. 1410.0) with 2015 data projected to 2016 using data from ABS (*Australian Demographic Statistics, Sep 2016*, Cat. no. 3101.0).

Source: Commission estimates based on unpublished NDIA data.

Participants by level of function

Since July 2016, participants have been assessed for their level of functional capacity when they enter the scheme (box 2.5). There is level of function data available for just over 70 per cent of participants. At the end of March 2017, of those who had been assessed:

- 39 per cent of participants had a high level of function
- 38 per cent had a medium level of function
- almost a quarter had a low level of function.

Box 2.5 **Assessing level of function**

As part of the planning process, the National Disability Insurance Agency assesses each participant's level of function. This is one of many pieces of information that it uses to develop plans to help participants progress towards their personal goals and aspirations.

The National Disability Insurance Agency currently uses different assessment tools for 11 key disability types and the World Health Organization Disability Assessment Schedule version II (for adults) and the Paediatric Evaluation of Disability Inventory-Computer Adaptive Test (for children) where no specific tool is identified. The scores of each assessment tool are mapped to a scale of 1 (high functional capacity) to 15 (low functional capacity), which provides a common measure across different types of disability.

To simplify its analysis, the Commission aggregated levels of function into three groups: high (levels 1-5), medium (levels 6-10) and low (levels 11-15).

Source: NDIA (sub. 161, p. 10).

Compared to the NDIA's long-term modelling assumptions, the distribution of participants by level of function to date is more heavily weighted towards the medium and low levels of function. This difference reflects, in part, the scheme's phasing schedules — participants with the greatest support needs are typically the first to enter the scheme in a region (figure 2.5). This is supported by the fact that the distribution of level of function for mature trial sites (Barwon and Hunter) is closer to the modelling assumptions.[11] (The distribution of level of function for the Hunter trial site is not expected to match modelling assumptions as it included a number of large residential facilities.)

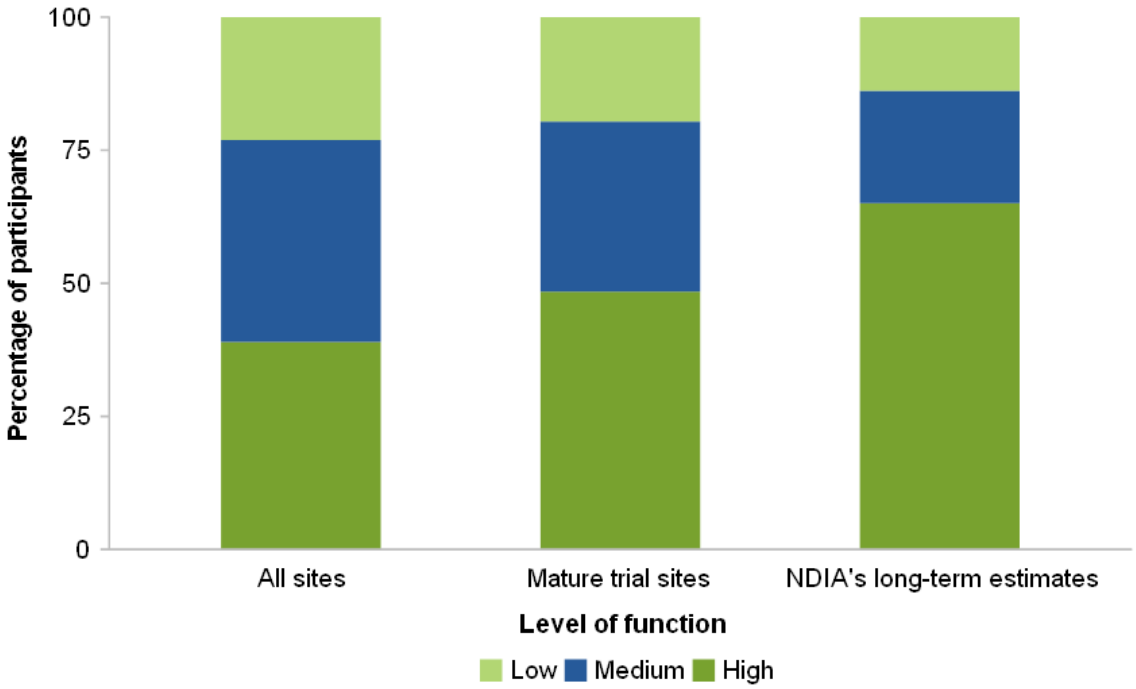
That said, scheme costs will be higher than estimated if the early trend of participants having lower levels of function than expected persisted at full scheme.

Participants by jurisdiction

About half of current NDIS participants are located in New South Wales (figure 2.2) — in comparison the state accounts for 32 per cent of Australia's total population. This overrepresentation is because New South Wales had two trial sites while other jurisdictions had one. New South Wales is also further along the transition to full scheme (NSW is scheduled to reach full scheme by the July 2018 — a year earlier than all the jurisdictions except South Australia and the ACT) (table 2.1).

[11] Data on level of function have not yet been collected for all trial participants.

Figure 2.5 **Distribution of participants by level of function at 31 March 2017 compared to the NDIA's long-term estimates[a]**



a 'All sites' denote all eligible scheme participants at 31 March 2017 for whom level of function data are available. 'Mature trial sites' denotes all eligible scheme participants at 31 March 2017 who were trial participants at the Barwon and Hunter trial sites and for whom level of function data are available. 'NDIA long-term estimates' denote the distribution of level of function implicitly assumed in the NDIA's projections of scheme costs.

Source: Commission estimates based on unpublished NDIA data.

What do the early data tell us about package costs?

The level of committed support (or a participant's package cost) is the dollar amount of support in a participant's plan. However, it is not necessarily the amount of support that a participant receives — there are a range of reasons why supports may be underutilised (discussed below).

Over the course of the trial, the average annualised package cost was $36 049.[12] This is slightly below long-term modelling assumptions of average package costs ($38 360 in 2015-16 dollars).

12 This figure excludes the cost of three large residential centres — Stockton and Kanangra (in the Hunter area trial site) and Colanda (in the Barwon area trial site) — which include a high concentration of high cost participants in one geographical area. The average annualised package cost increases to $39 065 when they are included (NDIA 2016g, p. 46).

However, making this comparison is of limited value because it does not account for the composition of participants included in the trial. Notably, the trial included a higher proportion of children (who typically receive less funded support than other participants because they receive more informal care). While participants with lower levels of function typically entered the scheme first during the trial — which would increase package costs — this was more than offset by the number of children entering the scheme.

To address this limitation, the Commission compared annualised package costs to the reference package amounts for each participant where level of function data were available. Reference packages represent the average expected package amount for a participant given their age, disability and level of function, and are a building block for the NDIA's modelling of scheme costs (box 2.6). Importantly, the package cost of a single participant is *not* expected to be equal to the reference package amount (factors such as scope for informal support and requirements for aids are important inputs into a participant's plan and can generate large differences between individual packages and reference package amounts), but package costs can be compared to reference packages at an aggregate level.

Box 2.6 Reference packages — fundamental to assessing financial sustainability, not individual packages

To acquit the study's terms of reference, it is necessary to examine the assumptions of the NDIA's financial sustainability modelling, and to consider the reference packages used to project costs for different cohorts of people with different disabilities over the long term. Reference packages form a key part of understanding long-term costs, and whether the scheme is 'on track' in aggregate. That said, reference packages (and the data presented in this chapter) should not be conflated with what an individual might expect to receive in an individualised funded package at any given time. This is because a package received by an individual is determined by much more than a reference package (chapter 4), and the reference package amount does not account for an individual's particular goals, nor what supports may be reasonable or necessary in a particular individual's circumstances.

Comparing annualised package costs to the reference package amounts is further complicated by participants in Shared Supported Accommodation (SSA). SSA is accommodation for people who require specialist housing solutions and intensive support needs. SSA is designed for participants with extreme functional impairment. As such, package costs for participants in these facilities are substantially higher than other scheme participants (typically about $200 000).

At 31 March 2017, 11 per cent of participants with plans approved from July 2016 were in SSA. While the Commission's estimates include participants in SSA, there are reasons why the package costs of these participants may be lower as the scheme matures. First, there are a number of participants with relatively high levels of function in SSA who will potentially require significantly less support if they receive appropriate capacity building supports early in their lives. Second, SSA services are currently delivered under in-kind

arrangements and for this reason may not be priced correctly (states and territories determine the price of in-kind services, chapter 10).

Using the above approach, the average annualised cost of packages effective after 1 July 2016 is higher than expected given the characteristics of participants ($60 000 compared to $56 000). (Unless otherwise stated, the Commission has used plans effective after 1 July 2016 when analysing package costs.)

Packages by disability

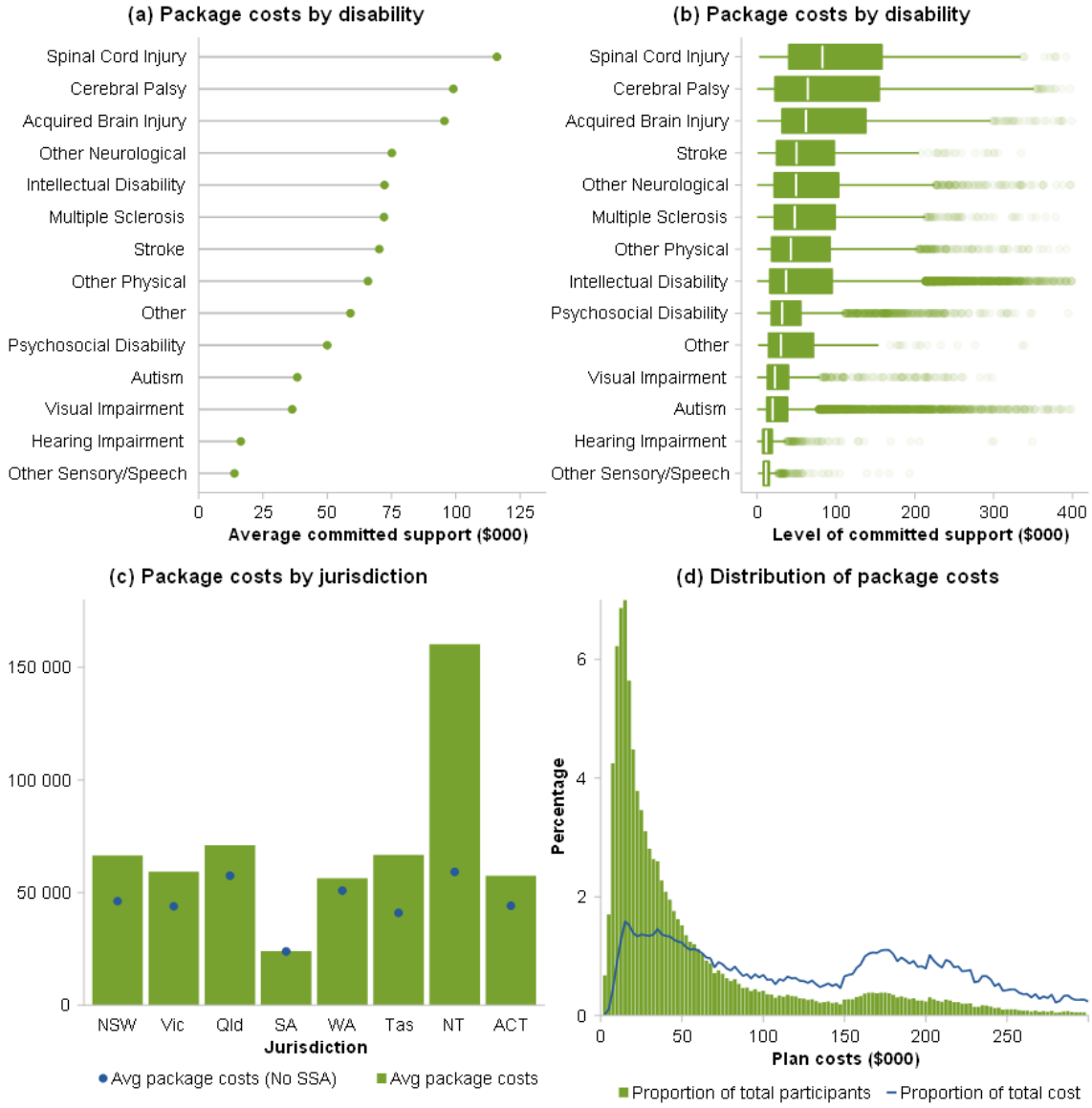
Scheme participants with spinal cord injuries have the highest annualised average level of committed support ($120 000), followed by those with cerebral palsy ($99 000) and acquired brain injury ($96 000) (figure 2.6). If participants included in SSA are excluded, the averages fall to $110 000, $78 000 and $74 000 respectively.

There is significant variation in the amount of committed support received by participants with high cost disabilities. The distribution of committed support for these disabilities is skewed towards some very high cost participants, many of which are in SSA (figure 2.6). Disabilities with lower average levels of committed support (like autism and visual and hearing impairment) exhibit less variation in costs. Some participants with high cost packages may have comorbidities that increase the level of support required, but are classified into a single disability group for reporting purposes.

Average annualised package costs are significantly lower than the NDIA's long-term modelling assumptions for five of the high-level disability groupings (figure 2.7). However, package costs for participants with intellectual disability (the most common disability grouping) and visual impairments are significantly higher than long term modelling assumptions (though the number of participants with visual impairment is much lower than the number with intellectual disability so the aggregated impact is much lower). Average annualised package costs are broadly in line with long-term modelling assumptions for the remaining disabilities.

Figure 2.6 **Some insights on annualised package costs[a,b,c]**

Plans effective from 1 July 2016

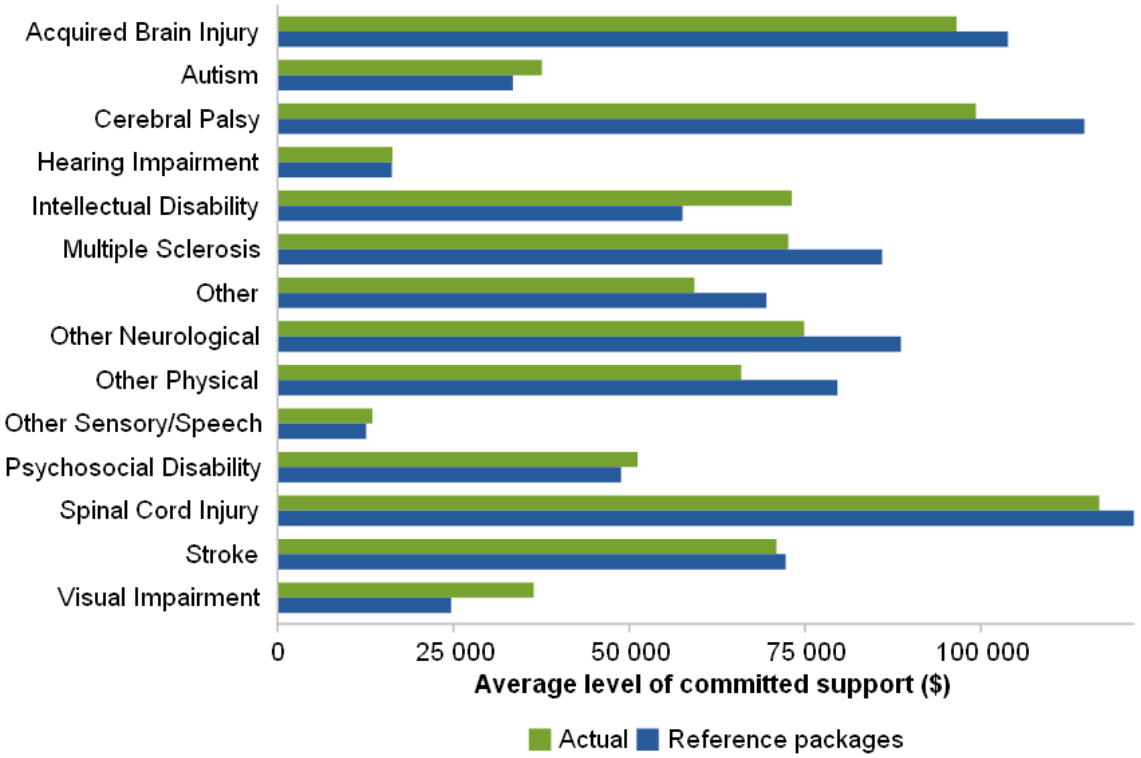


[a] For participants with multiple plans over the time period, the latest plan is used. [b] Figure (b) shows box plots of the distribution of the level of committed support for different disability groups. The white dash represents the median and the box shows the interquartile range (quartiles 1 and 3). The box plot tails show the minimum and maximum observations (though points that deviate by more than 1.5 times the interquartile range from the box are considered outliers and are denoted by a dot point). [c] In figure (c), Western Australia includes the Perth Hills NDIS trial site but not the WA NDIS MyWay trial.

Source: Commission estimates based on unpublished NDIA data.

Figure 2.7 **Average annualised level of committed support compared to reference packages, by disability[a,b,c]**

Plans effective from 1 July 2016



[a] Reference packages are the average package cost assumed in the NDIA's long term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used. [c] Reference packages are linked to assessment tools. Therefore, participants who are assessed using the generalised assessment tools (including all participants with psychosocial disability) are linked to a 'generalised' reference package.

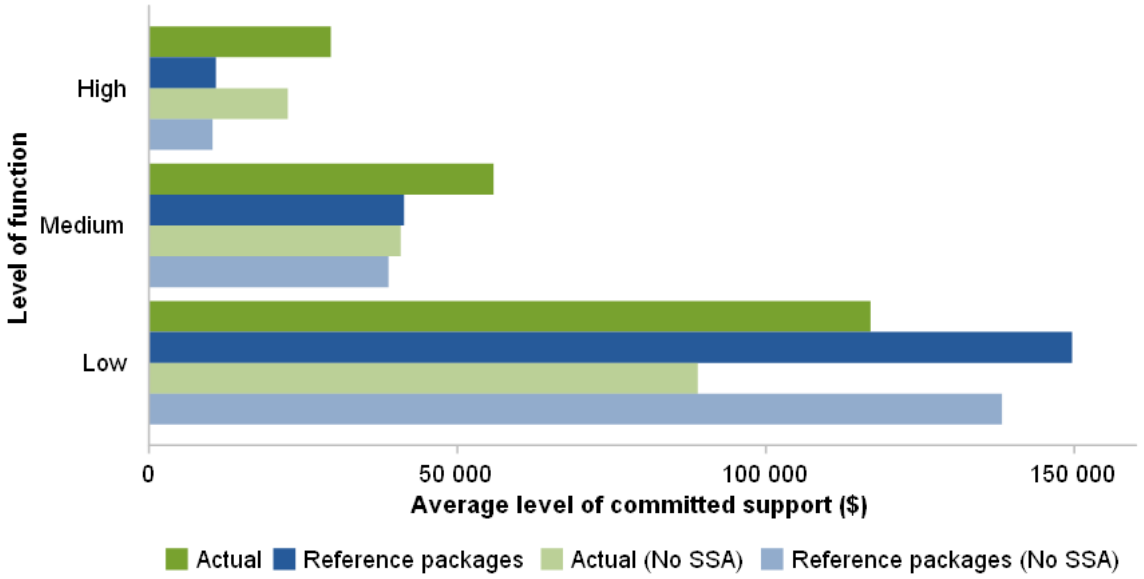
Source: Commission estimates based on unpublished NDIA data.

Packages by level of function

As expected, the average annualised package cost is highest for participants with the lowest level of function (figure 2.8). The average level of committed support for plans associated with low levels of function is almost $120 000, just under four times the amount for participants with high levels of function (about $31 000).

Figure 2.8 **Average annualised level of committed support compared to reference packages, by level of function[a,b]**

Plans effective from 1 July 2016



[a] Reference packages are the average package cost assumed in the NDIA's long-term modelling based on age, disability and level of function. They *are not* what an individual should expect to receive in an individualised funded package at any given time. [b] For participants with multiple plans over the time period, the latest plan is used.

Source: Commission estimates based on unpublished NDIA data.

There are significant differences between average annualised packages costs and the NDIA's long-term modelling assumptions by level of function (figure 2.8).

- The average level of committed support for participants with low levels of function (who require more support) is less than expected (about $120 000 compared to $150 000). One explanation for this result may be that reference packages are underestimating the amount of informal support provided by families and carers.
- The average level of committed support for participants with medium levels of function is higher than modelling assumptions ($56 000 compared to $41 000).
- Participants with high levels of function (who require less support) are obtaining higher packages on average than the modelling assumes ($29 000 compared to $11 000).[13] The NDIA noted that fewer participants than expected are entering the scheme with small package amounts (less than $10 000), and indicated that this is in part due to problems with planning processes (NDIA 2016b, p. 40).

[13] The average annualised package cost for participants with high levels of function presented here ($29 000) only includes participants for whom reference package data are available. Average annualised package costs equal $31 000 when all participants with high levels of function are included.

Participants in SSA are a significant driver of average costs for the high and medium levels of function cohorts (figure 2.8). Given that SSA is designed for people with low levels of function, this suggests that there may have been issues with how SSA has been managed in the past. Such historical experience suggests that investing in capacity building supports early to keep participants with high and medium levels of function out of SSA is critical for minimising scheme costs in the future.

Packages by jurisdiction

The average package cost is highest in the Northern Territory ($160 000) followed by Queensland ($71 000), and lowest in South Australia ($24 000) (figure 2.6(c)). These differences are driven by the phasing schedules. About 39 per cent of Northern Territory participants with an approved plan are in SSA with an average package cost of $320 000.[14] The NDIS only began operating in Queensland at the beginning of 2016 and therefore has a disproportionate number of participants with low levels of function. In contrast, because of the scope of their trial, almost all the scheme participants in South Australia are children who tend to have lower levels of committed support than older participants.

The distribution of total committed supports

The distribution of committed supports (for plans effective from July 2016) is heavily weighted to low cost packages with the most common package costing between $10 000-$15 000 (figure 2.6(d)). The distribution of committed supports weighted by total cost of packages is flatter, peaking at $10 000-$15 000 and $175 000. The second of these peaks is attributable to participants in SSA. A significant proportion of scheme costs is attributable to high cost participants — while only 18 per cent of packages cost more than $100 000, these account for 56 per cent of total committed supports.

Types of support provided

Over half of committed supports are earmarked to help scheme participants with their daily life — usually through support for daily activities (figure 2.9) (box 2.7).[15] A significant proportion of support is also allocated to help participants become more involved in social and community programs (19 per cent), and to improve their daily living skills (11 per cent).

[14] Scheme participants in SSA in the Northern Territory tend to be in the most complex types of SSA.

[15] Participants have some control over how they allocate their support budget depending on the support category (that is, they do have some scope to deviate from the support described in their plan).

Box 2.7 Types of support

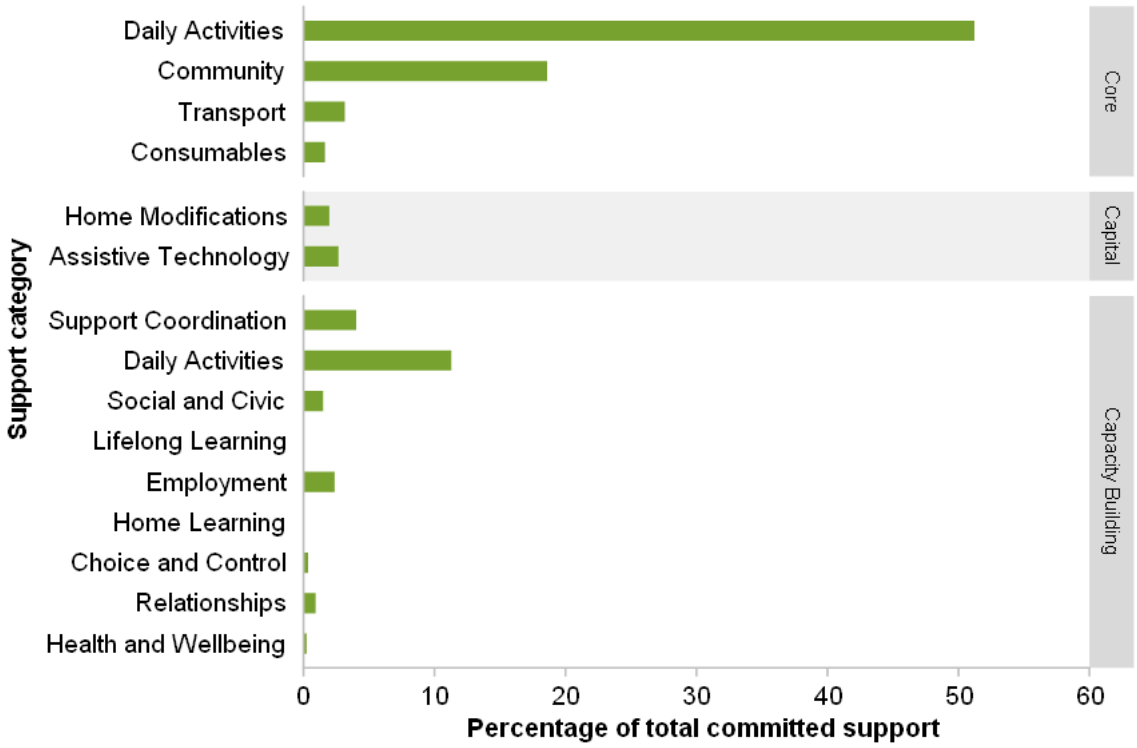
Supports provided under the National Disability Insurance Scheme fall into one of fifteen *support categories,* which in turn can be grouped into three *support purpose categories*:

- Core supports — support that enables participants to complete activities of daily living, and enables them to work towards their goals and meet their objectives.
- Capital supports — an investment, such as assistive technologies, equipment, home or vehicle modifications, and funding for capital costs associated with specialised housing.
- Capacity building supports — support that enables participants to build their independence and skills.

Source: NDIA (2016s).

Figure 2.9 Committed supports provided by support category[a]

Plans effective from 1 July 2016



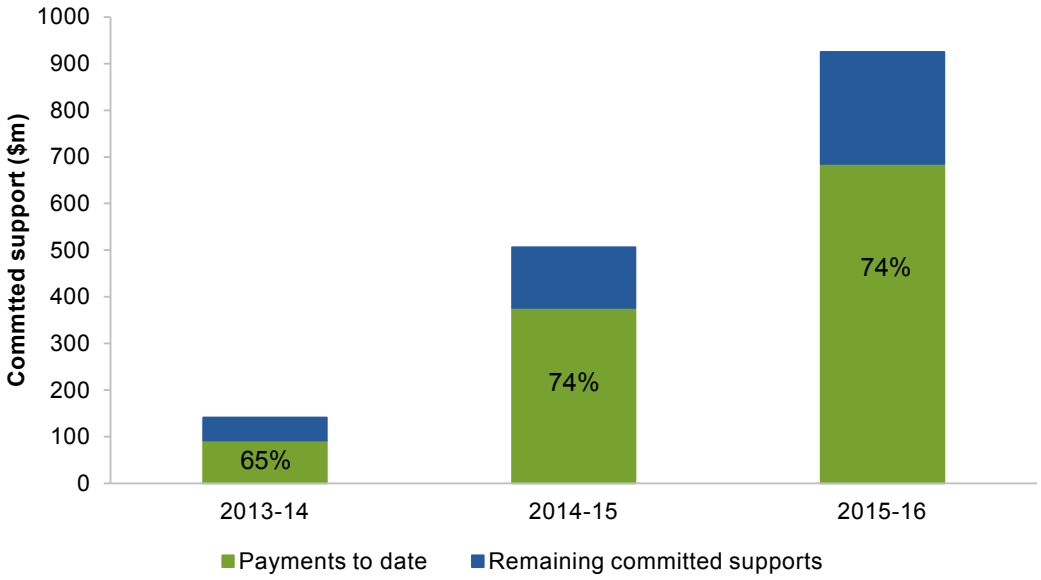
[a] For participants with multiple plans over the time period, the latest plan is used.

Source: Commission estimates based on unpublished NDIA data.

Utilisation

There has been significant underutilisation of committed supports in the scheme so far — in 2015-16, 74 per cent of committed supports have been utilised to date (figure 2.10).

Figure 2.10 **Utilisation of committed supports**



Source: NDIA (2017o, p. 34).

According to the NDIA (and supported by comments from other study participants), on-the-ground experience indicates that the reasons for the utilisation rates being below full utilisation vary by the individual and their circumstances. Some reasons include:

- insufficient supply of supports to meet demand, especially for specific supports (such as short-term accommodation) and in particular markets (such as remote and very remote areas) (PDCN, sub. 29; Public Service Research Group, sub. 56; Jeff Scobie, sub. 57; APA, sub. 93; Commonwealth Ombudsman, sub. 137)
- participants experiencing difficulties navigating the system, which can mean they are unable to implement a plan once it has been approved (PDA, sub. 38; ABF, sub. 48; Jeff Scobie, sub. 57; CSSA, sub. 166)
- scheme participants not needing all the supports they are entitled to (planners overestimating the amount of funded support that will be needed, or including supports that do not meet the needs of participants) (Jeff Scobie, sub. 57)
- the market for plan supports (such as support co-ordination and plan management) being relatively immature and therefore limiting the help that participants can obtain (Anglicare Australia, sub 157)
- some participants cannot easily access information about how much of their supports are available (Public Service Research Group, sub. 56).

Some underutilisation of supports could be expected in the early stages of the scheme as participants and providers adapt to a new system for providing disability care. While the NDIA's estimates of scheme costs implicitly assume that all committed supports are

completely spent when the scheme is fully implemented the NDIA said (sub. 161 p. 70) that 'in a person-centred system the utilisation rate will never be 100%'. The NDIA also noted experience in other schemes suggests a utilisation rate of between 80 and 95 per cent could be expected.

Some emerging cost pressures

Bringing the analysis of these three components of scheme costs together, the Commission is of the view that the early scheme data suggests that NDIS costs are broadly in line with the NDIA's long-term modelling estimates. While more children are entering the scheme than expected and package costs are higher than expected, these factors have been offset by lower levels of utilisation than expected.

However, it is critical that emerging cost pressures are managed as utilisation rates are expected to rise. The Department of Social Services (sub. 146, p. 20) echoed this sentiment, noting that 'better management of cost pressures should reduce the impact of increasing utilisation rates'. That said, if the cost pressures emerging from the trials and transition are not addressed, the financial sustainability of the scheme will be at risk.

The NDIA is tasked with ensuring that the NDIS is delivered within the funding envelope, and this involves identifying and managing emerging cost pressures. The Scheme Actuary compares the experience of the NDIS to projections on an ongoing basis and reports to the Board quarterly. If cost pressures are detected early, management responses can be put in place before problems become entrenched.

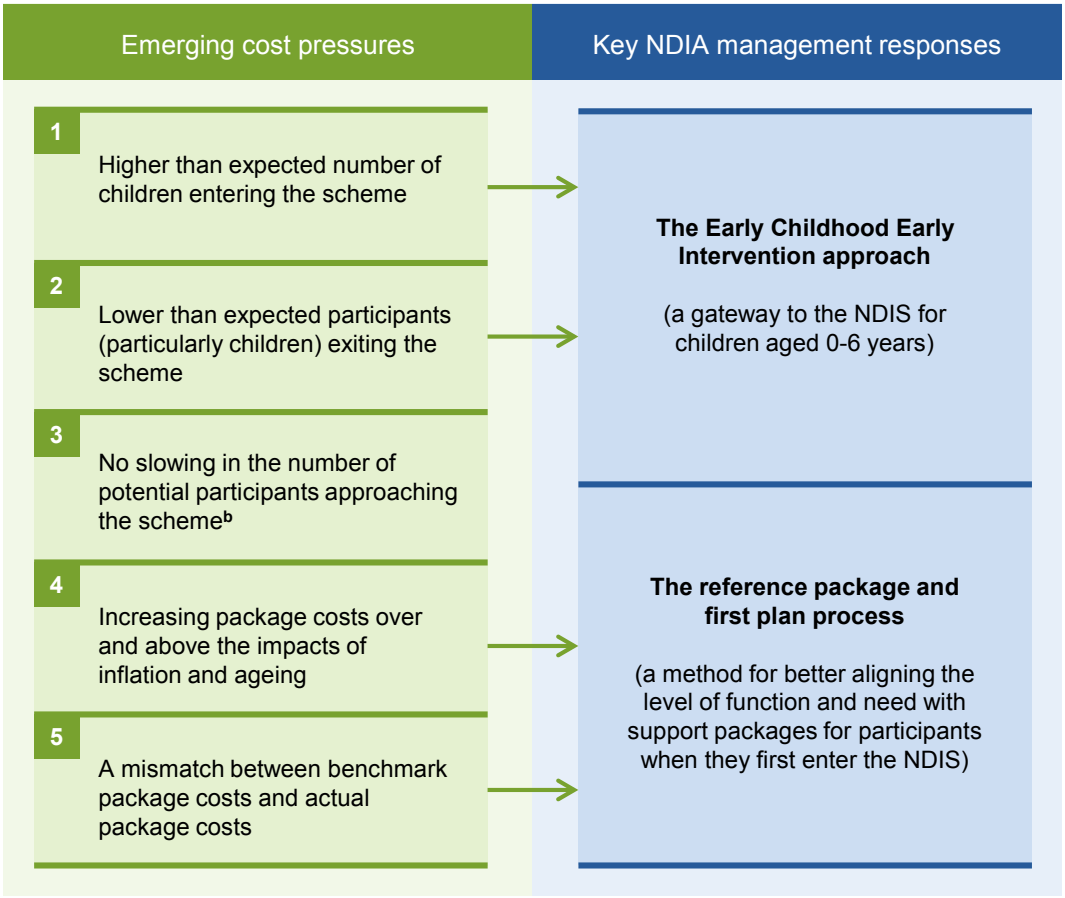
In the NDIA's most recent annual report, the Scheme Actuary identified five cost pressures from the trial sites that need to be managed for the full scheme, including:

- a higher than expected number of children (especially in the trial sites of South Australia, Victoria and the ACT)
- increasing package costs over and above the impacts of inflation and ageing (as plans are reviewed)
- potential participants continuing to approach the scheme (the number of people approaching the scheme in some trial sites that have been operating since 2013 is more than would be expected if only people with newly acquired disabilities were approaching the scheme)
- a lower than expected number of participants exiting the scheme (particularly children who entered the scheme under the early intervention requirements)
- a mismatch between benchmark package costs and actual package costs. There is a greater than expected level of variability in package costs for participants with similar conditions and levels of function (NDIA 2016g, pp. 16, 144).

In line with the insurance approach to identifying risks early and putting in place management responses, the NDIA has put in place initiatives to address these cost pressures

(figure 2.11). The responses include the Early Childhood Early Intervention approach (chapter 3), and the reference package and first plan process (chapter 4) (NDIA 2016g, pp. 16–17, 56–57). It is too early to assess the effectiveness of these initiatives.

Figure 2.11 **The NDIA's responses to emerging cost pressures**[a]



[a] This figure includes the NDIA's two main responses to emerging cost pressures. The NDIA has initiated several smaller projects to address emerging cost pressures, such as an analysis of reasonable and necessary costs across the lifespan of participants. These are detailed in the NDIA's 2015-16 Annual Report (NDIA 2016g, pp. 145–146). [b] Potential participants continuing to approach the scheme is not a cost pressure that can easily be addressed by the NDIA.

Source: NDIA (2016g, pp. 144–146).

DRAFT FINDING 2.3

The National Disability Insurance Scheme, at the end of trial, came in under budget. This was in large part because not all committed supports were used (in 2015-16 the utilisation rate was 74 per cent).

Based on trial and transition data, scheme costs are broadly on track compared to the National Disability Insurance Agency's (NDIA) long-term modelling. At this stage, early cost pressures (such as greater than expected numbers of children and higher than expected package costs) have been offset by lower than expected levels of utilisation.

The NDIA has put in place initiatives to address emerging cost pressures. It is too early to assess the effectiveness of these initiatives.

2.4 Are scheme benefits being realised?

Realising the benefits of the scheme is critical for the wellbeing of people with disability and for ensuring that the community continues to be willing to pay for the NDIS.

Comparing the benefits of the scheme relative to expectations is more difficult than making the same comparison for costs. Some of the benefits are difficult to calculate because they are intangible (for example, the benefits that people with disability receive from having greater choice and control) which makes it more challenging to compare actual and expected benefits.

Outcomes for participants, families and carers

Both the NDIS Outcomes Framework (box 2.8) and an evaluation undertaken by the National Institute of Labour Studies (box 2.9) provide some early insights on outcomes for participants.

- The NDIA has developed a NDIS Short Form Outcomes Framework for measuring the outcomes of scheme participants and their families and carers over time. Most questions ask participants to reflect on their life at the moment to form a baseline for assessment of the ongoing effects of the NDIS. However, there are some questions that ask participants how their life has improved after becoming a participant that can be used to assess scheme benefits to date.
- The intermediate report of the NDIS evaluation undertaken by the National Institute of Labour Studies uses both quantitative (from surveys) and qualitative data (from interviews) to assess the outcomes of the NDIS.

Box 2.8 **NDIS Short Form Outcomes Framework**

The National Disability Insurance Scheme Short Form Outcomes Framework is an approach to measuring the outcomes of the support experienced by scheme participants and their carers. It includes eight indicators of participant experience (known as participant domains) as well as outcomes related specifically to families (table below). It was piloted in the first three months of 2015 and is now being rolled out scheme wide. (At June 2016, over 23 000 questionnaires had been received — over 13 000 participant surveys and 10 000 family surveys.)

The Framework will allow tracking of participant and scheme progress over time, and demonstrate how participants are faring relative to other Australians and other OECD countries. It will also contribute to an understanding of what types of supports lead to good outcomes for people with disability, their families and carers.

Domain	*Description*
Choice and control	Improved choice and control over participant goals, as well as the planning and delivery of their supports.
Daily activities	Increased ability to undertake daily activities with adequate levels of support.
Relationships	Increased levels of social inclusion and reduced experiences of loneliness.
Home	Improved satisfaction with participants' home environment now and five years into the future.
Health and wellbeing	Improved health and wellbeing and increased ease of access to health services.
Lifelong learning	Increased opportunities to learn new things.
Work	Increased uptake of paid employment opportunities (as well as the associated feelings of social inclusion from being part of the workforce).
Social, community and civic participation	Increased participation in community activities chosen by the participant, and reduced negative experiences associated with being excluded.

Sources: NDIA (2015d, 2016g, p. 60).

Box 2.9 NDIS Evaluation

In 2013, the Australian Government Department of Social Services commissioned a consortium led by the National Institute of Labour Studies to conduct an evaluation of the trial of the National Disability Insurance Scheme. The study monitors and evaluates the experience of participants, and their families and carers, service providers and their workforces in the trial sites of the ACT, Victoria, New South Wales, Northern Territory, South Australia and Tasmania.

An initial report, which described how the evaluation was being conducted, was delivered to the Department of Social Services in December 2015.

An intermediate report presented a synthesis of the quantitative and qualitative evidence collected to date and was released in December 2016.

- The qualitative evidence was sourced from in-depth interviews of people with disability, their families and carers (62 interviews), disability service providers (5), disability workforce stakeholder organisations (15) and National Disability Insurance Agency staff (46).
- The quantitative evidence is based on a survey of about 4500 people with disability and about 3500 families. Survey participants are split into two groups — those covered by the NDIS trial and those not covered — and their experiences are compared.

A final report is scheduled to be completed in 2017. It will incorporate an additional wave of survey data. Unless otherwise stated, data presented in this chapter are from the intermediate report.

Source: Mavromaras, Moskos and Mahuteau (2016, p. ix–x, 18).

The NDIS is providing benefits to many

Data from the NDIS evaluation and NDIS Short Form Outcomes Framework suggest that the NDIS has provided a range of benefits to participants, their families and carers. The Commission also received many submissions supporting this finding (box 2.10). The NDIS is:

- providing participants with increased supports (more hours of support, a wider range of support and greater access to equipment) — on average more supports were available than under the previous system.
  - 88 per cent of carers with children aged under five years said the NDIS had improved their child's access to specialist services (NDIA, sub 161, p 36).
  - About two thirds of scheme participants aged 15 years and over said the NDIS had helped with daily living (64 per cent for participants aged 15-24 years and 71 per cent for participants aged 25 years and above) (NDIA, sub 161, p 38).
  - The NDIS evaluation found that 'the majority of respondents receive increased supports as a result of becoming NDIS participants' (Mavromaras, Moskos and Mahuteau 2016, p. xi). The average number of different supports accessed by participants increased from 2.02 to 3.3 under the NDIS (Mavromaras, Moskos and Mahuteau 2016, p. 32).
- improving the wellbeing of scheme participants and their families and carers.

  - 89 per cent of carers with children aged under five years said the NDIS had improved their child's development (NDIA, sub 161, p 36).
  - Almost two thirds of participants aged 15 years and over said the NDIS helped with health and wellbeing (62 per cent of participants aged 15-24 years and 65 per cent of participants aged 25 years and over) (NDIA, sub 161, p 38).
  - 49 per cent of participants said the quality of care had improved with the NDIS (although 15 per cent said quality had declined) (Mavromaras, Moskos and Mahuteau 2016, p. 38).
  - The NDIS evaluation notes that the qualitative evidence 'makes clear that on the whole the NDIS has improved the wellbeing of scheme participants and their family members and carers' (Mavromaras, Moskos and Mahuteau 2016, p. xv). Scheme participants attributed this increase in wellbeing to having better services than previously, and increased independence.
  - Carers reported an 'increased sense of positivity and wellbeing' because their NDIS participants were more involved in activities they enjoyed and were able to participate in wider interests outside of the home. (However, the greater administration burden associated with the NDIS was a cause of stress for some families.) (Mavromaras, Moskos and Mahuteau 2016, p. xv).
- giving participants more choice and control over the supports they receive (the types of supports they receive, the timing of those supports and who provides them).
  - The NDIS evaluation found that 44 per cent of participants surveyed had a greater say over the supports they received, while 46 per cent also had more choice over who provided their supports (Mavromaras, Moskos and Mahuteau 2016, p. 60).
  - The NDIS Short Form Outcomes Framework data suggest that 73 per cent of scheme participants aged 15 years and over had more choice and control over their life (NDIA, sub 161, p 38).
- increasing the social participation of scheme participants and their carers.
  - The NDIS evaluation shows that many participants can now take part in activities independently and are able to follow interests and social activities that had previously been inaccessible (Mavromaras, Moskos and Mahuteau 2016, p. xvi).

Box 2.10 **The NDIS has changed lives**

Anne Hansen:

> … I have seen the life changes in people with disability who now have NDIS funding. They are now accessing community, have a good life and have hope for their futures. The burdens are off the family, some aged carers, and there is job creation. Broken wheelchairs are now being replaced and people who never had wheelchairs, now have and can access the community. I now see happy people. (brief sub. 2)

Lorraine Rodrigues:

> The NDIS to me is knowing that my son will have a future of his own to look forward to if I am unable to care for him for whatever reason. (brief sub. 3)

Merle Searle:

> The NDIS has made such a huge difference to us and our young man on a day to day basis … Please keep up the NDIS it is so appreciated in our households. (brief sub. 17)

Julanne Sweeney:

> The strain on our busy family would be almost unbearable without NDIS … With NDIS help she [granddaughter Isi] is learning skills to equip her for independent living and employment in the future. (brief sub. 21)

Karen Wakely:

> We began implementing our plan in Jan 2016. In a little over 12 months, the change it has facilitated has been extraordinary. For the first time we have been able to access meaningful therapeutic supports. (brief sub. 43)

Lynne Foreman:

> … I can now choose who cares for me, as I now have a choice. I have the hours I need to live my life and also because of flexibility in my plan, I am now an employee … (brief sub. 71)

The stories of Oni and Harry provided by the National Disability Insurance Agency:

> 'I've been working with a speech therapist to get my speech up and it's really helping. I can say a few more words and actually pronounce them properly and all that,' Oni remarked … 'He's only been in one year and the changes have been remarkable. I've seen his confidence improve out of sight. I've heard him be able to speak and say words that we didn't even know he knew,' Chelinay remarked.
>
> 'The NDIS has definitely improved our lives – Harry's and ours as a family,' she said. 'We've been able to get funding to purchase Harry a manual wheelchair … now he can access places he could never in his electric wheelchair, so he now has more flexibility. He was recently able to go the beach with his classmates – something he had never been able to do before!' (sub. 161, pp. 41–43)

But not all are having a positive experience

Some people with disability, however, are experiencing poorer outcomes under the NDIS. And they tend to be some of the most vulnerable people with disability.

Qualitative evidence suggest that some people with disability are experiencing poorer outcomes under the NDIS and are receiving fewer services than previously (Mavromaras, Moskos and Mahuteau 2016, p. xi). According to the NDIS evaluation, participants who were receiving less support are often those who are unable to effectively advocate for services on their own behalf, including those with psychosocial disability, and/or

participants who struggle to understand the sometimes complex NDIS processes (Mavromaras, Moskos and Mahuteau 2016, p. xi).

About 15 per cent of participants reported feeling that they had less choice and control of their supports under the NDIS, while about one quarter of participants are accessing fewer distinct supports (Mavromaras, Moskos and Mahuteau 2016, pp. 60–61). Both the qualitative and quantitative data from the NDIS evaluation indicate that people with psychosocial disability are more likely to report less choice and control over supports since becoming NDIS participants.

The qualitative data also suggested that:

> … vulnerable families, those unable to navigate the NDIA website to find what services and providers were available, and those less able to articulate support needs, are less likely to experience greater choice over their supports. (Mavromaras, Moskos and Mahuteau 2016, p. xiii).

Many participants are not realising the benefits of the NDIS because they are finding it difficult to access disability supports for which they are receiving funding. The NDIS evaluation attributes this to lengthy waiting lists for some providers or types of support, a lack of local providers, and lack of quality provision. Unmet demand is more common for those living in rural and remote areas (15 per cent more likely than those in urban areas), and for older participants (Mavromaras, Moskos and Mahuteau 2016, p. 31).

There has also been a significant fall in participant satisfaction with the scheme since the scheme has entered the transition phase — the percentage of participants reporting they were satisfied or very satisfied dropped from an average of 95 per cent to around 85 per cent between 2015-16 and 2016-17 (first three quarters) (NDIA 2017o, p. 26). This could be linked to changes to planning processes over that period (discussed in chapter 4).

Recent surveys find consistent results

Every Australian Counts and the Melbourne Social Equity Institute have also surveyed participants to gauge the impact of the NDIS (box 2.11). And while the sample sizes are small and less representative than the NDIS Outcomes Framework and NDIS evaluation, the survey conclusions are broadly consistent.

Box 2.11 **Consistent results from recent surveys on the impact of the NDIS**

'NDIS Report Card' — Every Australian Counts

From November 2016 to January 2017, over 2100 Every Australian Counts supporters completed an online survey to gauge their views on the National Disability Insurance Scheme. About 30 per cent of respondents were participants (or carers of participants), while 23 per cent were workers employed in the sector. The remaining participants were either people expecting to be participants in the future (37 per cent) or supporters of the NDIS (11 per cent).

The survey found that:

- 71 per cent of participants and 61 per cent of carers had average or above satisfaction with the NDIS
- 78 per cent of participants and 74 per cent of carers had the same or more support than before the NDIS
- 64 per cent of participants and 61 per cent of carers said their life was the same or better with the NDIS.

Choice, control and the NDIS — Warr et al. (2017)

Researchers interviewed 42 NDIS participants and carers of participants who were part of the Barwon trial. The report found that:

- participants' expectations and experiences of the NDIS were strongly influenced by their circumstances
- resources to help people to exercise choice and control over their support was not always available
- in some cases service users had limited choice over what was available for them to purchase with their funding package, especially in regional areas
- participants feel like their views are often overlooked in planning processes
- participants who do not fully understand the system tend to feel disadvantaged.

Sources: Every Australian Counts (2017); Warr et al. (2017, pp. 7–8).

The broader benefits of the NDIS

The NDIS is expected to generate a number of broader benefits beyond the improved outcomes of people with disability and their families and carers. Based on the Commission's 2011 estimates of benefits, and a number of more recent studies, the NDIA's preliminary estimates suggest that:

- the NDIS will reduce costs for the health system by between $140-$300 million each year (by reducing hospitalisations for people with disability and limiting the need for people with disability to remain in hospital due to a lack of more appropriate arrangements)

- the NDIS will reduce justice system costs by between $350-$850 million each year (by reducing incarceration rates of those with mental disabilities)
- as a result of the NDIS, between 103 000–218 000 people with disability will be able to increase their hours worked or join the workforce
- as a result of the NDIS, between 56 000-104 000 carers will be able to increase their hours worked or join the workforce (sub. 161, pp. 29–31).

At this early stage of the rollout, it is difficult to measure whether these broader benefits are being realised.

The jury is out on economic participation

It is too early to tell whether the NDIS will lead to the economic participation benefits that were expected. While the NDIS evaluation and study participants provided individual examples of scheme participants and their carers entering the workforce (box 2.12), the (limited) quantitative evidence is less rosy. In the Outcomes Framework pilot, 13 per cent of respondents aged 25 to 55 indicated that the NDIS had helped with employment, the lowest of any domain (NDIA 2016g, p. 35).

Box 2.12 The NDIS has helped some scheme participants enter or remain in the workforce

Karene Gravener:

> I have improved physically, emotionally and mentally because of the support of the NDIS. We, as a family, have been able to live life, and pursue our dreams. My husband has been able to be in full-time employment without the stress of being a carer, and we are building our own home. (brief sub. 96)

Lauren McGowan-Slee:

> My condition got worse about seven years ago, and at my worst, I couldn't get out of the house and sometimes even bed. Last week I started full time work, a feat that was once seen as impossible. It's not easy. I get fatigued and crash out most evenings and end up in bed quite early, but I don't mind because I am living a meaningful life!
>
> Because of the NDIS, I have supports that mean I can do a job that works with my disability and have the physical home tasks I can't do taken care of. I can sit and use my brain with no worries, so that is what I do for work, but I struggle to do physical tasks so I get help for that. (brief sub. 52)

Richelle Carta:

> I was struggling to sustain my lifestyle with very minimal funding but due to the NDIS I can continue to be a wife, mum, work full time and have a life with my family by having ongoing funding to provide me with morning and night personal care support seven days a week. (brief sub. 111)

Susanna Goodrich:

> My son Toby is sixteen. He has Down Syndrome. He's had a rough few years with an autoimmune condition … The NDIS has provided funding that has changed Toby's life. His week has opened up from a routine of school, family life and the occasional social event, to a week that looks much like his other teenage brothers: he plays sport, goes out with peers, works in a part time job and will soon be learning how to catch the bus to the local shopping and entertainment hub. (brief sub. 39)

There are a number of reasons why increased economic participation flowing on from the NDIS may take some time.

- NDIS-funded initiatives to engage community and businesses to improve employment outcomes for people with disability have not occurred yet (ILC funding was not part of the NDIS trial).
- The NDIS is most likely to be effective for people entering the system for the first time and will thus have a greater effect as time goes on (PC 2011).[16]

DRAFT FINDING 2.4

Early evidence suggests that the National Disability Insurance Scheme is improving the lives of many participants and their families and carers. Many participants report more choice and control over the supports they receive and an increase in the amount of support provided.

However, not all participants are benefiting from the scheme. Participants with psychosocial disability, and those who struggle to navigate the scheme, are most at risk of experiencing poor outcomes.

16 In 2011, the Commission noted that those who have been in the system for a while often 'have missed opportunities for early intervention, had poor educational experiences, been dogged by low expectations by others, faced a community culture not strongly conducive to their employment and had long breaks from employment that erode skills and confidence'(PC 2011, p. 960).

3 Scheme eligibility

Key points

- The eligibility requirements of the National Disability Insurance Scheme (NDIS), as set out in the *National Disability Insurance Scheme Act 2013* (Cwlth), are consistent with the principles of the scheme.
- However, eligibility is broader than what the Commission recommended in 2011 in two key areas: the inclusion of people with substantially reduced functional capacity to undertake learning or social interaction; and children with developmental delay. This broader criteria have cost implications for the scheme. These groups were not included in the Commission's 2011 costings.
- Data are not available to assess the cost implications of adding learning and social interaction to the eligibility criteria for disability requirements. The National Disability Insurance Agency (NDIA) should improve its data collection in this area.
- Trial site data show that a significant number of children are entering the NDIS with developmental delay.
  - Early intervention for children with developmental delay can yield benefits, which suggests that including these children is consistent with the insurance principles of the scheme. The NDIA should monitor research in this area and build its evidence base on what early intervention supports work for children.
  - The definition of developmental delay, as prescribed in the NDIS Act, sets a high standard for children to be eligible for individualised supports. However, a high proportion of children in the scheme do not have a significant functional deficit relative to their peers.
  - The recently introduced Early Childhood Early Intervention (ECEI) pathway is a tighter gateway in principle, and should result in better enforcement of the eligibility criteria for children aged 0-6 years (in all areas, including developmental delay). However, it is too early to assess the effectiveness of the ECEI approach in practice.
- The Commission is seeking further information on the magnitude of the benefits and risks associated with maintaining lists that allow for automatic entry into the NDIS on the basis of a diagnosis.
- There is broad support for people with psychosocial disability being included in the NDIS. A high proportion of people with psychosocial disability who apply for support under the NDIS have been found to be eligible, despite concerns that demonstrating a condition is permanent could be a barrier to access.
  - The investment approach of the NDIS and the recovery model of treatment are both about building capacity and appear well aligned.
  - Reforms to the planning process should improve the way that people with psychosocial disability engage with the scheme. A specialised psychosocial gateway could be considered if planning reforms are not effective in improving engagement.

For the National Disability Insurance Scheme (NDIS) to deliver cost effective outcomes and remain financially sustainable, it is important that the eligibility criteria are aligned

with the objectives of the scheme. The legislated eligibility criteria, as they currently stand, do appear to target those people with disability who the Commission intended the scheme to cover. That said, the criteria are broader than that proposed by the Commission in 2011 (PC 2011, pp. 174–175), and this has cost implications for the scheme.

There are a number of factors that affect scheme participant numbers, including the:

- size and age profile of the Australian population
- prevalence, incidence, nature and severity of disability within the population
- eligibility criteria
- effectiveness of entry pathways in upholding the eligibility criteria
- effectiveness of exit pathways when people no longer meet the eligibility criteria for individualised supports.

This chapter looks at the eligibility criteria (section 3.1) and entry and exit pathways (section 3.2) — the two factors relevant to the design of the NDIS. One of the key eligibility issues raised in this study was the inclusion of psychosocial disability in the NDIS. This issue is discussed in section 3.3.

3.1 The eligibility criteria

The NDIS is for all Australians. It provides insurance against the costs of support in the event that a person acquires a significant disability. And anyone with, or affected by, a disability can approach the NDIS for information, linkages and capacity building. Individualised supports under the NDIS, however, are targeted at people with permanent and significant disability or those who meet early intervention requirements. In this context, 'eligibility criteria' refers to access to these individualised supports.

The eligibility criteria are critical in an uncapped scheme

The NDIS is a new way of providing disability services. When services were block-funded, governments had tight control of how much money was provided for disability services. Individualised supports provided under the NDIS are uncapped — so long as an individual meets the eligibility criteria, and the supports provided are 'reasonable and necessary' (chapter 4), an individual will receive the support that they need for as long as they need (often for their whole lifetime). This means that from a budgetary perspective, the NDIS is less certain than previous models of disability support.

The eligibility criteria are the main instrument available for determining how many people will receive individualised support through the NDIS. It is important that these criteria are clear, aligned with the objectives of the scheme, and rigorously upheld.

Eligibility differences when compared with the 2011 recommendations

When the Commission designed the NDIS in 2011, it recommended that the eligibility criteria for individualised supports uphold the following principles:

- individuals should have a disability that is, or is likely to be, permanent reflecting the irreversible nature of disabilities; and
- individuals would meet one of the following conditions:
  - have significantly reduced functioning in self-care, communication, mobility or self-management, and require significant ongoing support (restricting access to people with significant, ongoing support needs — rather than anyone with disability — reflects the objective that the NDIS embody a risk-pooled insurance scheme, which focuses on minimising the impact of high cost, low frequency events)
  - qualify for an early intervention group (covering people for whom there is good evidence that early intervention would be safe, cost-effective and significantly improve outcomes — box 3.1) (PC 2011, pp. 13–14).

The Commission also recommended that participants meet residence and age requirements.

Box 3.1 Why early intervention is important

An important recommendation in the Commission's 2011 *Disability Care and Support* inquiry was that individualised supports be available to 'an early intervention group, comprising of individuals for whom there is good evidence that the intervention is safe, significantly improves outcomes and is cost effective' (PC 2011, p. 63).

A key tenet of the NDIS is that it takes a lifetime approach to providing care and support. Early intervention is one way to embody this. Early intervention seeks to incur expenditure during the early stages of a person's disability in order to improve (or maintain) their functioning later on, or reduce the volume of supports that they need later in life.

Providing early intervention support through the NDIS can mean:

- a better quality of life for scheme participants by addressing many of their needs early, and building or maintaining their functional capacity
- a delay in the need for care (or a lower cost of providing care) in later stages of a participant's life, which contributes to a more financially sustainable scheme.

The eligibility criteria for the NDIS (as set out in ss. 21–25 of the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act)) are broadly in line with what the Commission recommended in 2011 (table 3.1). However, there are two key differences:

- a person can receive individualised supports under the disability requirements if they have substantially reduced functional capacity to undertake the activities of *learning or social interaction* — the activities proposed by the Commission were restricted to mobility, self-care, self-management and communication (PC 2011, p. 198)

- a child can receive individualised supports under the early intervention requirements if they have developmental delay.

Table 3.1 **A summary of the NDIS eligibility requirements**[a]

Age requirements	Residence requirements
Aged under 65	• Australian citizen • Permanent resident • Hold a protected special category visa
And meet either:	
Disability requirements	**Early intervention requirements**
Disability attributable to one or more: • intellectual • cognitive • neurological • sensory • physical impairments; or • an impairment attributable to a psychiatric condition; and	• Has one or more identified intellectual, cognitive, neurological, sensory or physical impairments, and likely to be **permanent**; or • Has one or more identified psychiatric conditions, and likely to be **permanent**; or • Is a child who has developmental delay; and
The impairments are, or are likely to be, **permanent**; and	The early intervention support is likely to benefit the person by **reducing the person's futures needs** for supports in relation to disability; and
Impairments substantially reduce **functional capacity** or **psychosocial functioning** to undertake one or more of the following activities: • communication • social interaction • learning • mobility • self-care • self-management	The early intervention support is likely to benefit the person by: • **mitigating or alleviating** the impact of the person's impairment on their functional capacity • **preventing the deterioration** of such functional capacity • **improving** functional capacity • strengthening the **sustainability of informal supports** available to the person, including through building the capacity of the person's carer.

[a] This figure represents an overview of what the Commission considers to be the main aspects of the eligibility criteria. The NDIS Act prescribes that more requirements are met than those outlined here.

Source: NDIS Act, ss 21-25.

Both these differences allow more people to qualify for individualised supports under the NDIS than the Commission included when costing the scheme. The extent to which the less restrictive eligibility criteria is contributing to scheme participation, and consequently, scheme costs, is a key question for this study.

Based on the eligibility criteria proposed in its 2011 report, the Commission estimated that approximately 410 000 people would be eligible for individualised supports under the NDIS (PC 2011, p. 160). Using the Commission's estimates as a basis, the NDIA has increased the estimated number of scheme participants to 460 000 (or 475 000 including those aged over 65 years, as discussed in chapter 2).

Adding learning and social interaction to the disability requirements — what is the effect?

Data are not available to make an assessment about the impact on scheme costs of adding learning and social interaction to the eligibility criteria for the disability requirements. However, Speech Pathology Australia said advice from their members who are NDIS providers is that:

> … they have not been providing services to children whose only disability relates to learning and literacy — thus, it is our conclusion that the increased numbers of people entering the Scheme is not due to the eligibility of people whose *only* functional disability relates to learning and/or social interaction. (sub. 136, p. 15)

It seems reasonable to assume that relationships across domains exists, however, the Commission understands that the NDIA does not collect data specifically on which, or how many, of the six activity domains specified in the Act that scheme participants enter through. This means that assessing the extent to which one particular domain is driving entry into the scheme, or how common it is for scheme participants to have reduced functional capacity across multiple domains, is not possible.

Collecting data at entry on which domains apply to each participant would not only inform what parts of the eligibility criteria are having a large impact on participant numbers (and therefore scheme costs), but also allow for more granular analysis of who is in the scheme and what their needs are likely to be. Such information may also be useful to the NDIA in its monitoring and forecasting roles.

DRAFT RECOMMENDATION 3.1

When determining that an individual is eligible for individualised support through the National Disability Insurance Scheme under the disability requirements, the National Disability Insurance Agency should collect data on which of the activity domains outlined in section 24 of the *National Disability Insurance Scheme Act 2013* (Cwlth) are relevant for each individual when they enter the scheme.

Including developmental delay in the early intervention requirements — what is the effect?

A child has developmental delay if it takes longer for them to reach age-specific milestones than other children. The term developmental delay is used in the absence of a diagnosed condition — that is, there is usually a more specific condition causing the developmental delay, including disability, but this condition is not yet able to be formally identified. This can be because it is difficult to reach an accurate diagnosis given the age and capabilities of the child.

The 'developmental trajectory' of children with developmental delay varies. In some cases, children may 'catch up' to their peers either with or without support. Others may need more substantial support for a longer period, which is often the case if the underlying condition causing the developmental delay is a significant disability.

The effect of including developmental delay as a condition eligible for individualised support was explored in detail by Dyson, Cutter and Moore (2015). The review, which was commissioned by the Department of Social Services (DSS), found that:

- about 11 600 children with developmental delay or global developmental delay would be eligible for support under the scheme (p. 15) (box 3.2), with an estimated annual cost of $155 million
- the vast majority of children in the scheme with developmental delay or global developmental delay could be expected to progress to full scheme participation — in part because of the high access requirements for developmental delay, and in part because developmental delay and global developmental delay is 'often predictive of the future diagnosis of intellectual disability' (p. 87)
- ' … the costs associated with including children correctly identified as having [developmental delay or global developmental delay] is of immaterial consequence to the sustainability of the NDIS' (p. 9)
- given the likelihood that a child with developmental delay would progress to the full scheme, early intervention could reduce costs to the scheme in the longer term by reducing future need (p. 17).

Box 3.2 Developmental delay and Global developmental delay — what is the difference?

Definitions for developmental delay and global developmental delay vary. The Commission looked at many definitions to draw out the key features that tend to define the conditions.

A child has *developmental delay* when they take longer than other children to meet age specific milestones in a specific area (or domain). Since children develop at different rates, and some will inevitably reach a milestone before others, most definitions require that a child be substantially or significantly behind their peers before they are identified as having developmental delay.

In contrast, a child is considered to have *global developmental delay* if they take longer to meet specific milestones across multiple domains. Some definitions require only more than one domain to be affected, while others require all domains to be affected. The definition of global developmental delay published by COAG in 2012, required a delay across a majority (out of five) domains.

Different definitions also outline different domains to be considered. However, they often include:

- motor skills (both gross and fine)
- speech and language skills
- social and/or emotional skills
- cognitive ability.

The definition of developmental delay for the purposes of the NDIS is set out in section 9 of the Act, and is spelled out in full in box 3.4.

Sources: COAG (2012a, p. 4); Disability Services Commission (2011, p. 12); Queensland Government (2017a).

Including developmental delay is consistent with the objectives of the scheme

The evidence base on the effectiveness of early intervention in improving the trajectories for children with developmental delay, or reducing the future costs of their care, is still being developed. Nevertheless, there is general acceptance that for children with developmental delay, access to early intervention leads to improved outcomes (box 3.3).

Such evidence suggests that there is a firm rationale for children with developmental delay to be eligible for individualised supports under the early intervention requirements of the NDIS. In 2011, the Commission recommended that the NDIA build an evidence base on early intervention, in part to inform what forms of intervention are beneficial and therefore warrant potential funding through the scheme (PC 2011, p. 632).

The evidence on early intervention for children with developmental delay should be a particular focus, given the developing evidence base, and given the higher than expected number of children entering (and the fewer than expected number of children leaving) the scheme.

Box 3.3 Evidence supports early intervention for developmental delay

Evidence points to children with developmental delay benefiting from early intervention supports. For example, when summarising the evidence, KPMG said:

> For children already exhibiting developmental delay, effective early intervention strategies can both alter the course of their developmental trajectories and prevent the onset of secondary complications … The earlier a child is identified as having a developmental delay or disability, the more likely they are to benefit from strategies targeted towards their needs. The success of early intervention strategies not only assists families through the provision of extra support for their child, but also decreases costs to schools and community in the later years as children transition to school. (2014, p. 3)

Dr Michael Guralnick — Director of the Center on Human Development and Disability in the University of Washington — presented a similar conclusion:

> Early intervention for children at risk and for those with established intellectual disabilities is now firmly embedded in the context of general early childhood development. An overarching developmental framework has been advanced and has achieved a high level of consensus; one that is relevant to typically developing young children and to those vulnerable to a range of developmental problems, particularly intellectual disability (2005, p. 318).

Guralnick also noted that:

> … long-established intervention science indicating that comprehensive early intervention programmes can, at a minimum, help prevent the substantial decline in intellectual development that generally occurs across the early childhood period for children with developmental delays. (2017, p. 11)

Early intervention for children with developmental disability was also described to be 'of clear benefit' by the Royal Australasian College of Physicians (2013, p. 2), while the World Health Organization (WHO) notes that early intervention for children with disability can enhance developmental competencies, minimise secondary complications and build the effectiveness of support networks (2012, p. 12).

Numbers in the scheme to date

Trial site data (to June 2016) show that just under 4000 individuals (or roughly one-third of the 11 600 estimate by Dyson, Cutter and Moore (2015)) entered the scheme with a primary health condition recorded as being either developmental delay or global developmental delay (NDIA 2016t, table 2.1.11(c)). If the prevalence rate experienced in trial sites was observed nationally, there would be more children with developmental delay in the scheme than Dyson, Cutter and Moore's estimate.

However, trial site prevalence rates may not be reflective of prevalence rates expected on a national level. Further, the NDIA has recently redesigned the entry pathway for children aged 0-6 years with the introduction of the Early Childhood Early Intervention (ECEI) approach (discussed below). This changes how the eligibility of children is assessed, and is designed to better ensure that the eligibility requirements for individualised supports are upheld.

Two possible explanations for higher numbers of children

There are two possible reasons why there may be more children with developmental delay in the scheme to date than expected:

- more children meet the eligibility criteria than expected or
- assessment processes allow children who do not meet the eligibility criteria to enter the scheme.

This section looks at the eligibility criteria for developmental delay. The extent to which assessment processes could be contributing to higher than expected numbers is discussed in the next section.

The definition of developmental delay for the purposes of the NDIS is outlined in box 3.4. A child with developmental delay must meet this definition to be eligible for individualised supports under the early intervention requirements (as well as meeting residency requirements).

Box 3.4 How does the NDIS define developmental delay?

The definition of developmental delay is set out in section 9 of the NDIS Act. It states that developmental delay means a delay in the development of a child under 6 years of age that:

(a) is attributable to a mental or physical impairment or a combination of mental or physical impairments; and

(b) results in substantial reduction in functional capacity in one or more of the following areas of major life activity:

  (i) self-care

  (ii) receptive and expressive language

  (iii) cognitive development

  (iv) motor development; and

(c) results in the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated.

Source: NDIS Act.

Some study participants raised concerns about the adequacy of the developmental delay definition in the NDIS Act. However, most of the evidence presented to the Commission on developmental delay suggests that the current definition requires a significant threshold to be met. For example, Dyson, Cutter and Moore (2015, p. 11) found that the definition of developmental delay prescribed in the NDIS Act sets 'a high access hurdle', particularly the requirements for there to be a substantial reduction in functional capacity, and the exclusion of children who only require uni-disciplinary intervention.

The ACT Government also said that a delay across one domain was in itself generally insufficient to qualify for individualised supports through the NDIS:

> … the NDIA has recently changed the operational guidelines relating to eligibility to the scheme for developmental delay. Specifically, the 'need for a combination and sequence or special interdisciplinary or generic care, treatment or other services that are of extended duration and are individually planned and coordinated' is being interpreted to mean children with only one area of delayed development are not eligible. As a result, the NDIA access team deems children with one area of delay not eligible for the scheme because they do not require interdisciplinary care and these children are no longer receiving (or renewing) packages or early intervention supports. (sub. 156, p. 9)

In making this point, the ACT Government expressed concern that this pushes the cost of providing support to people with a delay in only one area back onto State and Territory Governments. The fact that the NDIS sets a high access hurdle — which the Commission considers to be important — means that some children will require support outside of the scheme. Consequently, there is a need for all governments to work together to ensure that there are supports outside of the NDIS for children who do not meet the eligibility requirements.

Since the criteria that children must meet to qualify for individualised supports under the scheme is high, this suggest that it is the process by which children are entering the scheme (not the eligibility criteria) that is resulting in higher than expected numbers. This is consistent with evidence provided by the NDIA that a significant proportion of children in the scheme to date have little or no reduction in their functional capacity compared to their peers (discussed in the next section).

The number and cost of children with developmental delay in the scheme should continue to be monitored by the NDIA. Should changes to assessment processes be made, but children who do not meet the definition of developmental delay, as outlined in the Act, continue to enter the scheme, there is a strong case for changing the definition of developmental delay in the Act so that it is clearer under what circumstances a child would qualify for individualised supports.

3.2 Are entry and exit pathways effective?

Effective entry pathways are imperative to the successful functioning of the NDIS. They uphold the eligibility criteria of the scheme and only allow people who meet these criteria to qualify for supports. Excessively porous pathways may allow people who do not meet eligibility requirements to access the NDIS, placing cost pressures on the scheme.

There are two main pathways for people to enter the NDIS:

- the Early Childhood Early Intervention (ECEI) pathway for all children aged 0-6, including those with a disability or developmental delay (NDIA 2016i)
- a general pathway for people aged 7-65 years (NDIA 2016i, 2016q).

Entry into the NDIS can be self-initiated, or facilitated by the NDIA (the NDIA contacts people receiving disability services that are being phased into the NDIS when the NDIS becomes available in their area).

The NDIA also has a list of defined programs. People receiving supports through these programs do not need to show that they meet the disability requirements, as the requirements for the programs and the NDIS are considered 'equivalent' (NDIA 2016q). As an entry pathway, these lists are relevant during the transition phase of the scheme.

The Early Childhood Early Intervention pathway

In response to the higher than expected number of children entering the scheme in the trials, the NDIA established the ECEI pathway for children to enter into the scheme (NDIA 2016g, p. 16). Prior to the introduction of the ECEI pathway — which commenced in 2016 and is being rolled out in line with the full scheme — children entered the scheme via the general pathway — through the lodgment of an access request and subsequently an assessment of eligibility and need.

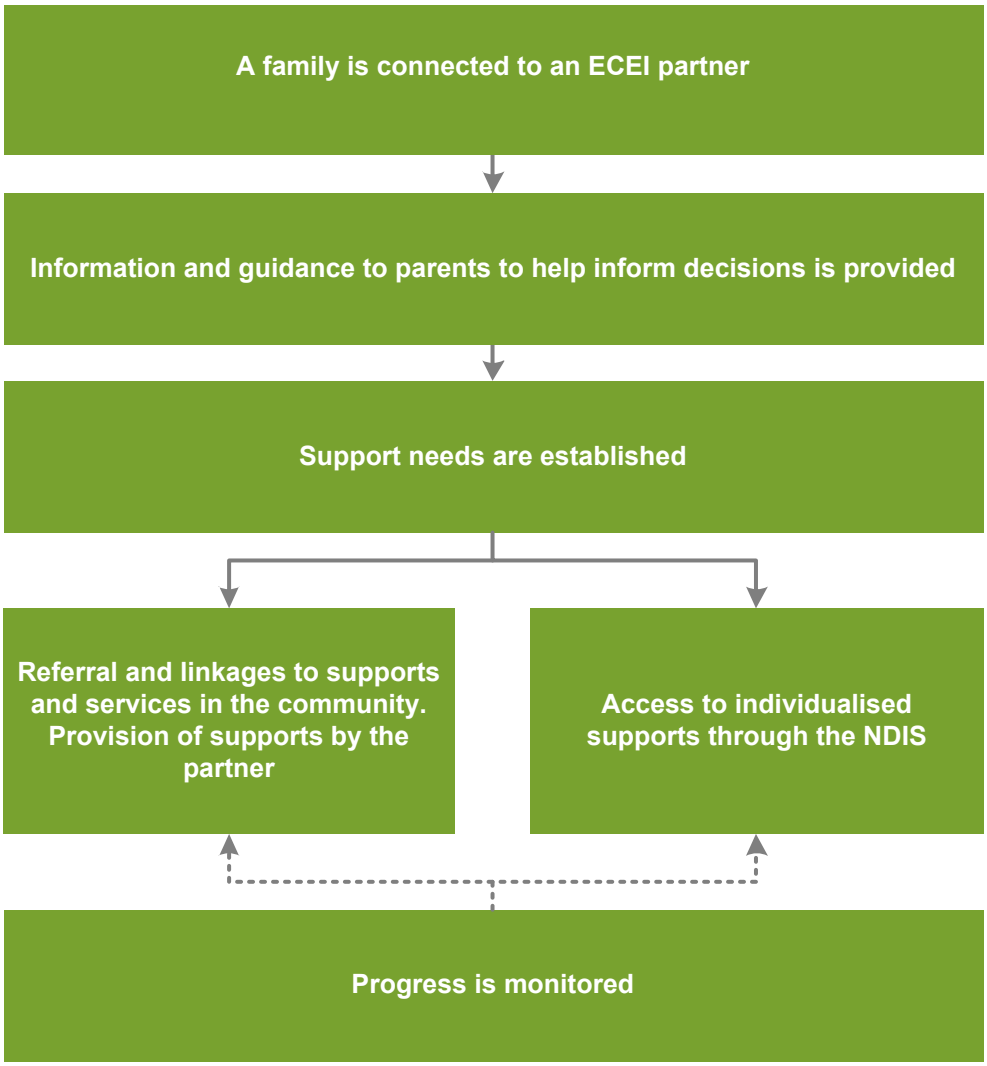
A summary of how the ECEI pathway works is provided in figure 3.1.

Under the ECEI approach, a family with a child with a disability or developmental delay seeking support is connected to an ECEI 'partner' in their local community. To be a partner, an organisation must be approved by the NDIA and have experience in early childhood intervention.

Partners assess the support needs of a child with disability and their family and, based on the assessment, determine the supports and services the child needs. Early childhood partners can provide:

- information and linkages to mainstream supports and services
- 'timely short to medium early childhood early intervention supports'. Examples of these supports include: information, family based education, parenting support services and therapy (DSS 2016a, p. 11)
- access to an NDIS plan. If it is considered that a child is best supported by a NDIS plan, it remains a NDIA delegate who determines whether a child is eligible and approves a plan, although the ECEI partner is responsible for providing information that will inform a decision on access and assisting with plan development (DSS 2016a, pp. 11–18).

Figure 3.1 **The ECEI process**



Source: Adapted from on NDIA (2017c).

On paper, the ECEI approach does not appear to be very different to how people enter the NDIS under the 'general' pathway. However, the specialised nature of ECEI partners, and the fact that they can provide short- and medium-term support, and refer children to mainstream services, means that the ECEI approach places significant emphasis on upholding eligibility while supporting less severe cases outside of the scheme. The ECEI approach seeks to reduce the number of children with milder levels of disability from entering the scheme, thereby reducing cost pressures.

Study participant's views on the likely effectiveness of the ECEI approach are largely positive (box 3.5).

Box 3.5 General support for the ECEI approach, but some concerns

Lifestart Co-operative Limited:

> Over time, if implemented correctly with experienced and well credentialed Early Childhood Partners, outcomes for children, their families and the scheme will be positive. [The ECEI approach] should ensure that children get the right support, in a timely manner and in the right amount. It should see the number of children requiring individualised plans decrease. This trend has emerged with the introduction of ECEI Partners in the Nepean Blue Mountains where Lifestart has provided children with supports and assistance where these children and families were able to be well supported without a plan. (sub. 97, p. 4)

The New South Wales Government:

> NSW believes that the ECEI process represents best practice for children under 7 years … A version of the ECEI approach was part of the early NDIS transition in the Nepean Blue Mountains, which commenced from July 2015 for children and young people under 18 years. Anecdotal evidence from this process suggests the effectiveness of the model in diverting children from specialist disability supports funded by the NDIS to mainstream and community based support options. (sub. 60, pp. 17-18)

National Disability Services:

> NDS … supports the concept of the ECEI approach. The broad gateway of ECEI enables some children with lesser needs to receive short-term assistance … It also allows time to see how a child responds to short-term early intervention before making a decision on eligibility, while still giving immediate access to an NDIS package to those with obvious significant and long-term disability. (sub. 51, p. 4)

The Department of Social Services:

> The early indications are that the inclusion of developmental delay in the NDIS and the Early Childhood Early Intervention (ECEI) gateway approach is effective in supporting children. It is expected a number of these children will meet their development goals and will not require long-term NDIS supports. (sub. 146, p. 3)

Allied Health Professions Australia:

> AHPA and its members support the role of early intervention but note that the early childhood early intervention (ECEI) approach may risk excluding children with a need for support, increasing the burden on other systems and schemes. If the scheme doesn't meet the child's needs there is the risk that this may result in higher levels of support in the future negating the purpose of early intervention programs. (sub. 37, p. 10)

Royal Institute for Deaf and Blind Children:

> Models such as the ECEI have resulted in a cost shift from the Agency to providers, with little specificity around specific abilities. The ECEI process has imposed significant and redundant elements for children with hearing impairment, and if strictly implemented would actually delay access to services. (sub. 95, p. 7)

Prior to the introduction of the ECEI approach, the number of children receiving individualised supports through the NDIS without having a substantial functional deficit relative to their peers was significant. The NDIA pointed to their analysis of PEDI-CAT scores which found that:

> … the aggregated scores indicated that, overall, around 40% of participants had scores of 30 or more ('average') across each of the four domains. *That is, these participants did not seem to have any identified deficits, compared to the normal range for their age.* (sub. 161, p. 78, emphasis added)

Some study participants questioned the appropriateness of the PEDI-CAT tool and how it was applied by the NDIA for some types of disability (chapter 4), and this may go some way to explaining the apparent anomaly. However, to have children with mild or no deficits in the NDIS clearly runs counter to the objectives of the scheme, and depending on the volume of supports that these children receive, could have significant cost and equity implications. As such, a tighter gateway that better assesses eligibility is necessary.

The ECEI approach can be this tighter gateway. Using specialised organisations with experience in identifying and treating developmental delay and childhood disability should result in more accurate assessments of whether children meet the criteria for individualised supports under the NDIS. The emphasis on providing timely short- and medium-term supports and support through mainstream services to children with needs, but not severe enough to warrant entry into the NDIS, is also positive.

However, it is too early to tell if the ECEI approach has been successful in upholding the eligibility criteria of the NDIS, and contributing to beneficial outcomes for children who are ineligible for individualised support. The DSS (sub. 146, p. 13) observed that the 'gateway's actual success will be dependent on services outside the NDIS being available, and the management of family expectations about how children's needs are better met'.

The NDIA has developed an evaluation and monitoring framework for the ECEI approach. In time, this framework should assist with monitoring children's pathways (including entry and exit from NDIS via the gateway) and evaluating the effectiveness of the ECEI approach.

Brotherhood of St Laurence commented on the importance of ECEI being evidenced-based:

> As the initial roll-out of the NDIS nears completion, children with developmental delays will be the largest group of people with disability entering the NDIS. Understanding what works for children who gain access to the NDIS is vital to manage costs. To ensure the NDIS provides value for money and can reduce the life-long impact of developmental delays on children, ECEI needs to be underpinned by a strong evidence-based practice, policy and research agenda. Most importantly, ECEI staff need access to the latest research and evidence to inform service design and practice. This is especially important given the emerging findings that some interventions and/or programs can be harmful and/or have limited evidence regarding their efficacy. (sub 189, p. 12)

The NDIA is also developing an early intervention approach for the 7-14 years cohort (sub. 161, p. 26).

Streamlined entry for early intervention

Under the NDIS Act, when assessing whether a potential participant is eligible for individualised supports under the early intervention requirements, the NDIA must be satisfied that the supports will benefit the child by reducing future need (s. 25(1)(b)) and

benefit the child in one of the ways prescribed in s. 25(1)(c) (table 3.1). If a child has a condition that is on List D (a list maintained under the NDIA's operational guidelines on access (NDIA 2016q)), the presence of the condition is deemed sufficient to satisfy s. 25(1)(b) and s. 25(1)(c).

List D contains about 130 conditions, including global developmental delay (NDIA 2016q). Developmental delay (as defined in the Act) is not contained in the list, however it is effectively given the same streamlined entry arrangements under the *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* (Cwlth) (r. 6.10).

Maintaining such a list represents a trade-off. The appeal of such a list is that it places less onus on families to demonstrate eligibility, reduces the administrative burden on the NDIA, and provides a degree of certainty for the families of children with these conditions.

However, such lists can be problematic. They can affect incentives, or can represent an overly generous entry gateway if set too expansively. Further, making assumptions that children will benefit from early intervention risks providing entry for children who, given their individual circumstances, may not benefit from individualised support — something that runs counter to the concept of early intervention.

A list can also stifle exits from the scheme. If diagnosis, rather than expected benefits, form the basis of early intervention, a child may remain eligible so long as their condition is present even if early intervention has been applied and expected benefits have been realised (or are unlikely to be realised).

The Commission is seeking feedback on the advantages and disadvantages of retaining List D, with a view to determining whether it should continue to be a pathway for children to enter the scheme under the early intervention requirements.

INFORMATION REQUEST 3.1

The Commission is seeking feedback on the advantages and disadvantages of maintaining 'List D — Permanent Impairment/Early Intervention, Under 7 years — No Further Assessment Required' *in the National Disability Insurance Agency's operational guidelines on access. Feedback is sought on the extent to which the list:*

- *reduces the burden on families to demonstrate that their child will benefit from early intervention and/or provides certainty that support will be provided*
- *reduces the burden on the National Disability Insurance Agency of assessing whether children are eligible for early intervention support under the* National Disability Insurance Scheme Act 2013 *(Cwlth)*
- *may be contributing to supports being provided to children who are unlikely to benefit from such supports*
- *may be discouraging or inhibiting exit from the scheme.*

The 'general' pathway

For people aged 7-65 years, entry to the NDIS begins with the lodgment of an access request. This can be lodged through a form, but is increasingly being completed by telephone. In lodging an access request, a potential scheme participant provides information on their age and residency status (the first two components of the eligibility criteria), as well as information about their disability.

To demonstrate their disability, an applicant is typically required to provide evidence of the condition from their treating doctor or specialist. The NDIA may also require evidence from an applicant's health professional on the impact of the disability on the applicant's ability to undertake tasks related to mobility, communication, social interaction, learning, self-care and self-management. For some conditions (contained in a list maintained by the NDIA), the impact of the disability on a person's functional capacity is assumed and further evidence is not required (NDIA nda).

The NDIA has 21 days to either decide whether the prospective participant meets the eligibility criteria, or to request additional information (NDIS Act s. 20). The additional information may require the potential participant being assessed or examined, and the NDIA has the authority to nominate where this occurs (s. 26(1)).

The Commission has been presented with little evidence to suggest that the entry pathway for people under disability requirements is having an undue influence on scheme costs.

The NDIA maintains a list of conditions designed to streamline access for people with disability (List A). If a person has a condition on List A, the permanence of their condition and the impact of their condition on their functional capacity is assumed, and the individual is deemed eligible for individualised supports under the NDIS without further assessment of their eligibility (NDIA 2016q, nda).

Maintaining List A offers benefits to both the NDIA and participants, but there is some risk that, in providing for that streamlining, it effectively lowers the hurdle to access the scheme to a level that is too low.

The Commission would value additional feedback on the effects of List A.

INFORMATION REQUEST 3.2

The Commission is seeking feedback on the benefits and risks of maintaining 'List A — Conditions which are Likely to Meet the Disability Requirements in section 24 of the NDIS Act'. *In particular:*

- *to what extent does List A reduce the burden for people with permanent and significant disability of entering the National Disability Insurance Scheme under the disability requirements?*
- *is there any evidence that people who do not meet the disability requirements are entering the scheme under List A?*

As discussed in chapter 2, a cost pressure identified by the NDIA is the lower than expected rate at which people are exiting the scheme. At the end of March 2017, just under 700 participants had exited the scheme. Over 90 per cent of these exits were people who had permanent disability plans, while only 10 per cent of exits were people with early intervention plans (NDIA 2017a, p. 15). The NDIA is monitoring exit rates and should continue to consider actions that will arrest trends in exit rates that do not appear to be consistent with the aims of the scheme.

3.3 Psychosocial disability and the NDIS

Support for including psychosocial disability in the NDIS is generally high

In 2011, the Commission recommended that people with permanent psychosocial disability with significant long-term support needs be supported through the NDIS (PC 2011, p. 189). The recommendation was made on the basis that:

- the day-to-day support needs for people with significant and enduring psychiatric disability are effectively the same as people who have an intellectual disability or an acquired brain injury
- some important parts of the care that is needed to be provided to people with psychosocial disability — namely community-based supports such as outreach or day programs — are best met through the NDIS
- providing supports to people with psychosocial disability through the NDIS provides them with the wider benefits of the scheme, including personalisation of supports to meet the needs of the individual, more choice over what supports are provided, when and by who, and greater access to early intervention supports (PC 2011, pp. 186–189).

These points remain salient, and lend support to people with psychosocial disability being supported through the NDIS. And, while the Commission heard a range of views about whether the NDIS represents the 'right' vehicle to provide support to people with psychosocial disability, the majority of submissions to this study were optimistic and/or

supportive about the role the NDIS is playing in meeting needs of people with psychosocial disability (box 3.6).

Box 3.6 Strong support for the NDIS from the mental health sector

Flourish Australia:

> Flourish Australia strongly supports the NDIS and the opportunity it provides for greater certainty, choice and control, and economic and social participation for people with disability who require life-long support. We are also strongly supportive of the inclusion of psychosocial disability within the Scheme's remit, and have seen firsthand the benefits of the Scheme for the people we support and their families. (sub. 74, p. 1)

Mental Health Community Coalition of the ACT:

> MHCC ACT views the NDIS with great hope. It holds promises for a better more integrated life for people living with disability. (sub. 135, p. 2)

The National Mental Health Commission:

> The NMHC considers the NDIS to be an important initiative with its promise of individualised care and choice for eligible people with psychosocial disability. It is a potentially very important element in addressing the long standing unmet needs of people with mental illness for effective community and disability supports. (sub. 153, p. 1)

Mental Health Australia:

> The National Disability Insurance Scheme (NDIS) is an historic opportunity to improve the lives of people who have for far too long missed out on the support they need to live contributing lives in the community. Mental Health Australia strongly supports the policy intent underpinning the Scheme, and hopes to work with government over the long term to maximise choice and control for people living with mental illness and psychosocial disability. (sub. 155, p. 3)

The Department of Health:

> There is broad stakeholder support for the inclusion of psychosocial disability in the NDIS, with feedback suggesting that participants are receiving better and more effective support and assistance under the NDIS than what was available to them before accessing the scheme. (sub. 175, p. 2)

That said, there is evidence that some people with psychosocial disability are experiencing less positive outcomes than others in the scheme. For example, people with psychosocial disability are more likely to report less choice and control over supports since becoming a NDIS participant compared to other groups of participants in the scheme (Mavromaras, Moskos and Mahuteau 2016) and are more at risk of experiencing poor outcomes (chapter 2).

Boundaries are important

Several study participants suggested that the requirement that an impairment be permanent is incompatible with the recovery models used in supporting people with mental health conditions. For example, the Royal Australian and New Zealand College of Psychiatrists said that:

> The RANZCP is concerned about the centrality of disability 'permanence' in the eligibility criteria for the NDIS as the language of 'permanence' does not fit with the recovery-oriented

> approach of the mental health sector … Eligibility criteria that relies on permanence may therefore contribute to many individuals not seeking, or opting out of, treatment if that treatment is predicated on their acceptance of the lifelong nature of their illness (sub. 158, p. 2)

The New South Wales Government also said that:

> The recovery focus in contemporary mental health practice does not align neatly with the NDIS requirement that psychosocial disability is considered a permanent disability. (sub. 60, p. 14)

Similar arguments were presented by the Butterfly Foundation (sub. 78, p. 3), Top End Association for Mental Health Inc (sub. 102, p. 9), Anglicare Tasmania (sub 145, p. 24), Mental Health Australia (sub. 155, p. 8) and VICSERV (sub. 169, p. 7).

The Victorian Council of Social Services (sub. 176, p. 11) argued that a recovery framework is widely accepted as best practice, and requiring people to identify as having a permanent psychosocial disability can 'create stigma, distress and limit people's hope and optimism'.

However, others, such as the National Mental Health Commission, argued that that the concepts of permanence and recovery are not necessarily mutually exclusive:

> The NDIS requirement for Tier 3 participants to establish a 'permanent impairment' can appear to be somewhat at odds with the more strengths-based concept of 'recovery' used in mental health. 'Recovery' is not synonymous with the absence of illness. Rather, it means people who are living with, or have experienced, mental illness can nevertheless lead contributing and meaningful lives, in which they feel safe and secure, have connections with community and family, are engaged in social and economic participation (whether paid or not), and are physically and mentally thriving (not just surviving).
>
> From this perspective, recovery is not inconsistent with the philosophical underpinnings of the NDIS that aim to support people with lifelong disability to live an ordinary life so they can engage in education, employment and community activities. (sub. 153, pp. 2–3)

The investment approach of the NDIS and the recovery model of mental health are both about building capacity, and appear to be well aligned.

While demonstrating permanence may be more difficult for people with psychosocial disability than for people with other types of disability, permanence is about the irreversible nature of a disability which may be of a chronic episodic nature. The NDIS Rules and operational guidelines accept that a permanent condition may be episodic in nature, requiring different amounts of support at different times.

Scheme participant numbers show that people with psychosocial disability have been able to demonstrate that their condition is, or is likely to be, permanent. At the end of March 2017, about 5000 people with psychosocial disability had approved plans, accounting for six per cent of scheme participants (NDIA 2017o, p. 18). And data (to December 2016) also indicate that 81 per cent of people with psychosocial disability who lodged an access request to the NDIS have been found eligible for the scheme (although this is a lower acceptance rate compared to other conditions) (NDIA 2016v, p. 56).

The Commission cautions against changing the eligibility criteria to relax or loosen the definition of permanency and how it relates to psychosocial disability. The requirement that a condition be permanent is a key tenet of the NDIS. Removing or relaxing this requirement would represent a significant risk to the financial sustainability of the scheme.

The NDIS is not meant to support everyone with psychosocial disability, and even for those who do qualify for individualised supports, other systems need to play their part (for example, the health system meeting clinical needs). Many people will not meet the eligibility criteria for individualised supports and therefore will need to be supported outside of the scheme. Clarity about the specific services that will be funded and/or provided by all governments once the rollout of the NDIS has been completed is essential (chapter 5).

A 'psychosocial gateway' is an option

Many participants to this study expressed frustration that people with psychosocial disability were subject to phone planning conversations and inconsistent or inequitable outcomes in plans. There were also concerns that a specific assessment tool for psychosocial disability is not being used and planners lack experience in understanding the needs of people with psychosocial disability (chapter 4).

While framed around people with psychosocial disability, these concerns are broadly in line with observations others have made about the planning process more generally. A discussion of planning — including reforms to improve the process — is provided in chapter 4. Such reforms may improve outcomes for people with psychosocial disability, or allay concerns about how the eligibility criteria are being applied.

That said, a case can be made that psychosocial disability is sufficiently different from other types of disability that a unique, specialised gateway could be of value. It was put to the Commission that people with psychosocial disability may not engage with the system effectively, may be hard to reach, may view the system with distrust, or may have particular difficulty identifying and articulating their goals and needs. It was also argued that more beneficial outcomes for scheme participants could be achieved if planners were familiar with psychosocial disability and had greater knowledge of the types of supports that could be provided within and outside of the scheme.

The finding that people with psychosocial disability are more likely than other scheme participants to report less positive outcomes from their involvement in the scheme suggests that the scheme might not be working as well for people with psychosocial disability as it could.

While a specialist gateway provides no guarantee of improved outcomes, it is something that could be explored if wider reforms to the planning process do not result in better engagement with the scheme for people with psychosocial disability.

Reforms to the wider planning process (chapter 4) should be the priority and may be sufficient to improve outcomes for people with psychosocial disability. However, the NDIA could also consider a unique entry pathway for people with psychosocial disability. This could build on the strengths of the ECEI approach, that is, a connection with partners who have considerable expertise in psychosocial disability, and linkages to supports outside of the scheme for people with needs that will not be supported through the NDIS.

4 Scheme supports

Key points

- The National Disability Insurance Scheme (NDIS) is designed to cover individualised disability supports that are reasonable and necessary. This includes supports that help people with disability to pursue their goals, live independently and participate in the community and employment. The NDIS is meant to complement other mainstream or specialist services available to the wider population, not replace them.
- The extent of supports coverage matters — over-coverage of supports could create cost pressures and pose a risk to the financial sustainability of the scheme, but under-coverage could mean that the benefits of the NDIS are not fully realised.
- The overall costs and benefits of the NDIS are affected by the volume of supports covered under the scheme, as well as how supports are allocated — that is, the planning process.
  - The touchstone of what is reasonable and necessary directly impacts the quantity and types of supports funded. The concept of 'reasonable and necessary' is malleable, and allows scheme participants the flexibility to exercise choice and control.
  - The quality of planning processes is a key determinant of the long-term sustainability of the NDIS, because it influences what costs are incurred; the predictability of costs; and the integrity of, and community support for, the scheme as a whole.
- The planning process is about matching scheme participants with supports. It involves conversations between the participant and the National Disability Insurance Agency to determine, for each participant: their goals and aspirations, their level of function and appropriate supports.
- The challenge for the planning process is finding the right balance between individualisation and good outcomes for scheme participants on the one hand, and ensuring equity among participants and the financial sustainability of the scheme on the other.
- Planning processes are not operating well. The speed of transition and performance indicators that focus on participant numbers have placed pressure on the National Disability Insurance Agency to finalise plans quickly, and the quality of plans has been compromised.
  - Planning conversations with scheme participants are said to be rushed and superficial. Most plans are prepared by phone, which limits engagement with participants and can mean that planners do not get the 'full picture'.
  - The planning process is not clear, transparent and accessible. Nor are processes inclusive or sufficiently flexible to accommodate differing needs, particularly for participants with complex needs or from culturally and linguistically diverse backgrounds.
  - There is variability in planner skills, experience and training. Planners often lack knowledge about different types of disability, which can hinder their ability to formulate a good plan. Planner performance could be improved by using specialised planning teams for some disabilities and better leveraging industry expertise.

The quantity and types of supports funded by the National Disability Insurance Scheme (NDIS) are key drivers of scheme costs. Supports are also important for realising many of the benefits of the NDIS (box 4.1) because they help scheme participants:

- pursue their goals, objectives and aspirations and increase their independence
- increase their social and economic participation (and increase the social and economic participation of carers)
- reduce their need for other supports and services
- develop their capacity to actively take part in the community.

For this reason, striking the right balance is crucial: over-coverage of supports could create cost pressures and pose a risk to the sustainability of the scheme, but under-coverage could mean that the benefits of the NDIS are not fully realised.

The overall costs and benefits of the NDIS are also affected by *how* supports are allocated to scheme participants. Good planning processes are important for matching scheme participants with the supports that will result in improved outcomes and help maintain the integrity of, and community support for, the scheme as a whole. Poor planning processes can increase the likelihood of cost blowouts and undermine the accuracy of cost projections, compromising the ability of governments to plan for the future of the scheme.

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) provides for two types of supports for people with disability.

- Specialist disability supports funded by the NDIS are called *reasonable and necessary supports*. The types of supports that may be funded include: assistance with daily personal activities and household tasks; therapeutic supports (such as occupational therapy, speech therapy and behavioural support); mobility equipment; home and vehicle modifications; and services that enable employment and participation in community and social activities (NDIA ndf).
- The National Disability Insurance Agency (NDIA) may also provide *general supports* to people with disability, even if they are not eligible for the NDIS. General supports include: coordination, strategic and referral services and activities, to help people with disability access mainstream services, such as health, education and transport services (Commonwealth of Australia 2013, p. 8).

This chapter is about the specialist supports that are funded under the NDIS — that is, reasonable and necessary supports. The rules governing the scope of supports covered by the NDIS are covered in section 4.1. Section 4.2 gives an overview of the process for allocating supports to individual scheme participants — the planning process. Section 4.3 discusses the key concerns raised by study participants about the planning process and considers what implications these have for scheme sustainability. Section 4.4 looks at the evidence on the effectiveness of supports. The interface between the NDIS and other services is discussed in chapter 5.

Box 4.1 Many of the NDIS's benefits are realised through supports

Brenda Gillett:

> My adult son James (39 years old) who has an intellectual disability, lived at home until almost two years ago, when we then decided it was time for him to try to live as independently as possible without our total support … James just loves his own 'unit' and his new (and much loved) support person who is enabling James to become more independent each day; and is helping him to become more inclusive in his community … James also has used funding specifically set aside for a speech pathology assessment and is looking forward to catching up with the 21st century and the rest of his generation by buying an iPad with which to look at his photos and use a communication app to help him express his needs and wants. (brief sub. 15)

Sally Shackcloth:

> My adult daughter's life has improved in many ways since she was a member of the trial group in Tasmania. An occupational therapist found that her bed was unsafe both for her and for the support workers dressing her. The physio review recommended a hip x-ray because of increasing mobility problems. The result is she is now having preventative treatment so her condition doesn't deteriorate … Very importantly, she is now participating in an ongoing speech pathology program with an expert speech pathologist as she needs a communication system tailored to her needs. Up to now she has no reliable way to communicate. (brief sub. 19)

Karen Wakely:

> For the first time we have been able to access meaningful therapeutic supports. Previously therapy was only once a month, and was inadequate for gaining any momentum. Now we access either psyc or occ therapy every week, and it has been far more effective in developing the social and practical skills needed for independent living. For the first time, my child is beginning to successfully participate in mainstream community activities. (brief sub. 43)

Lauren McGowan-Slee:

> Because of the NDIS I have supports that mean I can do a job that works with my disability and have the physical home tasks I can't do taken care of … I am excited to be a taxpayer again, it fills me with so much pride to be giving back again. With the NDIS I can afford to get to work, the transport contributions mean I don't have to reduce my work days to afford taxis. I have adaptive technology which means I can do things by myself and be safe. I am also blind and I can finally read again and I used funding to get me to a functional level so I could work. … I can afford to buy healthier food and get help preparing it instead of having to buy pre prepared meals so I have had less digestive problems, and I don't see the doctor as often. I have a person who can be with me when I do exercise so I can exercise effectively without being afraid of falling over or getting injured when I lose muscle control. (brief sub. 52)

Graham Lawrence:

> Under her NDIS approved plan, Michelle has the ability to purchase a 5 day/week community access program with a group of her peers, with arranged leisure, craft and life education activities … [this] makes it possible for the Government to save an estimated $300,000 -$400,000 p/a. This is the typical net cost of providing care (equivalent to their own home), for people with the severe levels of disability which Michelle has. (brief sub. 78)

Sonya & Stephanie Nicolaides:

> My Daughter Stephi has been on the NDIS for three months now and it has made a dramatic change to her life. She now has the same life opportunities other Australians take for granted. She is able to have regular physio and hydro therapy now, which helps with all her tight muscles. Stephi seems to be a lot happier within herself and able to move a lot easier without much pain. We were able to get ramps to the front and rear of the house, making it very easy to get Stephi in and out of the house in her wheelchair now. (brief sub. 132)

4.1 What supports are funded under the NDIS?

The NDIS is designed to cover individualised disability supports that are 'reasonable and necessary' (Gillard 2012; PC 2011, pp. 257–261).

This includes supports that help people with disability to:

- pursue their goals and maximise their independence
- live independently and be included in the community as fully participating citizens
- participate in the community and in employment (NDIS Act s. 4(11)).

However, the NDIS is not meant to replace mainstream or other specialist services available to the broader population, and does not fund supports that are covered by other areas of government (including hospital and GP visits, and school teacher aides).

In addition, the NDIS Act s. 34(1) specifies criteria for determining whether supports (general or individualised) may be provided to scheme participants. This includes whether the support:

- will assist the participant in achieving their stated goals and aspirations
- will facilitate the participant's social and economic participation
- represents good value for money
- will (or is likely to) be effective and beneficial for the participant
- should (within reasonable expectations) be provided by families, carers, informal networks or the community
- is most appropriately funded or provided through the NDIS.

The *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cwlth) and operational guidelines maintained by the NDIA provide additional rules and guidance for deciding what supports may be approved.

What is reasonable and necessary?

Individualised support funding under the NDIS is bounded by the touchstone of what is reasonable and necessary. However, the concept of 'reasonable and necessary' is not specifically defined in the legislative framework. Notably, the NDIS Act 'does not prescribe the types of supports that would be considered 'reasonable and necessary' across all participants' (EY 2015, p. 9), nor does it provide direct guidance on how to determine whether a support is reasonable and necessary.

As the court in *McGarrigle v National Disability Insurance Agency* observed:

> Although the phrase 'reasonable and necessary supports' is used throughout the legislative scheme, including in the objects and principles provisions, it is not defined. Its meaning can be

> derived from the context in which it is used, especially in my opinion s 4(11), which sets out what reasonable and necessary supports should enable and empower people with a disability to do, read with s 14 which sets out the purposes for which funding for reasonable and necessary supports is provided. ([2017] FCA 308 at [41])

As such, the bounds of what is reasonable and necessary will ultimately be shaped by court and tribunal decisions over time, having regard to the text of the legislation, rules and operational guidelines. These decisions will affect what will be funded under the NDIS, and therefore overall scheme costs. On this basis, the NDIA identified 'decisions by the Administrative Appeals Tribunal (AAT) or court system in interpreting the boundaries of … reasonable and necessary supports' (sub. 161, p. 45) as a policy lever affecting the financial sustainability of the NDIS that is outside of its control (box 4.2).

Box 4.2 McGarrigle v National Disability Insurance Agency

Mr Liam McGarrigle is a scheme participant with autism spectrum disorder and intellectual disability. Each week, he attends a group program for three days and is employed for two days. Transport to and from these activities is by taxi or provided by a support worker. As part of his third plan, Mr McGarrigle was allocated $11 850 for 'transport to access daily activities'. This represented about 75 per cent of his total transport costs ($15 850).

Administrative Appeals Tribunal decision

Mr McGarrigle sought a review of this decision in the Administrative Appeals Tribunal, seeking to have his transport costs fully funded. The Tribunal found that, while transport is a reasonable and necessary support for Mr McGarrigle, it was open to the National Disability Insurance Agency (NDIA) to decide to fund less than the full cost of the support. The Tribunal said, 'I am satisfied that the decision to fund 75 per cent of his weekday transport costs strikes an appropriate balance between what is reasonable and necessary for him and the overall financial sustainability of the NDIS' [64].

Federal Court decision

On appeal, the Federal Court of Australia overturned the Tribunal's decision. It reasoned that the imperative language of the NDIS Act (specifically, the words 'will be funded' in s. 33(2)(b)) does not permit partial funding of supports. That is, if a support has been determined to be a reasonable and necessary support, the support must be fully funded. The Court also noted that the Act does not refer to contributions from the participant towards the cost of supports.

Appeal to the Full Federal Court

The NDIA has lodged an appeal of this decision to the Full Federal Court. Mr David Bowen, Chief Executive of the NDIA, said:

> The appeal is an important test case which arises from a set of circumstances in the trial phase of the NDIS. It could affect the future of the whole NDIS … We have, therefore, decided to ask the court for the fullest clarity, given the serious implications for the future sustainability of the Scheme for many thousands of present and future participants.

Sources: *McGarrigle v National Disability Insurance Agency* [2016] AATA 498; *McGarrigle v National Disability Insurance Agency* [2017] FCA 308; NDIA (2017l).

In 2011, the Commission made recommendations about various criteria for determining whether a support is reasonable and necessary (PC 2011, pp. 258–259). These criteria were adapted from the Lifetime Care and Support Scheme in New South Wales and are echoed in the NDIS Act s. 34(1) (discussed above).

However, the NDIS's legislative regime is different to that of the Lifetime Care and Support Scheme — and the scheme contemplated in PC (2011) — in two subtle ways.

- While the NDIS Act repeatedly refers to 'reasonable and necessary supports', it does not explicitly state that individualised supports funded under the NDIS must be or assessed to be 'reasonable and necessary'. (That said, such a requirement may be implied by the text of the legislation.) By contrast, the Lifetime Care and Support Scheme explicitly requires a direct assessment of what treatment and care needs are reasonable and necessary in the circumstances (*Motor Accidents (Lifetime Care and Support) Act 2006* (NSW) ss. 11A, 23).
- The considerations outlined in the NDIS Act s. 34(1) are not framed as criteria exclusively for deciding whether a support is reasonable or necessary. Instead, they are considerations for deciding whether *any* type of support (that is, general *or* individualised) may be provided to scheme participants. The NDIS Act does not explicitly provide a schema for determining whether a support is reasonable and necessary.

On this basis, there may be scope for additional and specific legislative guidance on whether and how the NDIA should apply the 'reasonable and necessary' test.

INFORMATION REQUEST 4.1

Is the National Disability Insurance Scheme Act 2013 *(Cwlth) sufficiently clear about how or whether the 'reasonable and necessary' criterion should be applied? Is there sufficient clarity around how the section 34(1) criteria relate to the consideration of what is reasonable and necessary?*

Is better legislative direction about what is reasonable and necessary required? If so, what improvements should be made? What would be the implications of these changes for the financial sustainability of the scheme?

Putting 'reasonable and necessary' into practice

Some study participants identified issues with operationalising the concept of 'reasonable and necessary'. One particular concern is that there are different perceptions about what supports are reasonable and necessary (Flourish Australia, sub. 74, p. 5; PDA, sub. 38, p. 9). Alzheimer's Australia, for example, said:

> In our experience, there are large variances in what is considered 'reasonable and necessary' in relation to assessment planning. For example, one person with younger onset dementia was

> assessed and given horse riding lessons, while another person was not allowed bathroom aids. There also needs to be an oversight and improvement process that monitors how an assessor or planner determines what is considered 'reasonable and necessary'. (sub. 10, p. 13)

The NDIA (sub. 161, p. 92) also acknowledged that 'there is still confusion within the sector and the community, and to some extent within the NDIA, around the scope of reasonable and necessary supports'.

Flexibility around the concept of 'reasonable and necessary' allows scheme participants to exercise choice and control, and to be innovative in terms of supports. As the NDIA explained:

> Decisions around reasonable and necessary supports require balancing the need to empower participants to explore different ways of achieving increased participation with the need to spend taxpayers' money consistent with legislation and in a way that minimizes risk of misuse or fraud. (sub. 161, p. 92)

However, Physical Disability Australia argued:

> … what is 'reasonable and necessary' also needs to be elucidated with many benchmark examples so that planners and participants can approach planning conversations with similar frames of reference. (sub. 38, p. 8)

The NDIA has operational guidelines, practice guides, work practices and task cards to help planners exercise their judgment about what is reasonable and necessary. The NDIA indicated that it intends to update these to reflect outcomes of court and tribunal decisions and planners' experiences.

4.2 About plans and the planning process

Supports are allocated to scheme participants through a plan, which is prepared through conversations between a planner and the participant. As the NDIS Act (s. 31) states, where practicable, the development of a plan should be individualised, directed by the participant and maximise participant choice and control.

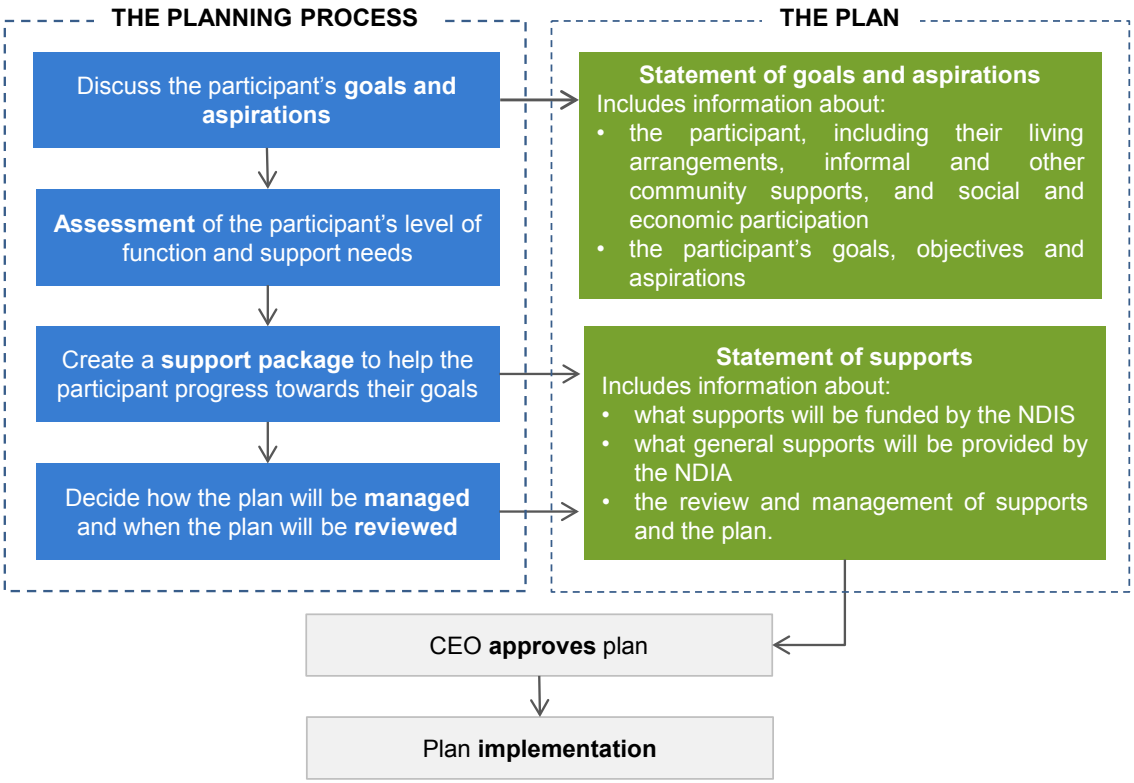
The planning process involves several steps (figure 4.1), designed to elicit information about the scheme participant, which is used to inform the content of the plan.

1. The participant and planner discuss the participant's goals and aspirations. This conversation is used to help put together a statement of goals and aspirations, which includes information about the participant, including: their living arrangements, informal and other community supports, and social and economic participation, as well as their goals, objectives and aspirations.
2. The NDIA conducts or considers assessments of how the participant is performing in different areas of their life ('level of function' or 'functional capacity'), including their 'activity limitations, participation restrictions and support needs arising from [the]

participant's disability' (*National Disability Insurance (Supports for Participants) Rules 2013* (Cwlth) r. 4.1), and identifies areas where the participant requires support.

3. A support package is put together to help the participant progress towards their goals. The support package may include general supports, as well as reasonable and necessary supports, and is set out in a statement of supports.
4. The planner and the participant decide when or under what circumstances the plan will be reviewed. They also decide how the plan will be managed (such as self-management, management by the NDIA, or using a plan management provider), including whether support coordination is required. (Plan management and support coordination are discussed in chapter 8.) This information is also included in the statement of supports.
5. Before the plan is finalised, it must be approved by the CEO of the NDIA (or a delegate).

Figure 4.1 **Making a plan**



For most people, their first plan is completed over the phone, although some planning conversations do take place face to face (NDIA 2016e, p. 1).

Assessment and tools

The assessment process is about evaluating the scheme participant's level of function and identifying the supports that will allow them to progress towards their personal goals and aspirations. Choosing the right tools for the job is challenging, as there is no universally agreed assessment tool for evaluating the care and support needs of people with disability. There are, however, several features that an assessment tool should have (box 4.3).

Box 4.3 Desirable features of assessment tools

To ensure the sustainability of scheme costs, it is important that assessment tools are:

- *valid* — the tools should test what they purport to and provide a basis for accurately identifying the nature, frequency and intensity of a person's support needs. Assessment tools that are not appropriate could threaten scheme sustainability.
- *reliable* — the tools should yield consistent measures across time, individuals and situations; results should not be influenced by when or where the assessment is undertaken, who is undertaking the assessment, or the identity of the individual per se.
- *accurate* — the tools should reduce the risk that assessors and individuals overstate or understate their support needs.
- *efficient* — an efficient tool is one that collects sufficient information to assess support needs in the least costly manner.

Assessment tools also need to be continually monitored and refined to ensure that they remain in line with scheme objectives, and keep pace with evolving best practice and community expectations.

Source: PC (2011, pp. 315–320).

Since the commencement of the NDIS, the NDIA has used several different assessment tools as part of the planning process (box 4.4).

Feedback about the NDIA's use of assessment tools was mixed.

- Some study participants were critical of the NDIA's assessment tools, but it was sometimes unclear which specific tools they were referring to (ABF, sub. 48; Alzheimer's Australia, sub. 10; Belinda Jane, sub. 80; Macarthur Disability Services, sub. 57; Queensland Advocacy Incorporated, sub. 115).
- Other study participants were critical of how certain tools were used, particularly in relation to early childhood and early intervention (chapter 3). For example, the AEIOU Foundation (sub. 32, p. 8) said that PEDI-CAT is not appropriate for children with intellectual disability. The Shepherd Centre (sub. 107, p. 12) made a similar observation about young children with hearing loss. Others questioned whether NDIA staff had been adequately trained to apply the PEDI-CAT tool (Early Intervention Australia Victoria/Tasmania, sub. 129, p. 10; Noah's Ark, sub. 108, pp. 10–11).

Box 4.4 The evolution of NDIS assessment tools

The National Disability Insurance Agency (NDIA) has undertaken significant work to identify appropriate assessment tools for identifying the support needs of scheme participants.

- *Mid-2013*: the NDIA commenced delivering the National Disability Insurance Scheme without an assessment tool, as none was available.
- *Late 2013*: adoption of the Support Needs Assessment Tool (SNAT). The SNAT attempted to identify functional support needs through a planning discussion, and provided the participant with a detailed, personalised support plan. After the first year of trial, it became apparent that the SNAT was not fit for purpose.
- *Late 2014*: further work on identifying appropriate assessment tools. This entailed a survey of functional assessment tools used around the world, and evaluating these tools for relevance, usability and reliability. The cost of acquiring and using these tools was also a crucial consideration. The process included extensive consultation and engagement with key stakeholders and experts across the key disability types, including clinical experts and researchers, and disability associations.
- *Mid-2015*: identification and testing of a new suite of assessment tools. This included different tools for 11 key disability types, and the World Health Organization Disability Assessment Schedule version II (WHODAS II) where no specific tool was identified.
- *Mid-2016*: adoption of the new suite of assessment tools. The NDIA has the capability to administer some of these assessments tools in house, but they can also rely on assessments performed by specialists.

Considerable work around assessment tools remains to be done. For example, the NDIA still has no tool for evaluating the support needs of people with psychosocial disability. Engagement with representatives in the mental health sector on this point is ongoing.

Source: NDIA (sub. 161, pp. 9–11).

But many study participants said that they were unable to obtain information about what assessment tools the NDIA uses (including tools for assessing level of function). Physical Disability Australia said this made it difficult to comment on the appropriateness of assessment tools.

> Information about assessment tools is scarce on the NDIS website … Furthermore, there is no mention of them on the pages dealing with planning processes and planning conversations. It is therefore difficult for [Physical Disability Australia] (or anyone) to comment on them as it is not clear which assessment tools are being used and by whom. (sub. 38, p. 7)

The Centre for Disability Studies also said:

> A major barrier to the on-going improvement and implementation of the NDIS is the lack of access to, or public domain information on the assessment tool(s) in use by the National Disability Insurance Agency … we do not see why the assessment tool itself is not public domain, unless for commercial copyright reasons. Many support needs assessments in use across jurisdictions are in the public domain, or are available upon purchase or enquiry. (sub. 49, p. 2)

The NDIA is required to specify what assessment tools it uses in its operational guidelines (*National Disability Insurance (Supports for Participants) Rules 2013* (Cwlth) r. 4.4), which must be published and kept accurate, up-to-date and complete (*Freedom of Information Act 1982* (Cwlth), ss. 8, 8A, 8B). But, in practice, study participants' knowledge about what assessment tools the NDIA uses appears to be sourced indirectly, through word of mouth or via experiences with the planning process. Information about the role of assessment tools in the planning process could also help participants understand how or to what extent assessment tool results influence the supports that they receive.

The first plan process

As discussed in chapter 2, the NDIA has identified increasing package costs (over and above the impacts of inflation and ageing) as a source of cost pressures. The NDIA developed reference packages to assist with monitoring scheme experience and assessing cost pressures (box 4.5). Reference packages are based on age, disability type and level of function. Reference packages can also help improve equity in the scheme by giving clearer guidance on 'typical' arrangements.

Box 4.5 Reference packages

Reference packages are an 'indicative' support package, developed as a way to identify typical support needs and funding for different cohorts of scheme participants.

The National Disability Insurance Agency currently uses a suite of assessment tools for evaluating scheme participants' level of function, covering 11 key disability types (box 4.4). The reference package cohorts are based, in part, on these 11 disability types. They are also based on age and level of function.

Reference package data were tested and validated using:

- back-captured data — that is, data about previous support packages
- expert groups in each of the 11 disability categories — these groups included academics, consumers and providers.

Back-captured data and the work of expert groups were also used to identify how different variables impact the value of support packages. This information allowed the Scheme Actuary to validate the assessment tools, and develop a basis for determining 'reasonable and necessary' funding at an aggregated level.

Work to refine reference packages is ongoing. For example, no reference package is currently available for people with psychosocial disability. Reference packages also have limited utility where a person has more than one disability and the secondary disability is an important contributor to support needs. As more data are collected, reference packages will become more sophisticated and better informed by actual experience.

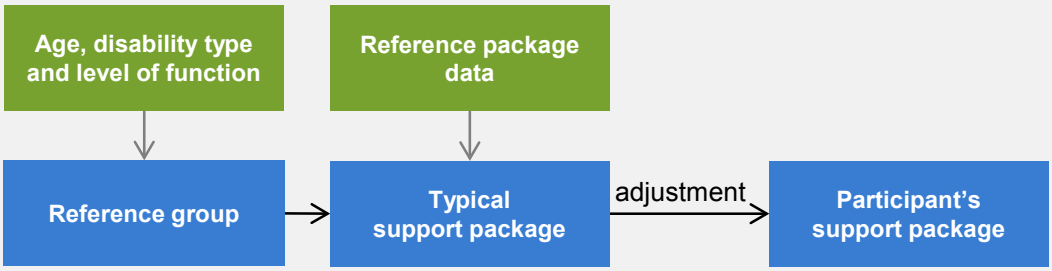
Source: NDIA (sub. 161, pp. 10–11).

Based on the learnings from trial, the NDIA adopted a new approach to determining support packages — the 'first plan process'. The first plan process uses reference package

data to assign scheme participants a 'typical support package' based on their age, disability type and level of function. This is adjusted to account for the individual support needs of participants to create the participant's plan (box 4.6).

Box 4.6 The first plan process

The first plan process was introduced on 1 July 2016. Scheme participants are first allocated a 'typical support package', based on their reference group (which is determined by their age, disability type and level of function). The typical support package may include funding across the following eight core domains: daily activities; social participation; consumables; transport; home modifications; assistive technology; capacity building; and support coordination.



For each participant, the level of funding is adjusted according to the participant's circumstances. This is done using a questionnaire, which asks the participant about each of the domains, including what supports they already have in place and whether these are sufficient and sustainable. For example, where it is reasonable that sustainable informal, community or mainstream supports continue to assist the participant, or where the participant believes that other informal, community or mainstream supports may provide a better outcome, funding is adjusted in the participant's support package.

Source: NDIA (sub. 161, pp. 10–11).

Balancing different considerations

A number of study participants argued that the use of reference package data is at odds with person-centred planning and that it limits choice and control during the planning process (AASW, sub. 124, p. 4; Down Syndrome Australia, sub. 121, p. 7; Flourish Australia, sub. 74, p. 13; Lifestart Co-operative, sub. 97, p. 9). ACT Disability, Aged and Carer Advocacy Service (sub. 87, p. 14) said that the approach 'carries inherent risks that planners (and assessment tools) will overly rely on reference plans as opposed to taking a person-centred approach'.

A person-centred or individualised approach to planning is central to the NDIS. The scheme is about matching participants with the supports that are right for them; however, this needs to be done in the context of the sustainability of the scheme and achieving a consistent approach to funding packages.

During the first year of trial, a highly detailed and person-centred approach was taken to planning, but according to the NDIA it was found not to be fit for purpose.

> [The] Support Needs Assessment Tool (SNAT) was a construct that attempted to identify functional support need and through a planning discussion using the tool to provide the participant with a detailed personalised support plan. The SNAT was used throughout the first year of trial. However, at the end of this period, it had become apparent that the SNAT was not fit for purpose. While the SNAT delivered an individualised outcome, there was no correlation of the SNAT to the reference packages upon which the funding of the Scheme was based. (sub. 161, pp. 9–10)

While some scheme participants expressed greater satisfaction with processes during trial (for example, Down Syndrome Australia, sub. 121), according to the NDIA (sub. 161, p. 10), it led to 'highly prescriptive plans that provided detail at the daily and sometimes the hourly level minimising the flexibility for participants to exercise choice and control'.

The first plan process, introduced in 2016, sought to improve the approach taken at trial by enabling people greater flexibility in how they used their funds against goals and outcomes that they identified. It also sought to address the issues of consistency between support packages by providing guidance to planners about what support packages for different groups should look like.

The challenge for the future of the planning process is to find the right balance between individualisation and good outcomes for scheme participants on the one hand, and ensuring equity among participants and the financial sustainability of the scheme on the other. It is likely to be some time before the right balance is struck.

A dynamic process

As with all insurance-based schemes, the tools and processes for handling and assessing claims are a matter of ongoing refinement. This is necessary to ensure that the insurance scheme remains 'on track' and is viable in the long term. Dynamic processes are also important to allow the scheme to adapt to changing circumstances or incorporate information that becomes newly-available over time.

Part of this process is ongoing monitoring and evaluation (chapter 9). The NDIA undertakes internal monitoring of its processes.

> The first plan process is a dynamic process which will include ongoing refinement as more data and information becomes available. The process allows continuous monitoring of committed support and utilised support, with benchmark costs. As the NDIS moves through transition, the NDIA is continually monitoring and seeking opportunities to enhance the planning process from a participant, provider and staff perspective. The NDIA is currently reviewing the plan review process to streamline the process and ensure it continues to meet the needs of both the participants and Scheme sustainability. (sub. 161 p. 89)

The COAG Disability Reform Council has also undertaken to review the first plan process at the end of June 2017 (DRC 2016). This review should consider whether the first plan process strikes the right balance between individualisation and ensuring equity across participants, and whether the process helps ensure that the scheme is sustainable in the long term.

Information about how the planning process works is important

Many study participants were unsure or unaware of how the first plan process operates. Scope Australia (sub. 72, p. 15) suggested that this was because 'communication from the Agency and its contractors has been inconsistent and at times poor'.

A number of study participants were unsure or mistaken about:

- what the first plan process was
- the rationale for adopting the first plan process
- whether or to what extent support packages were adjusted for individual circumstances
- whether or how supports received under legacy programs were taken into account.

With evolving processes, it is important that scheme participants and their families and carers can access accurate and up-to-date information about the planning process. ACT Disability, Aged and Carer Advocacy Service (sub. 87, p. 14) said, 'we would encourage a transparent and rigorous approach to consideration of benchmarking and reference plan topics'. Clear messaging about how and why things are changing is also important for maintaining the credibility of evolving planning practices.

Plan reviews

Usually, plan reviews occur as part of the planning cycle — that is, at the expiry of a scheme participant's previous plan (usually after 12 months). However, unexpected plan reviews can be triggered if the scheme participant changes their statement of goals and aspirations or requests a plan review (NDIS Act, ss. 47–48). Often plan reviews are initiated by the scheme participant because their supports do not, or cease to, meet their needs or expectations. Changes to a plan may also be required if information in the plan is incorrect or missing.

Currently, any changes to a plan require a full plan review. Several study participants advocated to allow plans to be amended or varied without triggering a full review (Blind Citizens Australia, sub. 130, p. 5; MND Australia, sub. 45, p. 3; Woden Community Service, sub. 159, p. 10).

Full plan reviews can be time-consuming and costly, and scheme participants may also be unable to access the supports they need while they wait for their plan to be reviewed (CPSU, sub. 76). A process for amending or adjusting plans would improve the cost effectiveness of review processes, especially when the proposed changes to the plan are minor (Jacqueline Pierce and Associations, sub. 147, p. 5).

Some also suggested that amendment processes could be used to manage supports for participants when needs change quickly — such as in the case of episodic or degenerative disorders (ABF, sub. 48; MND Australia, sub. 45). However, where there has been a

significant change in the participant's circumstances, it may be most appropriate to undertake a full plan review (provided it is undertaken with sufficient expediency).

The role of Local Area Co-ordinators in the planning process

In some areas, planning discussions are conducted and plans are prepared by Local Area Co-ordinators (LACs). However, under current legislative arrangements, LACs do not have the power to approve plans; that is, plans prepared by LACs must still be approved by the NDIA.

The NDIA (sub. 161) suggested that there may be some benefits to allowing approval functions to be delegated to LACs. This could lead to efficiencies in plan administration as it would reduce double-handling of plans by LACs and the NDIA. The NDIA also said that delegating approval functions could lead to greater certainty for scheme participants.

> More importantly, it would improve the experience of participants by allowing the LAC, while in discussion about support needs and within defined parameters and agreed reporting and monitoring arrangements, to be able to confirm the level of reasonable and necessary funding and move straight to a discussion on plan implementation. (sub. 161, p. 13)

However, there are risks associated with allowing the NDIA to delegate its plan approval functions to LACs.

- Delegating plan approval functions could reduce the NDIA's control and oversight over plans and allocated supports. This could compromise scheme sustainability and the realisation of outcomes within the scheme.
- Transferring additional functions to LACs may limit their capacity to perform other important functions, due to time and resource constraints. It could also lead to conflicts of interest (real or perceived) between different roles — for example, it may compromise LACs' ability to provide impartial pre-planning support.
- Sharing approval functions between the NDIA and LACs may reduce clarity and transparency around roles and responsibilities, particularly if approval functions are delegated to some LACs but not others. There is also a risk that it could reduce or obfuscate the NDIA's accountability for plans and allocated supports.

The Commission is seeking feedback on whether the NDIS Act should be changed to allow the NDIA to delegate plan approval functions to LACs — and, if so, how the risks of doing so might be managed.

INFORMATION REQUEST 4.2

Should the National Disability Insurance Agency have the ability to delegate plan approval functions to Local Area Coordinators? What are the costs, benefits and risks of doing so? How can these be managed?

4.3 How is the planning process tracking?

Good planning processes are essential for the success of the scheme and long-term sustainability, as the quality of the planning process has a bearing on what costs are incurred in the scheme, the predictability of scheme costs and the integrity of the scheme (box 4.7). The Northern Territory Government said it considers the planning process to be one of the most important elements of the scheme.

> The quantity of supports received by participants is a key driver of costs, and therefore a consideration for the ongoing financial sustainability of the Scheme. However, without a high quality planning process which supports participants to identify and work towards their goals and aspirations, choice and control for participants will not be achieved. (sub. 205, p. 3)

The planning process has not been operating well. The Commonwealth Ombudsman (sub. 137, p. 7) reported that the planning process is one of the main sources of complaints to the office.

Participants to this study also expressed dissatisfaction with planning processes. In particular, participants expressed concern about:

- the lack of consultation and engagement with scheme participants
- the accessibility and transparency of processes and planners
- the quality of planners (including LACs undertaking planning functions).

Study participants overwhelmingly considered that poor planning processes have compromised the quality of plans. As a result, plans are not meeting scheme participants' needs or expectations, and sometimes include supports that they do not want or need (Macarthur Disability Services, sub. 57, p. 4). Several study participants also reported that there was considerable variability in plans for scheme participants with similar needs (Macarthur Disability Services, sub. 57, p. 4; Neami National, sub. 63, p. 3; PDA, sub. 38, p. 8; PDCN, sub. 29, p. 3). For example, Brain Injury SA said:

> Brain Injury SA is aware of one household with multiple children with similar needs. Each child had a different planner and each plan provided funding for different services. In another instance, involving twins with developmental delays and similar levels of need, the plan for one child included support coordination while the plan for the other child did not. (sub. 116, p. 5)

The NDIS is a major reform and the NDIA has been given a monumental task under highly ambitious timeframes and a resource-constrained environment. Many of the NDIA's decisions about how to operationalise the planning process have been influenced by bilateral estimates and community expectations around reaching new participants quickly. In addition, planning processes have had little time to mature.

However, there is real concern that some of the practices adopted to address the pressures of rollout will become entrenched in practice and in the culture of the NDIS, with implications for the long-term costs and benefits of the scheme.

Box 4.7 Why are good planning processes important?

Outcomes, benefits and equity

As discussed in chapter 1, financial sustainability is not just about costs. It is also about whether outcomes are being realised, and whether those who are paying for the scheme remain willing to do so (NDIA 2016j).

Poor planning processes can mean that scheme participants are allocated supports that are not right for them. This can mean that many of the benefits of the scheme (such as increased quality of life, greater social and economic participation, and reduced need for other or future supports) are not fully realised. Poor planning processes can also result in greater variability in plans and outcomes for scheme participants with similar needs, compromising equity within the scheme. Together, these factors can undermine the credibility of, and community support for, the scheme as a whole — and hence its long-term sustainability.

Costs associated with reviews

Poor planning processes can result in plans that do not reflect the needs or expectations of scheme participants. This can place greater stress on review processes.

Increased requests for plan reviews can add to the workload of planners. Review processes can also place greater stress on scheme participants and providers. As Occupational Therapy Australia said:

> … reviews can take months to complete, resulting in added frustration for families and potentially affecting the relationship between participant and provider. (sub. 15, p. 5)

Greater use of review processes can increase the administrative costs of the National Disability Insurance Agency, as well as costs in other areas. For example, appeals to the Administrative Appeals Tribunal or the Federal Court of Australia place a greater burden on the justice system (chapter 9).

Certainty about costs

Poor planning can introduce additional uncertainty about scheme costs (New South Wales Government, sub. 60, p. 15; PDA, sub. 38, p. 9).

- Poor planning processes can be unreliable — that is, they do not yield consistent results across time, individuals and situations. This increases the variance in the value of support packages, increasing the unpredictability of scheme costs overall.
- Poor planning increases the likelihood that participants' plans do not match their needs and expectations. This can contribute to underutilisation of plans, driving a wedge between committed and actual support funding.

Greater uncertainty around scheme costs can undermine the accuracy of cost projections, which can make it difficult for governments to plan for the future of the scheme. High variability of scheme costs also increase the risk of cost blowouts.

The following sections discuss the key concerns raised by study participants, and policy options for ensuring poor practices do not become structural issues that continue to affect the operation of the NDIS in the medium and long term.

Engagement with scheme participants

Engaging with scheme participants during the planning process is important not only for ensuring that they receive the supports that are right for them, but also for the long-term success of the NDIS. Physical Disability Australia suggested that engaging with scheme participants is particularly important in the early stages of planning.

> Given that many planners are new to this type of work and may have limited lived experience of disability, the validity, reliability and accessibility of the processes they use to determine what constitutes an appropriate support package depends on deep engagement with participants, their families and supporters. (sub. 38, p. 7)

The planning process needs to be sufficiently 'deep' so that planners can obtain sufficient information about a participant for them to make a decision about reasonable and necessary supports that minimise lifetime costs, while also making the process person-centred and convenient for scheme participants and their carers. Involving families, carers, support workers and advocates in the planning process can also improve understanding of the functional impact of the participant's disability, their needs and the supports that they require (VCOSS, sub. 176, p. 16).

Concerns about rushed planning

The speed of transition, as set out in Bilateral Agreements, has placed a lot of pressure on the NDIA to finalise plans quickly. This has detrimentally affected the quality of the planning process. SCIA Australia said:

> The rush to get new participants into the scheme against bilateral agreements is proving to be a major headache for the Agency and is severely affecting the quality of first plans. (sub. 61, p. 3)

Similarly, United Voice said:

> Workloads and inadequate time to do the job is one of the most often cited concerns of our members. United Voice members are concerned that [planners] do not have time to do their job properly, that they rush from client to client preventing them from providing quality support. (sub. 118, p. 8)

Study participants also reported feeling that planning meetings are rushed (Flourish Australia, sub. 74, p. 3; Hannah Potapczyk, sub. 26, p. 1; Leadership Plus, sub. 128, p. 2; Maurice Blackburn Lawyers, sub. 58, p. 13; New South Wales Government, sub. 60, p. 15; University of Sydney, sub. 55, p. 3). Engagement with scheme participants during the planning process appears to be fairly superficial, and the NDIA accepted that the focus on throughput during the first two quarters of transition has contributed to poorer plans (sub. 161, p. 11).

Phone planning

Most planning conversations are now taking place over the phone, although face to face meetings are accommodated if required. The NDIA (sub. 161, p. 12) explained that this was a deliberate decision to allow people to enter the scheme as quickly as possible, with provision for scheme participants to consider how they will use their supports and amend their goals over the first year.

This decision was based on trial experience that recognised that people want to join the scheme as soon as they can, but also want time to think about their goals, supports and how they will use them. While it is recognised that this approach is not perfect, it was designed as a short-term measure to meet both of these objectives (NDIA, sub. 161, p. 10).

Study participants overwhelmingly expressed dissatisfaction with this approach to planning,[17] and many provided examples of poor experiences (box 4.8).

Carers Australia Victoria also identified issues with:

> … limited access to supporting documentation whilst on the phone; limited time to properly consider goals and aspirations; confusion about who they are being contacted by and for what; whether the plan will be as comprehensive as it could have been if the participant had the opportunity for a face-to-face meeting; the ability for the planner to recognise opportunities for capacity building. (sub. 131, p. 8)

Some felt that phone planning limits engagement with the scheme participant and does not allow the planner to see the full picture. For example:

> [Phone planning] is a transactional and blunt approach at a critical stage of a participant's navigation and interaction with the scheme … We feel utilization of phone-planning also creates assumptions of living situation by planners, who are unable to adequately capture the requirements and considerations of participants and respect the role of family, carers and other persons who are significant in the life of the participant. (Social Support & Precarious Workforce Research Discussion Group, sub. 71, pp. 2–3)

[17] Study participants who were critical of phone planning included: ADACAS (sub. 87); AHPA (sub. 37); Alzheimer's Australia (sub. 10); Brain Injury SA (sub. 116); Carers Australia Victoria (sub. 131); CMHA (sub. 9); ECCV (sub. 31); Flourish Australia (sub. 74); Jacqueline Pierce and Associates (sub. 147); Macarthur Disability Services (sub. 57); Mental Health Community Coalition of the ACT (sub. 135); OTA (sub. 15); PDCN (sub. 29); PDA (sub. 38); The Shepherd Centre (sub. 107); Social Support & Precarious Workforce Research Discussion Group (sub. 71); VCOSS (sub. 176); VMIAC (sub. 167).

Box 4.8 Experiences with phone planning

Alzheimer's Australia:

> Annie called the Parkinson's 1800 support line as she worried about an over the phone NDIS planning session that had taken place earlier that day. Annie's volume and quality of speech has been impaired due to Parkinson's and she also requires longer to respond to questions. She felt rushed and because her response is delayed she felt that the assessor didn't get a clear indication of her needs. Annie and a Parkinson's Nurse Specialist were able to take the time [to] put information together in order to apply for a review for Annie's plan. (sub. 10, p. 8)

Ethnic Communities' Council of Victoria:

> … anecdotal evidence from advocates and providers in the North Eastern Melbourne Region indicates that some participants are not being adequately informed about the purpose of phone contact by the NDIA or their LAC. These participants are having plans being completed without realising that they are engaging in the process or providing informed consent. (sub. 31, p. 1)

Carers Australia Victoria:

> I received a telephone call from an NDIA representative and requested a face-to- face meeting … The planner requested information regarding my son and said there were notes from his case manager which would be used to help create his plan. I inquired about the case manager, as I was not aware my son had one. The name given was of a man I had spoken to about 20 years ago. The planner said they have all his needs documented. I reiterated the need for a face-to-face meeting to discuss our changing circumstances and the support that my son needs to live independently and future support needs. I was offered a meeting three days later, 90 km from my home, which was not possible for me to attend. When I received a follow up call, I thought it was to schedule another time for a meeting, instead it was to tell me that a plan had been created for my son and that I should login to the Portal to see it. A week later I received a copy of the plan in the mail. The plan contained information about my son from over 20 years ago. (sub. 131, p. 9)

And:

> … an assessment completed by phone does not take the person's disability into account and fails to provide the added awareness and accommodation that are possible in a face-to-face meeting. Planners ask questions over the phone, which sometimes assume ability that does not exist. However, this is not evident to the planner because they are not with the person being assessed. They also lack the ability to make observations about the situation of the participant at the time of the phone call, which may involve distractions. (Brain Injury SA, sub. 116, p. 9)

Blind Citizens Australia (sub. 130, p. 3) also said that conducting meetings over the phone 'severely compromises the ability of people who are blind or vision impaired to demonstrate the difficulties they may face with completing tasks like reading, navigating the environment or household chores'.

Others expressed concern that phone planning takes scheme participants by surprise or does not allow participants to be supported by family, carers or advocates (Flourish Australia, sub. 74, p. 12). Physical Disability Council of New South Wales said:

> Phone plans to do not allow for participants to be supported simultaneously by carers or other important parties; physical sharing of important resources such as weekly planners or aspirational plans; equal access for peoples with specific communication needs; or allow

> planners to observe physical cues and surroundings for possible supports or equipment needs. (sub. 29, p. 3)

Phone planning is especially problematic for scheme participants with particular accessibility requirements (discussed below), such as mental illness (CMHA, sub. 11, p. 6; Flourish Australia, sub. 74, p. 3), cognitive impairment and neurodegenerative diseases (Alzheimer's Australia, sub. 10, p. 5) or people of culturally and linguistically diverse backgrounds (ECCV, sub. 31, p. 1; VCOSS, sub. 176, p. 11).

The Commonwealth Ombudsman reported that the bulk of complaints he had received about the planning process were from people who participated in phone planning. The Ombudsman suggested that it would be useful to compare the outcomes, satisfaction and review rates of face to face and phone planning discussions, noting that:

> While phone meetings likely provide the most cost effective method for planning when only simple administrative overheads are considered, there may be merit in considering whether — if participants who have phone meetings are likely to subsequently complain or seek review — the time spent on those subsequent interactions detracts from the cost effectiveness of planning by phone. (sub. 137, p. 8)

Consulting with participants about plan content

Consulting with scheme participants and their family, carers and advocates is essential to the success of the planning process. However, the Commission heard that, in many instances, scheme participants were not consulted about the content of their plan.

In particular, scheme participants were not permitted to view plans before they were finalised. National Disability Services explained:

> During the trial phase of the NDIS, participants were invited to comment on their draft plan before it was finalised. That practice has largely ceased. The consequence is that participants can end up with a plan that doesn't reflect their needs and goals. Some participants receive plans they don't recognise. Consistent with the NDIS's focus on choice and control, participants should always have the opportunity to comment on their plan before it is finalised. (2017a, p. 7)

And Community Mental Health Australia said:

> Clients are generally not permitted to see a plan before it is finalised, which anecdotally providers state is hindering clients understanding of their plan … There are incidents where people don't know what they are going to get until the plan is submitted — and there is currently no opportunity to take time to consider the plan before it is finalised. (sub. 11, pp. 3, 11)

The lack of participant involvement is not confined to first plans. Several study participants said that consultation around subsequent plans was also inadequate, and reported that first plans were simply being 'rolled over' (CPSU, sub. 76, p. 9; Health Services Union,

sub. 132, p. 12). For example, the Summer Foundation recounted a mother's experience with her child's third plan.

> No actual review took place and her daughter received a 'form' letter advising that her plan would continue 'as was' for the next 12 months and if she required any changes to apply for an internal plan review within 3 months of receiving this letter! This letter was not even signed! (sub. 113, p. 21)

Conversely, others said that requests to have a plan rolled over were ignored.

> In February I was contacted by an NDIA employee to have my plan review early. I tried to ask for it to be rolled over as I had not been able to fully activate the plan. I explained about the portal being down for months which was experience[d] by a large number of service providers. This person would not consider this and proceeded to state I was to be reviewed by phone. (Tricia Curley, sub. 140, p. 4)

Under the current timetable, the NDIA is required to complete a large number of plans in a relatively short period of time, and this has influenced how planning processes are undertaken. However, it is essential that the NDIA undertakes its planning function adequately and in a way that does not undermine the objectives of the scheme. An increased focus on the quality of the planning process will no doubt make it more difficult for the NDIA to keep to the timetable set out in the Bilateral Agreements. But if the quality of plans is compromised because of a focus on participant numbers, this will undermine the effectiveness of the scheme and have implications for long-term costs.

For this reason, in the medium to long term, it is important that the NDIA's performance is measured in relation to whether and how effectively it is realising outcomes under the NDIS, rather than participant numbers alone (chapter 9). A greater emphasis on reporting on the quality of planning processes would help shift the focus towards better quality plans and give the NDIA the incentive and latitude to focus on participant experience and outcomes.

Accessibility of the planning process

A lack of clear and transparent information

Study participants expressed frustration about the lack of clarity and transparency around the planning process (Autism Aspergers Advocacy Australia, sub. 178, p. 19; DPO Australia, sub. 165, p. 13; Flourish Australia, sub. 74, p. 11; Mamre Association, sub. 47, p. 1; Mental Health Community Coalition of the ACT, sub. 135, p. 19; Noah's Ark, sub. 108, p. 10; SWAN Australia, sub. 86, p. 1). Limited information is publicly available to help scheme participants and their families, carers and advocates to navigate the system. Noah's Ark, for example, said:

> … there is no information about the planning process and how it is supported in the public domain. There has been a significant change in how plans have been written. These changes have not been documented or an explanation provided. (sub. 108, p. 9)

Mamre Association also identified problems with:

> The lack of consistency with clear, concise and factual information. It is often left up to the general disability sector to try to navigate their way through 'forensic' investigation as to what the information means. There simply is very little capacity within the sector itself to invest in something so time consuming. (sub. 47, p. 1)

Poor information can be especially stressful for scheme participants who do not have the time or capacity to navigate a complex and confusing system.

Scheme participants are also often not aware or informed about their rights and options. For example, some participants did not know that they could request a face to face planning meeting instead of phone planning (ADACAS, sub. 87, p. 15; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 3).

Participants were also often unaware of their entitlement to have an advocate present at their planning meeting, which can negatively affect outcomes for participants with limited ability to self-advocate (ABF, sub. 48, p. 9; New South Wales Government, sub. 60, p. 15). Brain Injury SA also identified problems with the failure to provide information about review processes.

> … information provided to participants about review is unclear and inadequate. There is minimal information about the process and no information about how or where participants can get help with a review … Further, Brain Injury SA has received anecdotal evidence from parents and guardians that NDIA has not been informing participants of their right to an internal review or external merits review through the [Administrative Appeals Tribunal]. (sub. 116, pp. 9–10)

Planners are not easily reachable

Study participants also felt that planners were not identifiable and accessible to scheme participants (AHPA, sub. 37, p. 14; Disability Services Commissioner, sub. 35, p. 5; OTA, sub. 15, pp. 4–5). The Disability Services Commissioner said:

> Planners are not clearly identifiable and accountable. A participant told us that the planner got his plan wrong and he couldn't call the planner directly to talk about the issue. He raised further concerns that no one at the NDIA records his calls, so he feels he cannot escalate his complaint, as there is no record of his previous contact. (sub. 35, p. 5)

Brain Injury SA also said:

> The 1800 phone number is the only number provided to participants and service providers. Anyone wanting to speak to a planner, even in response to a message that has been left by the planner, must use this number … there is usually a 45 minute wait for calls to be answered. When the call is answered, there is no certainty that the call will be transferred to the relevant office or planner. (sub. 116, p. 10)

Planning processes are not inclusive for all

It is important that planning processes are accessible, inclusive, and sufficiently flexible to accommodate the needs of different scheme participants. This is especially true for participants with complex needs or from culturally and linguistically diverse backgrounds. For example, the New South Wales Government said:

> Many NDIS participants that are participants of other state services (justice, mental health) do not have the capacity or capability to interact with the NDIS without intensive support. They may have no natural supports, like family or friends in their lives; they may have family that do not support their best interests; or they may have limited experience as consumers generally and may not be able to exert their rights as participants in the NDIS. Some people with complex needs may not be able to define their needs or understand what reasonable and necessary supports they would need to support them. (sub. 60, p. 17)

Planning processes also need to be sensitive to the intersection between disability and other social issues, such as homelessness, family violence, and alcohol and other drug use. Study participants also highlighted the importance of providing gender-responsive services (ACT Government, sub. 156, pp. 28–9; DPO Australia, sub. 165, p. 15; Leadership Plus, sub. 128, p. 2; Richard Kennedy, sub. 2, p 2; VCOSS, sub. 176, p. 10; Women with Disabilities Victoria, sub. 111, p. 2).

Needs arising from disability

Many study participants said that planning processes are not inclusive and overlook the needs of people with disability. Sharing Places said:

> People with intellectual disabilities and very high and complex support needs are not understood by NDIA. People with high and complex needs would greatly benefit from a more in depth assessment and planning process. (sub. 53, p. 2)

Communication accessible processes are also important for people with vision or hearing impairment (ABF, sub. 48, p. 9; Deafness Forum of Australia, sub. 127, pp. 16–7; Speech Pathology Australia, sub. 136, pp. 28–9). But Australian Blindness Forum said:

> … participants in the NDIS cannot access any NDIS information in alternative formats. This means that people who are blind or vision impaired cannot independently register themselves with the NDIS or read their own plans. (sub. 48, p. 9)

Planning can also be challenging for people whose needs can change quickly — such as episodic or progressive disorders. Study participants identified psychosocial disability (box 4.9) and degenerative disorders (box 4.10) as particular problem areas.

Box 4.9 Mental illness and psychosocial disability

The National Disability Insurance Scheme is designed to cover disabilities that are permanent, including those of a chronic episodic nature, such as mental illness and psychosocial disability.

> 'Permanent' refers to the irreversible nature of the disability, even though it may be of a chronic episodic nature. For example, this would include people with significant and enduring psychiatric disabilities, who periodically rely exclusively on support from the clinical services of the mental health system, but at other times are able to live in the community provided they have appropriate supports. (PC 2011, p. 14)

However, the episodic nature of mental illness can mean that some scheme participants' needs are unpredictable. To some extent, this runs contrary to the planning process, which, in broad terms, requires a forecast of the participant's support needs over the life of the plan.

This problem is exacerbated by 'inflexibility in changing arrangements in response to fluctuations in support need because of escalating illness' (Mind Australia, sub. 144, p. 8). This can create incentives for participants to overstate their support needs, so that they can be sure that they have access to adequate support during times of high need.

Due to the nature of their disability, people with psychosocial disability may at times find it difficult to articulate or disclose their support needs during the planning conversation (Anglicare Tasmania, sub. 145, p. 32; VMIAC, sub. 167, p. 7; VICSERV, sub. 169, p. 4). For this reason, such participants 'may need more than one meeting to develop plans due to [the] fluctuating nature of conditions' (Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6).

Box 4.10 Progressive and degenerative disorders

Study participants said that certain progressive or degenerative disorders sat poorly with the 'investment approach' of the scheme. For example, Neurological Alliance Australia said:

> … the progressing and complex needs of people with neurodegenerative diseases have been overlooked due to lack of understanding of these diseases or for the sake of expediency … People with a progressive neurological disease run counter to the 'traditional' trajectory of someone on the NDIS: that is, an ability to enhance independence and re-ablement through a more effective engagement of services. For someone with a neurodegenerative disease, however, care needs inevitably increase over time. (sub. 30, pp. 1–2)

In addition, current planning processes do not account for the changing needs of people with progressive or degenerative disorders. Calvary Health Care Bethlehem said:

> For people with progressive disorders, the person's needs can change more rapidly than expected, so there needs to be sufficient flexibility in the plan being reviewed and amended to accommodate unforeseen needs arising. This needs to happen in a timely manner. (sub. 64, p. 2)

Similarly, MND Australia said:

> Plans are based on the 'now' and do not take account of the rapid and increasing needs caused by the progressive degenerative nature of [motor neurone disease], requiring review planning earlier than is necessary. (sub. 45, p. 9)

MND Australia (sub. 45, p. 7) also reported that between June 2016 and January 2017, all plans for people with Motor Neurone Disease in New South Wales and the ACT required review, primarily due to a poor understanding by planners of degenerative diseases.

Language and cultural barriers

Study participants observed that planning processes do not adequately cater for people of different cultural and linguistic backgrounds (Companion House, sub. 84, p. 2; Jesuit Social Services, sub. 117, p. 7; Neami National, sub. 63, p. 6; Northern Territory Government, sub. 205, p. 7; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6; VCOSS, sub. 176, p. 9; VMIAC, sub. 167, pp. 6–7).

For many, language barriers can prevent meaningful engagement with planning processes. Neami National (sub. 63, p. 6) said that 'consumers without English as their first language describe difficulties in participating in planning and in getting plans that they can fully implement on account of their language needs'. This is an issue which disproportionately affects Aboriginal and Torres Strait Islander communities:

> English is a second language for many Indigenous people in remote communities. The majority of participants in Barkly identify as being Aboriginal or Torres Strait Islander and for 67% English is not their first language. Many have limited capacity to understand or read it. This has a significant impact on their ability to have genuine input into the formulation of their plans and also impacts on decision making and choice. (Brain Injury SA, sub. 116, p. 3)

and those of refugee background:

> People with disability from a refugee background are often not well equipped to navigate the NDIS in planning meetings and to negotiate a package of supports from providers. Many have little or no understanding of the context of the broader social support system in Australia. (Companion House, sub. 84, p. 2)

Cultural barriers can also make accessing and interacting with the planning process difficult. In particular, there may be confusion as to the purpose of planning conversations and there is a risk that scheme participants do not communicate their needs due to different cultural or social norms. (Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 6). There may also be greater mistrust of government services or an aversion to sharing personal information (VCOSS, sub. 176, p. 9).

Access can be especially difficult for some Aboriginal and Torres Strait Islander communities. Brain Injury SA said:

> Many Aboriginal people can be transient in nature and to uphold their cultural requirements. Therefore, participants are not in regular receipt of mail or telephone communication. In the Barkly region there is no mail delivery to homes and most people do not regularly check their PO Box. If they do not receive a hard copy of their plan they are advised to go onto the portal and get it online. However, many do not have access to computers, nor the awareness of how to use them. Consequently, many participants do not know they have a plan or, if they do, what is in it. (sub. 116, p. 3)

The Australian Medical Association emphasised the need to have culturally appropriate processes and cited evidence of poor planning practices.

> … we were told that in one Aboriginal community, NDIA assessors did not leave their vehicle, instead they yelled questions of Aboriginal people regarding their disabilities … there was no verification of the person's identity other than to ask their name and conduct a conversation from a driveway. Another reported case was that Aboriginal people with disability were asked to leave their homes and find their way to a waiting vehicle for an assessment; this included an Aboriginal person in a wheelchair. (sub. 120, p. 5)

The role of pre-planning support

For many scheme participants, pre-planning support can assist them in navigating a confusing and complex system. Pre-planning support is directed at helping the participant prepare for the planning conversation, including:

- thinking about their goals and aspirations
- preparing documentation to support the assessment process
- thinking about what supports are available and can help them.

Demand for pre-planning support services is influenced by how accessible and complex planning processes are, as well as the scheme participant's capacity (including their ability, willingness, skills and resources) to navigate those processes (chapter 8). At present, pre-planning support is provided by a range of different organisations, including advocacy groups and service providers.

Several study participants noted that pre-planning assistance is costly to provide (House with No Steps, sub. 104, p. 5; Mamre Association, sub. 47, p. 2). Some participants said that the NDIA should play a greater role in providing pre-planning support (ADACAS, sub. 87, p. 16; CMHA, sub. 11, p. 10; Cohealth, sub. 50, p. 10). Others called for governments to provide additional funds to facilitate pre-planning support (Amaze, sub. 160, p. 5; Cohealth, sub. 50, p. 10; NSW Disability Network Forum, sub. 18, p. 3; Social Support & Precarious Workforce Research Discussion Group, sub. 71, p. 9; VICSERV, sub. 169, p. 4).

Providing pre-planning services is one of the core functions of LACs. It was intended that, during transition, LACs would be 'on the ground' in each area six months before the NDIS was rolled out in that area, in part to provide pre-planning support. However, the speed of the rollout has meant that this was not possible and LACs have not been performing their pre-planning functions as envisaged (NDIA, sub. 161, p. 56). The NDIA should also ensure that LACs are able to perform their pre-planning functions properly.

In addition, the Commission considers that there is considerable scope for the NDIA to improve transparency and clarity around planning processes. This includes providing clear and up-to-date information about what to expect during the planning conversation, when it will occur, and how the information gathered during that conversation will be used. There

is also considerable scope for improving the accessibility of planning processes, especially in relation to people with complex needs and those of different cultural and linguistic backgrounds.

These advancements could go a long way to mitigating the need for extensive pre-planning support, and relieve some of the pressure on advocacy groups and service providers to provide such services. It is likely that there will always be some scheme participants for whom more pre-planning support is necessary, and so it may be necessary in the future for government or the NDIA to play a greater role in providing that support. However, the first steps in helping scheme participants navigate the NDIS must be to ensure that LACs are able to properly perform their pre-planning functions and improve the transparency, clarity and accessibility of planning processes.

The NDIA is currently undertaking a review of the participant pathway to identify what changes or improvements should be made to planning processes (while achieving the number of completed plans as specified in Bilateral Agreements) to achieve plans that:

- maximise choice and control for scheme participants and contribute to improved participant outcomes
- are of a high quality in terms of a positive participant experience, compliance with all statutory requirements and consistency
- are financially sustainable so that the aggregate value of all plans remains within the funding envelope (sub. 161, p. 4).

However, the NDIA is operating under demanding time and resource constraints, and there are trade-offs between the quality of planning processes and how quickly the scheme can reach new participants. As noted earlier, better planning processes could involve compromises in terms of participant throughput.

DRAFT RECOMMENDATION 4.1

The National Disability Insurance Agency should:

- implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review
- review its protocols relating to how phone planning is used
- provide clear, comprehensive and up-to-date information about how the planning process operates, what to expect during the planning process, and participants' rights and options
- ensure that Local Area Coordinators are on the ground six months before the scheme is rolled out in an area and are engaging in pre-planning with participants.

Planners

Planners are an essential part of the planning process and exert considerable influence on scheme participants' experiences within the NDIS. Sufficiently skilled and impartial planners can improve the quality of the planning process and outcomes for scheme participants. As ACT Disability, Aged and Carer Advocacy Service said:

> It is crucial that the NDIA continue to recruit planners with the right combination of skills, experience and passion, that they offer good training and that workload pressures for NDIA staff are managed. Planners need the skills to be able to tailor the planning approach, and their communication style to participants with different needs. (sub. 87, p. 13)

Conversely, planners with less experience, skill or training can have a detrimental effect on the quality of plans and outcomes. This is because they may have less knowledge about what supports are appropriate, meaning that plans may include inappropriate supports or fail to include appropriate ones (Brain Injury SA, sub. 116, p. 5).

Impartial planners are also important for scheme participants' experience of the planning process and the quality of plans.

> The planners can have a great impact both positive and negative on the resulting plans. The planners biases also have an impact on both the discussion and resulting plan of a participant. For two years, the planner I had, put me in a box and thought she knew what and how I wanted supports. She would not listen until I had a panic attack in the meeting. It was only then she started listening. (Hanna Potapczyk, sub. 26, p. 1)

Skills, training and knowledge of specific conditions

A number of study participants were critical of the skills, experience and training of planners as a whole (Carers Australia Victoria, sub. 131, p. 12; DAA, sub. 119, p. 3; Matt Burrows, sub. 7, p. 3; Mental Health and NDIS Facebook Support Group, sub. 8, p. 3; Macarthur Disability Services, sub. 57, p. 4). The Public Service Research Group reported feedback that:

> There's not adequate induction support and supervision training provided to the people who are doing the planning … If we can't get the planning right we're not going to get the scheme right. (sub. 56, p. 6)

Others said that there was considerable variability in the skills, knowledge and competency across planners (including LACs undertaking planning functions), leading to uneven outcomes for scheme participants (AHPA, sub. 37, p. 8; Autism Aspergers Advocacy Australia, sub. 178, p. 20; Companion House, sub. 84, p. 2; New South Wales Government, sub. 60, p. 15; OPG, sub. 143, p. 3; Summer Foundation, sub. 113, p. 4; PDCN, sub. 29, p. 3; VCOSS, sub. 176, p. 12; South Australian Government, sub. 203, p. 11). Speech Pathology Australia (sub. 136, p. 28) also noted that information about the level of qualifications and training required of planners is not publicly available.

Study participants overwhelmingly agreed that planners performed better when they understood what needs arise from a person's disability. As Community Mental Health Australia said:

> If a planner understands the depths of a person's disability and what is needed to support the individual, the package developed will suit them over a longer term. This reduces the need for a plan to be amended in the future, thereby reducing administrative burden on the NDIA and building confidence in the process for the consumer. (sub. 11, p. 4)

However, many participants expressed concern about planners' limited disability knowledge.[18] For example, the Australia Physiotherapy Association said:

> Our members report that service planning is being undertaken by staff who have little competence in the specific field of disability relevant to the participant's needs and thus that service plans are at odds with the needs which the NDIS is designed to meet. (sub. 93, p. 13)

In particular, study participants expressed concern that planners had limited knowledge about specific conditions, such as motor neurone disease (MND Australia, sub. 45, p. 8), multiple sclerosis and dementia (Alzheimer's Australia, sub. 10, p. 16), Prader-Willi Syndrome (PWSAA, sub. 112, p. 4), and mental illness and psychosocial disability (CMHA, sub. 11, pp. 9–10; Cohealth, sub. 50, p. 10; Macarthur Disability Services, sub. 57, p. 4; Mental Health Carers Australia, sub. 181, p. 10; Neami National, sub. 63, p. 6). The Commonwealth Ombudsman reported that:

> Some stakeholders have told us about planners who asked parents when their child was likely to 'recover' from a life-long disability, and others who told people with psychosocial disabilities they should 'try to be more positive'. (sub. 137, p. 8)

Others also said that planners had limited knowledge of appropriate supports for certain conditions, such as the role of occupational therapists (Occupational Therapy Australia, sub. 15, pp. 4–5) and podiatry (Australian Podiatry Council, sub. 52, p. 2). For example, VCOSS (sub. 176, p. 12) gave the example of 'a deaf participant with cochlear implants [being] allocated two hearing aids in their package, despite hearing aids being ineffective for people with cochlear implants'. The Commission also heard that planners are ill-equipped to connect scheme participants with employment supports (House with No Steps, sub. 104, pp. 5–6; Round Squared, sub. 170, pp. 5–6).

[18] Study participants who commented on planners' limited knowledge of disabilities included: ABF (sub. 48); ACIA (sub. 141); AHPA (sub. 37); Alzheimer's Australia (sub. 10); Anglicare Tasmania (sub. 145); APA (sub. 93); Australian Podiatry Council (sub. 52); Belinda Jane (sub. 80); Cheryl McDonnell (sub. 79); CMHA (sub. 11); Cohealth (sub. 50); Commonwealth Ombudsman (sub. 137); DPO Australia (sub. 165); Macarthur Disability Services (sub. 57); Macular Disease Foundation Australia (sub. 75); Mental Health Australia (sub. 155); Mental Health Community Coalition of the ACT (sub. 135); Mind Australia (sub. 144); MND Australia(sub. 45); Neami National (sub. 63); OPA (sub. 46); OTA (sub. 15); PWSAA (sub. 112); VMIAC (sub. 167).

Improving planners' performance

Planners should, at a minimum, have a general understanding about different types of disability. Several study participants called for planners to receive more education on specific conditions and supports (Alzheimer's Australia, sub. 10, p. 13; Cheryl McDonnell, sub. 79, p. 2; CMHA, sub. 11, p. 4; Cohealth, sub. 50, p. 5; Neami National, sub. 63, p. 6; PWSAA, sub. 112, p. 4).

Others saw a role for specialised planners, especially for people with psychosocial disability (Cohealth, sub. 50, p. 10). The Office of the Public Advocate argued that these specialised planners should hold professional certifications.

> NDIS planners and support coordinators should be required to hold professional certifications. If assisting a participant with a primary psychosocial disability, for example, planners and coordinators should be trained mental health professionals. (sub. 46, p. 2)

The Commission also considers that there is value in having specialised planning teams for some types of disability. This is in line with industry practice for insurance companies. For example, Allianz Australia (sub. 42, p. 6) submitted that, in the context of workers' compensation claims, it employs specific psychological claims teams, given the unique nature of mental health related claims. However, specialised planners may not be appropriate for all types of disability, especially where:

- the person does not have a diagnosis
- the benefit of having a specialised planner is minimal
- the group affected is small, such that the cost of specialisation is not justified.

An alternative (or complementary) approach would involve leveraging expertise from the disability support sector. Macular Disease Foundation Australia advocated better use of existing resources.

> Whilst it is acknowledged that it is not physically or logistically possible for planners with specialist disability knowledge to be matched with every NDIS participants' disabilities and conditions on a national scale, the NDIS appears to not be effectively leveraging existing expertise from specialist disability organisations. (sub. 75, p. 5)

In many cases, providers may also have valuable knowledge about the scheme participant's needs. Anglicare Australia said:

> Many of our agencies have experienced reluctance from the NDIA to involve sector providers in the planning stage, and believe it is a major weakness that needs to be addressed … Service providers, due to their many years' experience (including vital rapport with scheme participants, particularly necessary for people with a psychosocial disability), are often better placed to accurately identify the scope and cost of an appropriate plan. (sub. 157, pp. 8–9)

Similarly, National Disability Services said:

> The quality of planning would improve if disability service organisations were involved. Providers of specialist supports have deep knowledge of disability – and they know their

> clients. Using this knowledge to inform planning would make sense. This is particularly true for people with complex needs … Planning partnerships between the NDIA and specialist providers should be extended. (2017a, pp. 6–7)

While leveraging expertise from the sector could give rise to potential conflicts of interest, these could be managed or mitigated by ensuring that such organisations only have an advisory role, with final decision-making powers exercised by an impartial planner. This approach would also mean that the NDIA would not need to compete with others in an already thin market to recruit planners with specialist qualifications or experience.

Over the longer term, satisfaction with planners could also be improved through monitoring and assessing their performance (OTA, sub. 15, p. 5; PDA, sub. 38, p. 7). According to the NDIA (sub. 161, pp. 89–90), planner performance is currently monitored through:

- participant satisfaction measures
- complaints, accounting for the volume and substance of complaints
- the National Quality Framework, where monthly audits are conducted on planner records and feedback provided through coaching and supervision.

Regular and public reporting around planner performance could help increase the accountability of planners, and improve community confidence in planners and the planning process.

DRAFT RECOMMENDATION 4.2

The National Disability Insurance Agency should ensure that planners have a general understanding about different types of disability. For types of disability that require specialist knowledge (such as psychosocial disability), there should be specialised planning teams and/or more use of industry knowledge and expertise.

4.4 Linking supports and outcomes

Supports are one of the core mechanisms through which the benefits of the NDIS are realised. In the short term, many of these benefits arise because supports can help address the care and support needs of people with disability (chapter 2).

However, many benefits will only be realised over a longer time horizon. This is due to the NDIS's insurance approach to funding supports, which takes a lifetime view of participant needs and seeks early investment opportunities, in order to optimise long-term outcomes (chapter 1). This includes capacity building for scheme participants to:

- maximise participant independence
- increase social and economic participation (of scheme participants and their carers)

- reduce scheme participants' support requirements.

Examples of capacity building supports include: therapeutic supports; transport to enable participation in community and social activities; and employment supports to help a participant obtain and keep a job.

It is still too early to fully evaluate whether, and to what extent, these long-term benefits will be realised, although the NDIA has developed an Outcomes Framework to allow outcomes of scheme participants, their families and carers to be measured over time (chapter 2). However, the Commission heard that supports directed at capacity building and early investment are under-represented in participants' plans.

In particular, some study participants pointed to early signs that scheme participants are not being supported to work, meaning that economic participation outcomes may not be realised (chapter 2). This is because plans do not include or do not make adequate provision for employment supports. Westhaven Association said:

> The evidence from the plans being produced to date shows NDIA has failed to ensure that NDIS participants are supported to gain productive employment. Without the employment outcomes expected from the scheme, NDIS may not achieve the return originally projected by the Productivity Commission. (sub. 81, p. 2)

And National Disability Services argued:

> A broad spectrum of employment options should be open to people with disability, including Supported Employment Enterprises … More must be done to boost demand for, and access to, NDIS employment supports. NDIS planners and LACs should adopt a 'work first' approach which motivates and assists an increased proportion of NDIS participants to connect with work. (2017a, pp. 8–9)

In part, this stems from community attitudes towards disability and employment embedded in legacy support systems. These attitudes have persisted despite the move to an early investment approach to disability care and support arrangements, and can mean that scheme participants are unaware of or do not seek employment supports. As Epic Employment Service said:

> After four years of the NDIS trial and full scheme roll out, EPIC believes the small amount of plans focusing on employment is due to widely-held beliefs … . We believe the Australian community broadly accepts that NDIS participants will not primarily be seeking employment through their NDIS packages … Furthermore, participants and their families are often led to believe open employment is simply not a viable option. (sub. 70, pp. 2–3)

However, some study participants said that planners do not have a good understanding of what employment supports are appropriate for scheme participants (House with No Steps, sub. 104, pp. 5–6; Roundsquared, sub. 170, pp. 5–6). As a result, scheme participants are not offered employment supports, or encouraged to think about how they might increase their economic participation.

Going forward, the challenge for the NDIA will be to develop a planning process that fosters capacity building, independence, and social and economic participation. Community attitudes about disability and community involvement are unlikely to change without evidence that people with disability can be supported to work and participate in the community. Therefore, as a first step, it will be up to the NDIA and planners to 'lead the way' and encourage scheme participants to think about, and connect them with, capacity building and employment supports that are right for them.

5 Boundaries and interfaces with the NDIS

Key points

- Effective interfaces between the National Disability Insurance Scheme (NDIS), other disability services and mainstream services are essential for good outcomes for scheme participants and the financial sustainability of the scheme. To provide the right incentives, services available to people who just qualify for the NDIS and those who just miss out should be as seamless as possible. This requires coordination of services within and outside of the NDIS.
- The Information Linkages and Capacity Building (ILC) program is a key component of the NDIS. It is a false economy to have too few resources for ILC activities, particularly during transition when it is critical to have structures in place to ensure people with disability are adequately connected with appropriate services.
- For people with disability who are not eligible for the NDIS, the Australian, State and Territory Governments have agreed to provide continuity of support.
  - But in practice, there is confusion and uncertainty about what services will continue to be provided and/or funded outside the NDIS.
  - Governments need to be clearer about their approach on continuity of care, and what disability services they will provide for non-NDIS participants.
- The NDIS is meant to work alongside mainstream services (such as services in health, education, aged care and transport), not replace them.
  - The Bilateral Agreements between the Australian Government and State and Territory Governments delineates responsibilities in terms of which services are to be provided by the NDIS and mainstream services.
  - While it is still too early to identify service gaps, there are emerging issues in a number of areas, including justice, emergency, transport and mental health services.
  - Each COAG Council that has responsibility for a service area that interfaces with the NDIS should have a standing item on their agenda to address the provision of those services and how they interface with NDIS services.
  - Further investment in the *National Disability Strategy* could improve accountability.
  - ILC and Local Area Coordinators can play a role in ensuring mainstream services are better informed about their roles and responsibilities.
- The National Injury Insurance Scheme (NIIS) was envisaged to cover the care needs of individuals who newly acquire a disability through a catastrophic injury or accident. Two of the four streams proposed have been implemented. While the cost implications of the two remaining streams are not large for the NDIS, the States and Territories should bear the cost of participants who were intended to be covered by the NIIS.

People with disability, and their families and carers rely on a wide range of services — including mainstream services, specialist disability services and community supports — for their care needs and to maintain the quality of their lives. For the National Disability Insurance Scheme (NDIS) to work efficiently and effectively, the interface of the scheme with these other services must be as seamless as possible. By design, the NDIS is intended to complement these other supports, not replace them. A requirement of any supports provided through the NDIS is that they are most appropriately funded through the scheme and not by other services.

While the level of funding provided to the NDIS recognised that the aggregate level of funding available to people with disability was inadequate, the NDIS was not expected to fill *all* of the very large gaps in services that existed before the scheme was established. The responsibility to provide services to people with disability remains a shared responsibility between all levels of government.

The interface between all kinds of assistance for people with disability will take time to determine at the coalface, but until these interfaces are settled, it is important that governments do not withdraw from services too quickly, as any gaps that emerge will place added burdens on people with disabilities and their families.

As the interface issues become clearer, it is essential to consider the incentives that are set up where boundaries exist. Most critically, it is important that people with disability do not see the NDIS as an oasis of support, surrounded by a desert, where little or nothing is available. Should such a dynamic develop, the financial pressures on the NDIS could be unsustainable, particularly if people feel the need to test their ability to qualify for the scheme, and/or remain in the scheme for as long as possible, for fear of not gaining access again should the need arise.

This can be compared with a situation where the gap between participants with the lowest needs (and therefore the lowest level of supports), and those outside the scheme, is not large. In such a system, people will not have an incentive to enter the scheme as their needs will be adequately met outside it, and those inside the scheme who are assisted sufficiently to no longer need individualised supports will have little incentive to stay in the scheme longer than necessary.

There is a lot of detail yet to be worked through. Nevertheless, establishing clear and robust boundaries is essential for the fiscal sustainability of the NDIS, and for the surrounding network of supports. When people are accessing the services they need, the system as a whole should be providing supports at the most efficient and cost effective level.

This chapter first looks at bridging and capacity building services provided under the NDIS (section 5.1), then how the NDIS interfaces with other disability services (section 5.2). The interface between the NDIS and mainstream services is examined in section 5.3. How the NDIS interfaces with the aged care sector (section 5.4) and the National Injury Insurance Scheme (section 5.5) are also examined.

5.1 Linking people to the right services

About the Information, Linkages and Capacity Building program

The NDIS is just one part of a wider disability system. While the NDIS will benefit all Australians, only a proportion of people with disability will become scheme participants. Of the 4.3 million Australians with disability just 475 000 (those people with a 'permanent and significant' disability) will receive individualised supports under the NDIS (chapter 1, figure 1.1). As the National Disability Insurance Agency (NDIA) said:

> The NDIS is intended to benefit a wide range of Australians, only a proportion of whom will become participants and receive an individualised plan. … short-term or light touch assistance from the NDIS, in collaboration with a capable and inclusive community and mainstream response, can help them better access mainstream supports, build connections into community supports and strengthen natural supports in order to achieve their outcomes. (sub. 161, p. 53)

The Commission recommended a bridging and capacity building service for anyone with, or affected by, disability (PC 2011, pp. 163–165, 198). The Information, Linkages and Capacity Building (ILC) program, to be provided under the NDIS from July 2017, is a key component of the NDIS. It will provide information, linkages and referrals to people with disability, their families and carers, helping them to connect with appropriate community and mainstream supports (NDIA 2017e). The focus of ILC is community inclusion. According to the NDIA, it is to:

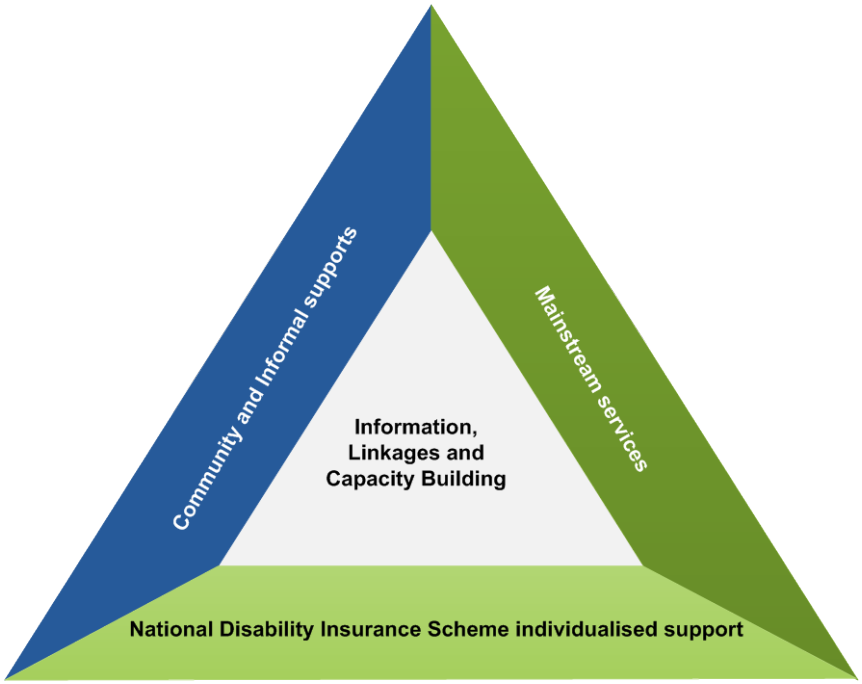
> … build innovative ways to increase the independence, social and community participation of people with a disability. (NDIA 2016d, p. 5)

ILC will also facilitate capacity building support and greater inclusivity by promoting collaboration and partnership with local communities and mainstream services (figure 5.1).

In August 2015, COAG endorsed the ILC Policy Framework (NDIA 2015a). The framework describes five streams to achieve the objective of ILC.

- Information, Linkages and Referrals — connecting people with disability, their families and carers with appropriate disability, community and mainstream supports.
- Capacity building for mainstream services — ensuring people with disability connect with and access mainstream supports.
- Community awareness and capacity building — supporting organisations (such as not-for-profit organisations, local councils and businesses) and people within communities to be inclusive of people with disability, and understand the needs of families and carers.
- Individual capacity building — fostering the principle of choice and control, improving outcomes for people with disability, their families and carers.
- Local Area Coordinators (LACs) — developing relationships between the NDIS, people with disability, their families and carers, and the local community (NDIA 2015a).

Figure 5.1 **Bridging services — Information, Linkages and Capacity Building**



Source: NDIA (2015a, p. 4).

ILC is an important tenet of the NDIS insurance model, and will affect scheme sustainability because it is expected to reduce reliance on NDIS funded support and thus reduce costs over time. ILC is expected to:

- *reduce the demand for individualised packages* — ILC is a lever to divert people from needing to access individualised packages and instead connect them to the appropriate supports for their needs
- *reduce the need for supports within funded packages* — ILC can maximise the ability of participants to access mainstream, community and informal supports, which in turn can reduce the need for funded supports (for example, targeted supports to assist a person to navigate the public transport system can reduce the need for funded taxi travel)
- *make supports more effective at helping people achieve their goals* — many supports are more effective in helping a participant achieve their goals when complemented by informal and community support (for example, a fitness goal is more likely to be achieved if funded support to use gym equipment is complemented by an inclusive gym community or a friend for companionship and motivation) (NDIA, sub. 161, p. 54).

ILC in practice

ILC is still to be rolled out. Grant rounds are completed for ILC activities in the ACT (2017-18) and for national activities (2016-17). ILC activities are expected to begin operating in ACT on 1 July 2017 (NDIA 2017e, 2017h). Only one component of ILC — Local Area Coordinators (box 5.1 and chapter 4) — has been implemented. LACs will be the single largest investment by the NDIA in delivering outcomes for ILC.

Box 5.1 Local Area Coordinators

LACs plays a central role in the delivery of ILC, by ensuring people with disability participate in and contribute to social and economic life, and that people with disability receive appropriate services. LACs connect across each of the first four streams of ILC, including information and linkages and individual capacity building as well as working with mainstream services and communities to better enable access and participation.

LACs also provide support for people with disability to understand their plans and how changes in funding and processes of the scheme are likely to affect them. LACs can help people put their plan into action and help them build capacity to self-manage their plan.

LACs have three primary roles:

- to work directly with people who have an NDIS plan, by connecting them to mainstream services, community activities, and getting their plans into action (chapter 4)
- provide some short-term assistance to non-NDIS plan participants and connect them into mainstream services and community activities
- work with the local community to ensure it is more accessible and inclusive for people with disability.

It is agreed with LAC partners that 20 per cent of their effort (and funding) should be allocated to the delivery of ILC activities.

Sources: NDIA (2015a, 2017k);. NDIA (sub. 161, p. 56).

In November 2016, the NDIA released its ILC Commissioning Framework (NDIA 2016f). The framework reflects the ILC Policy activities and identifies five focus areas which are deemed 'priority areas' for funding. These focus areas provide broad indications of the types of services that are eligible to be supported through ILC (table 5.1).

Table 5.1 **ILC Focus Areas**

Focus Area	*Definition*	*Example*
Specialist or expert delivery	Focus on activities that provide specific skills and knowledge in relation to disability — for example, diagnostic specific expertise or expertise in particular models of support or capacity building.	A comprehensive website that provides information about particular disabilities or conditions.
Cohort-focused delivery	Focus on activities for specific groups of people that require detailed cultural or other knowledge to be effective — for example, multilingual activities to assist Aboriginal and Torres Strait Islander peoples or people from culturally or linguistically diverse backgrounds.	A yarning circle (peer group) for Aboriginal women run by local Aboriginal organisations.
Multi-regional activities	Focus on activities that would be inefficient if delivered separately in different local areas – for example, advice or information that is not based on location and could be relevant anywhere.	A community awareness campaign to increase employment opportunities for people with disability.
Remote/rural delivery	Focus on ensuring activities are designed to address local needs, circumstances and conditions in rural and remote locations.	A project that connects young people with disability in a rural area with each other via multimedia or social media.
Delivery by people with disability, for people with disability	Focus on supporting organisations that are run and controlled by people with disability. These are sometimes called user-led organisations.	A telephone information service for people with disability, staffed by people with disability.

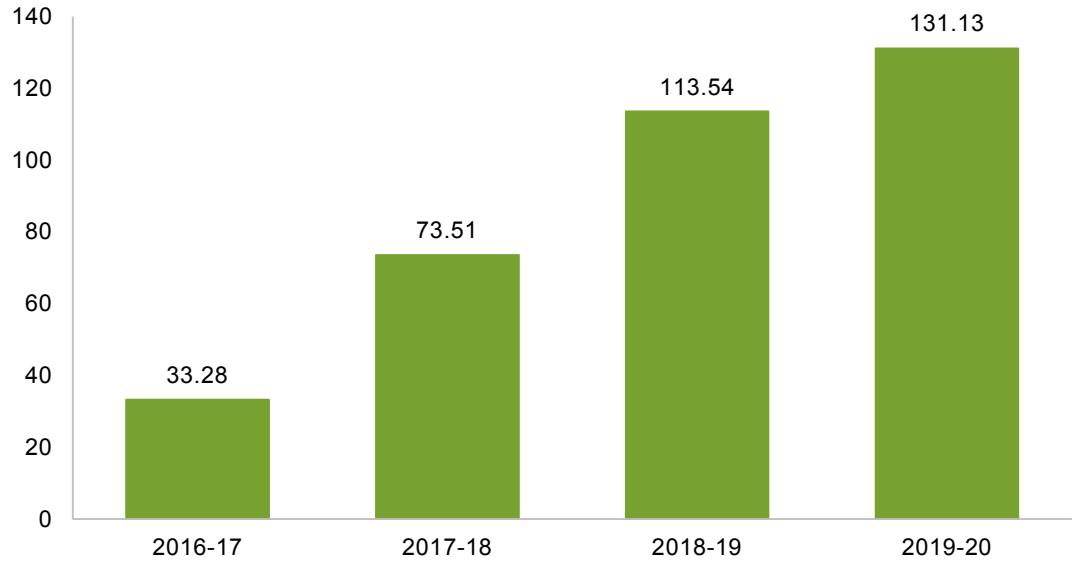
Source: NDIA (2016f, p. 18).

The ILC Commissioning Framework developed five strands of outcomes which programs funded through ILC will be measured against. They include the extent to which people with disability:

- participate in and benefit from, the same community activities as everyone else
- use and benefit from the same mainstream services as everyone else
- have the skills and confidence to participate and contribute to the economy
- have the appropriate information so they can make informed decisions and choices
- contribute to, lead, shape and influence their community (NDIA 2016f, p. 8).

Funding for ILC will gradually increase over the transition period from $33 million in 2016-17 to $131 million in 2019-20 (figure 5.2).

Figure 5.2 **ILC Funding[a]**
$million



[a] These numbers include funding for ILC activities in Western Australia; excluding Western Australia, the budget is about $119 million for 2019-20.

Sources: Australian Treasury (2017b, p. 140); NDIA (2016d).

Tendering processes are staggered across jurisdictions in line with the rollout timeline. Accordingly, the ACT will be the first jurisdiction to have ILC activities (commencing on 1 July 2017) (NDIA 2017e). Some of the successful grants in the ACT include:

- changing the ACT Health Care System to be more inclusive of people with impaired decision making ability
- educating Aboriginal and Torres Strait Islander people about what is meant by the term 'disability'
- establishing a peer support network for people with mild and borderline cognitive disability (NDIA 2017i).

As part of the ILC program, the successful ILC organisations and the NDIA will collect detailed data on ILC activities. The collection of data is important for measuring how effective ILC activities are in achieving outcomes for people with disability. The data will be used by the NDIA to identify and address performance issues, and inform future decisions on the allocation of funds.

Data collected will include the outcome success of activities in the short, medium and long term; quality and effectiveness of the activities; and performance over time. Data will be both qualitative and quantitative (NDIA 2016f, p. 27).

Is the funding for ILC adequate?

It is difficult to measure the adequacy of current ILC funding …

According to the NDIA, the timing of ILC funding has prevented it from investing in ILC activities and delayed the rollout of initiatives which would allow the infrastructure of a national ILC framework.

> The budget for ILC will increase over time and will reach a total budget of approximately A$131 million. This budget allocation severely hampers the NDIA's flexibility to use ILC at the time when the greatest impact could be realised. … The timing of payments means that the NDIA cannot apply ILC to assist the community or people with disability to prepare for the NDIS in advance of the NDIS rolling out in their area. … The timing of funding, linked to State and Territory contributions also prevents the NDIA from rolling out widespread national initiatives which would allow the infrastructure of a national ILC framework to be established. (sub. 161, pp. 54–55)

Many study participants questioned the adequacy of funding for ILC services given the scope outlined in the commissioning framework. For example:

> The PC should consider whether the one per cent cap (of scheme costs) on ILC expenditure should be adjusted to more flexibly accommodate investment in these areas that would generate better participant outcomes. (Victorian Government, sub. 174, p. 11)

> It is a widely reported view from the disability sector that there is a significant under-funding of the ILC in order to meet the needs of people with disability. (Speech Pathology Australia, sub. 136, p. 24)

> It appears that ILC is significantly underfunded and therefore will not deliver on rising community expectations. (Goldfields Individual & Family Support Association, sub. 13, p. 4)

> While some supports may be available through the Information, Linkage and Capacity Building (ILC) framework, it currently is not sufficiently resourced to meet the gaps. (Cohealth, sub. 50, p. 8)

> The total funding package for ILC at full roll out … when split across all types of disability is not adequate. (Mental Illness Fellowship of Australia sub. 122, p. 15)

> The implementation of the [ILC] framework … is dependent on adequate resourcing. Under full roll out, only $132 million is being allocated to the ILC. This is equivalent to approximately $30 to provide services to each person with a disability as well as to support mainstream services in capacity building. (Down Syndrome Australia, sub. 121, p. 12)

> Currently, only $132 million … has been allocated to the ILC. This is not sufficient and means that one of the key foundations on which the NDIS is being built is weak. (Bruce Bonyhady, sub. 100, p. 5)

Others said that the scope of ILC is too narrow to accommodate ILC's intended purpose (box 5.2), particularly in the context of what the Commission proposed would be covered under tier 2 of the NDIS.

Box 5.2 Many participants consider the scope of ILC too narrow

Physical Disability Australia (PDA):

> … it is PDA's understanding that the original tier 2 of the NDIS (that the ILC program replaces) was supposed to boost all non-participants' capacity to access to mainstream services. For example, we envisioned this might involve an 'Access Fund' to support the building of ramps and accessible toilets in the community.
>
> As such, PDA finds the current scope of the ILC (and its proposed budget) to be somewhat disappointing. (sub. 38, p. 6)

Australian Blindness Forum:

> … the range and type of services initially promised to be funded under the ILC program has changed substantially. The original proposal was that ILC would reflect the 'Tier 2' programs including block funding and early intervention programs. The goal of this was to continue to provide disability services to those who were not eligible for the NDIS. Now, the way the ILC program has been developed, it is only tools and awareness programs, delivered by mainstream services for a limited time or on an ad hoc basis. (sub. 48, p. 7)

Belconnen Community Service Board:

> ILC does not appear to cover the apparent lack of low intensity early intervention services needed for people who are not eligible for an NDIS package. The limited amount of funding for ILC and the competitive nature of these resources means people living with low to moderate mental health/psychosocial disabilities will struggle to access the supports required to maintain good mental health. (sub. 39, p. 4)

Woden Community Service:

> For the ILC to be able to make meaningful referrals block funded programs will need to continue in parallel with individually funded arrangements. (sub. 159, p. 11)

Allied Health Professions Australia (AHPA):

> AHPA believes the range and types of services proposed for funding under the Information, Linkages and Capacity Building (ILC) program does not currently fit well with the goals of the NDIS, particularly the intention to create and support small and innovative programs. (sub. 37, p. 12)

Centre for Disability Research and Policy:

> The ILC will be an important tool in developing or enhancing services to meet the needs of people where services do not currently exist. This is particularly important in 'thin markets' and within rural and regional contexts. (sub. 55, p. 4)

Psychiatric Disability Services of Victoria.

> Under the current framework, there is no real benefit to mental health services from the ILC because the funding provided through the framework is so minimal; the ILC simply does not have the capacity to provide for the scope of what existing services deliver, whilst also responding to the needs of people who won't be eligible for the NDIS. (sub. 169, p. 9)

ILC services could be broader than envisaged, at least in New South Wales. Under the New South Wales Bilateral Agreement[19], it has been agreed that the NDIA will establish ILC arrangements to support people who have been in receipt of state-based specialist disability supports but not eligible for the NDIS. The ILC supports will enable the person

[19] The Bilateral Agreements are individual agreements between the Commonwealth Government and each State and Territory Government, covering the roles and responsibilities afforded to each government for the implementation of the NDIS.

to transition to alternative arrangements over time. What this means in terms of funding adequacy is hard to determine, as it is not clear what specific ILC services will be provided (Australian Government and New South Wales Government 2015).

The question of whether the funding for ILC is adequate is difficult to answer for a number of reasons. First, the program is still to be rolled out. Second, there do not appear to be any comparable programs, either within Australia or overseas. Third, it is unclear where gaps may exist in services, or what activities should be funded by ILC. As the New South Wales Government said:

> … there is still a gap in the information presented in relation to the Commissioning Framework not setting out what activities the NDIA will actually fund under the ILC budget for full scheme. (sub 60, p. 18)

Further, without appropriate information, it is too early to pass judgment on whether ILC will reduce the demand to access individualised support and how ILC initiatives will affect individualised support related services. This was noted in a report commissioned by the Department of Social Services which found:

> The evidence … suggests that the existing funding allocation ($120 million per annum) may not be sufficient to achieve intended social outcomes; although it is difficult to determine budget adequacy in terms of either ILC outcomes or avoiding escalation to Individually Funded Packages. (URBIS 2017, p. 11)

… but additional funding is critical in the short term

Although directing additional funds to ILC in transition could crowd out state and territory 'ILC like' activities, the grants process by which organisations receive ILC funding means these activities can be targeted to where they are most needed. There could also be a risk of duplicating services, but the risk of service gaps appears a much more likely prospect under current arrangements, particularly as determining precisely what ILC should cover is unclear at the operational level.

It is a false economy to have too few resources for ILC activities in the transition period when it is critical to have structures in place to ensure that people eligible for the NDIS access the scheme and those who are not eligible can access supports and services outside the NDIS. Withdrawal of existing ILC type activities by State and Territory Governments may also have affected the supports available. The NDIA, in relation to ILC and LACs funding, stated that:

> The success of this [ILC and LACs] strategy will … be heavily reliant on the quality and availability of such supports that largely remain the responsibility of state and territory governments to fund. The experience of trial is that this is not a certain or consistent base upon which the NDIS is building. (sub. 161, p. 53)

The Commission recommends increasing ILC funding by $75 million so that the ILC is resourced with $131 million for each year in the transition period (2017-18 to 2018-19) to

allow a national rollout of ILC activities. This additional funding should come from the program delivery budget.

Data on the effectiveness of programs funded through ILC in improving outcomes for people with disability, or reducing scheme costs by lowering demand for supports through individualised supports will be critical to determining funding in the future. The requirement for organisations to collect data as a condition of receiving an ILC grant will help build this evidence base.

COAG has agreed to a review of NDIS costs in 2023 (Heads of Agreements). This will provide an opportunity to review the performance of the ILC program and the magnitude of any benefits from increasing its funding. It is reasonable to expect that there will be more data on ILC by this time, and many of the transitional issues which may be exacerbating concerns about the adequacy of ILC funding could be resolved.

Given that underfunding ILC carries significant risk for the sustainability of the scheme, the Commission recommends that the funding for ILC continue to be funded at a minimum of $131 million per year until the review in 2023.

DRAFT FINDING 5.1

It is a false economy to have too few resources for Information Linkages and Capacity Building, particularly during the transition period when it is critical to have structures in place to ensure people with disability (both inside and outside the National Disability Insurance Scheme) are adequately connected with appropriate services.

DRAFT RECOMMENDATION 5.1

Funding for Information, Linkages and Capacity Building (ILC) should be increased to the full scheme amount (of $131 million) for each year during the transition. The funds that are required beyond the amounts already allocated to ILC to reach $131 million should be made available from the National Disability Insurance Agency's program delivery budget.

The effectiveness of the ILC program in improving outcomes for people with disability and its impact on the sustainability of the National Disability Insurance Scheme should be reviewed as part of the next COAG agreed five-yearly review of scheme costs. The ILC budget should be maintained at a minimum of $131 million per annum until results from this review are available.

5.2 The NDIS and other disability services

Prior to the NDIS, the delivery and funding of disability services was primarily governed by the National Disability Agreement (NDA). The Agreement, of which the Australian

Government and all State and Territory Governments are signatories, was established in 2009 and revised in 2012. It features clear roles and responsibilities for each level of government and nationally agreed objectives and outcomes for people with disability, their families and carers (COAG 2012c).

The NDA also establishes that the Australian Government is responsible for providing income support and employment services for people with disability. States and territories are responsible for the delivery of specialist disability services such as supported accommodation, respite and community support services, therapy, early childhood interventions, life skills and case management (SCRGSP 2017, p. 15.3).

Other services available to people with disability, prior to the introduction of the NDIS, included (but were not limited to):

- home and community care
- residential aged care (provided to a person under the age of 65)
- taxi and transport subsidy schemes
- psychiatric disability community supports.

While the scope of these services and their eligibility requirements varied by jurisdiction, they typically included programs that covered both people who would be eligible and not eligible for individualised supports under the NDIS. Continuity of service and program interfaces are therefore critical to ensure that people with disability do not 'fall between the cracks' when services are split between NDIS and non-NDIS provision.

How does the NDIS affect other disability services?

As individuals transition to the NDIS, many existing services will be defunded, with previous funds used to offset the cost of the NDIS. Funds transferred from these services to the NDIS are calculated on a predetermined per person basis. The funds move with the individual when they transition to the NDIS, as agreed in the Bilateral Agreements. However, not all individuals will meet the NDIS eligibility criteria and not all services will be funded by the NDIS. Consequently, some services provided under the NDA and other avenues will need to continue.

Unless agreed otherwise, the responsibility of governments to provide services under the NDA remains (part 2, subsection 16 of Bilateral Agreements). The Australian and State and Territory Governments have also agreed in the Bilateral Agreements to continuity of disability support services for:

- people who receive support but do not meet the access requirements outlined in the *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act), or are receiving supports that do not meet the definition of reasonable and necessary support in the NDIS Act; and

- funding for supports attributed to a program/service that will cease when the NDIS is introduced.

All states and territories have agreed to provide continuity of support to people in receipt of state and territory administered disability programs/services. The Australian Government is responsible for providing Commonwealth administered disability programs/services (Bilateral Agreements schedule D). As part of annex E of the Continuity of Support Agreement (COAG 2013), the Australian, State and Territory Governments are also obliged to make clear their policy approach to providing continuity of support.

On the basis of the agreements that are in place, if the State, Territory and Australian Governments adhere to their responsibilities there should be few, if any, gaps in disability services for existing users (or at least the funding for these services). People previously receiving a disability service will continue to receive the same level of service — either through the NDIS or from other services funded by the State, Territory and Australian Governments.

Continuity of support is less straightforward in practice

Where programs are transitioning into the NDIS (closing) and there are people not eligible for the NDIS, these clients should receive services under continuity of support arrangements. In practice, however, there is a lot of uncertainty around continuity of support arrangements (box 5.3).

Most states and territories (to date) have not demonstrated how they will deliver on their commitment to provide continuity of support. There is varying detail on what disability support services will continue after the full rollout of the NDIS, and who will fund them. And where it is clear that services will continue, the detail on what will be provided varies. For example, the Queensland Government stated that they will continue providing some disability services (Queensland Government 2017b), while the Department of Social Services (DSS) have made public that 17 DSS and Department of Health programs will be affected by the introduction of the NDIS (DSS 2016e). Beyond this, little information is provided on specific programs that will cease or continue and who may be able to access the services. Those governments that have made public their intentions (the New South Wales and Australian Capital Territory Governments), are ceasing to provide specialist disability services altogether (NDS 2014; NSW Government nd).

Box 5.3 Participants point to uncertainty around continuity of support

Flourish Australia:

> People not eligible for the NDIS are already experiencing uncertainty and confusion. Continuity of support arrangements are still not finalised, so it is unclear whether they will be able to continue to access the services they currently receive, post full Scheme rollout. The concern is that if people currently accessing support in the community have this support 'switched off' at a future point, their needs and circumstances could be exacerbated, pushing up demand for the NDIS. (sub. 74, p. 9)

National Mental Health Commission:

> It is not clear how continuity of support for carers will be addressed through the NDIS. For example, the NDIS does not include direct provision of respite support for carers. Anecdotal evidence indicates that some applicants are being encouraged not to include family support in order to enhance their chances of getting a package. (sub. 153, p. 4)

Department of Health:

> The continuity of support commitment has been raised as a concern by service providers. It is currently unknown the proportion of program clients that will be deemed ineligible for the NDIS. Further information is needed of this cohort to inform continuity of support planning, such as the reasons for the ineligible access decision and the type of supports that individuals are currently accessing. (sub. 175, p. 5)

Rather than having a clear framework around the continuity of support, there seems to be some signs of brinkmanship, with governments holding off implementing policies (perhaps until another jurisdiction acts, or waiting for gaps to emerge before engaging in renegotiations).

While the Commission heard concerns about the quantum and nature of supports that will be provided outside the NDIS across a number of areas, mental health is one area where these concerns were particularly pronounced (box 5.4). In this case, the non-clinical supports that will be available for people with mental health disabilities who are not eligible for the NDIS is very unclear (box 5.4). State and Territory Governments have primary responsibility for mental health services — in 2014-15, state spending on community mental health services accounted for 83 per cent of all spending with the Commonwealth accounting for 17 per cent (DSS, sub. 146, p. 16).

In March this year, the Disability Reform Council agreed to focus on mental health to ensure mainstream systems are effectively supporting people with disability in Australia (DRC 2017, p. 2). In the most recent budget, the Australian Government also allocated $80 million over four years for support services for people with mental health illnesses who do not qualify for the NDIS, contingent on State and Territory Governments matching this contribution (Australian Treasury 2017a, p. 120). This should go some way to addressing support gaps, but continual monitoring will be required to ensure that people with significant needs are not missing out because they do not satisfy the NDIS eligibility criteria.

Box 5.4 Mental health — an area where uncertainty abounds

Many participants to this study raised concerns about people with severe mental illness missing out on services. In 2011, the Commission assumed that around 57 000 people with a psychosocial disability would be eligible for individualised supports under the NDIS (PC 2011, p. 190). The NDIA has since revised this number to 64 000 people (NDIA 2016g, p. 26).

The National Mental Health Commission's report on Mental Health Programs and Services estimated that around 700 000 Australians experience severe mental illness in any one year (and there are estimated to be over three million people in Australia with some sort of mental illness in any one year) (NMHC 2014, p. 5). The Department of Health (sub. 175, p. 4) submitted that through their internal modelling, around 282 000 people aged 0–64 years have a severe psychosocial disability requiring supports, and about 92 000 (aged 18–64 years) would 'most closely align' with the NDIS (although this did not involve modelling against the NDIS eligibility criteria per se).

For those people with a psychosocial disability not eligible for an individualised package under the NDIS, it is intended that mainstream or other disability supports will assist them. However, many submissions to this study pointed to current uncertainty around what services and supports will be provided to individuals with a psychosocial disability outside the NDIS. For example:

Mental Illness Fellowship of Australia said:

> While there have been assurances under the principle of continuity of service, in practice there is no clear indication of who and how the system will provide for those not eligible for the NDIS yet in existing programs, and more generally, those who were never Commonwealth clients to begin with. Members have reported emerging evidence of cost-shifting and ambiguities in responsibility, resulting in program uncertainty. (sub. 122, p. 12)

The National Mental Health Commission submitted:

> A particular concern is that there seem to be many people in existing community mental health programs at the Commonwealth and the State and Territory level who are being found ineligible for the NDIS, and while governments' commitment to continuity of support for existing clients is welcome (subject to the details of how such support is to be provided into the future), there appears to be no clear strategy for dealing with future cohorts of people who would otherwise have accessed such programs but who are not eligible for the NDIS. (sub. 153, p. 6)

And the Mental Health Community Coalition of the ACT said:

> … there is a need for both the NDIS and a mental health system. One is not a substitute for the other. However, since the introduction of the NDIS, the intersection between these systems has become very unclear and difficult; as well as inconsistent between States and Territories.
>
> - States and Territories made different decisions about what was in and out of scope for the NDIS.
> - Further, these decisions were made very early in the process when detail of scheme design was limited — it's fair to say that in many cases decisions would now be different given how the scheme has evolved. (sub. 135, p. 15)

The DSS (sub. 146) also noted that service gaps in this area have been known for some time. The implications of gaps are significant — uncertainty about what supports will be provided is distressing for people who rely on them and places an additional call on the generosity of informal support. They can also threaten the sustainability of the scheme by encouraging scope creep, or by forcing those who are unlikely to meet eligibility requirements to test their access anyway.

The DSS argued that the States and Territories:

> … need to demonstrate they are delivering their undertakings to provide continuity of support to clients not eligible for NDIS. (sub. 146, p. 27)

The DSS also noted that while measurement and reporting of service gaps are difficult, the agreed development of a new reporting framework for the *National Disability Strategy* could assist and better cross-system reporting could make any moves away from those services more obvious (and therefore more difficult to shift costs).

An important first step to ensuring an effective interface between the NDIS and other disability services is for governments to set out what disability services outside the NDIS will be funded, including the value of supports and number of people covered. Without this, it is impossible to work out where the gaps are and where cost-shifting is occurring. Delineation of services at the operational level should be made public immediately. This will help ensure that gaps do not emerge and the burden of these gaps do not fall on people with disability and their family. A schedule setting out the value of supports and number of people covered by disability support programs outside the NDIS should be included in the upcoming bilateral agreements for the full scheme.

The NDIA should also report — as part of the quarterly COAG DRC report — on boundary issues, including the number and value of supports being refused by the NDIS on the grounds that they are best provided by another support system, such as other disability services and mainstream services. The Commonwealth, State and Territory Governments should also publically report on the number of people covered by their disability programs pre and post NDIS, and the value of these services.

The delineation and reporting of disability services at the operational level will encourage discussions between the NDIA and disability service providers (including governments, local communities and businesses), and help identify gaps as they emerge.

ILC programs and LACs should also assist in identifying any gaps and reporting them back to the NDIA.

DRAFT RECOMMENDATION 5.2

The Australian, State and Territory Governments should make public their approach to providing continuity of support and the services they intend to provide to people (including the value of supports and number of people covered), beyond supports provided through the National Disability Insurance Scheme. These arrangements for services should be reflected in the upcoming bilateral agreements for the full scheme.

The National Disability Insurance Agency should report, in its quarterly COAG Disability Reform Council report, on boundary issues as they are playing out on the ground, including identifying service gaps and actions to address barriers to accessing disability and mainstream services for people with disability.

5.3 The interface between NDIS and mainstream services

A key requirement of any support provided under the NDIS is that the support is most appropriately provided and funded by the scheme and not by another service.[20] The NDIS is not designed nor funded to replace mainstream services. But for the NDIS to be successful and financially sustainable, there must be clear lines of responsibility between the mainstream services and the scheme. Also, as people with disability can require supports across a number of service systems, it is essential that service systems work well together.

In theory, the delineation between NDIS and mainstream services is clear cut. The *National Disability Strategy* 2010–2020 sets out the guiding principles around the supports to be provided by mainstream services (box 5.5). The Strategy's Second Implementation Plan (Driving Action 2015–2018) states that:

> While the NDIS is a significant step forward for many people with disability, the strategy remains the key to achieving improvements in access to mainstream services and support for all people with disability, regardless of age or type and level of support required. (COAG 2016b, p. 6)

However, as the NDIA (sub. 161, p. 57) put it, 'the Strategy is an overarching framework rather than a binding agreement for action'. It does not include 'substantial commitments, key performance indicators or targets' and 'there are limited identifiable consequences for governments if there is a lack of action'.

The Australian Government has also entered into Bilateral Agreements with State and Territory Governments to delineate the types of supports to be provided and funded by the NDIS and mainstream services (table 5.2). COAG has endorsed Principles to Determine the Responsibilities of the NDIS and other service systems, which are to be used to determine the funding and delivery responsibilities of the NDIS. The Principles are incorporated into the reasonable and necessary decision making of the NDIA by being incorporated in the *National Disability Insurance Scheme (Supports for Participants) Rules 2013*, Schedule 1.

[20] NDIS Act subsection 34(f).

Box 5.5 National Disability Strategy 2010–2020

The *National Disability Strategy 2010–2020* provides a ten-year national policy framework for improving life for Australians with disability, their families and carers. It represents a commitment by all levels of government, industry and the community to a unified, national approach to policy and program development. The vision of the Strategy is for 'an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens' (COAG 2011b, p. 8).

The Strategy was endorsed by the Council of Australian Governments in February 2011. It guides public policy across all level of governments and aims to bring about change in mainstream services, specialist programs and services, and community infrastructure — to meet the needs of people with disability, their families and carers. It is the first time the Australian, State and Territory Governments have agreed to such a wide range of policy directions for disability. The Strategy sets out six priority policy areas for action. They are:

1. inclusive and accessible communities
2. rights protection, justice and legislation
3. economic security
4. personal and community support
5. learning and skills
6. health and wellbeing.

The first implementation plan, *Laying the Groundwork 2011–2014*, established the foundations to bring about reform in the planning and delivery of both mainstream and disability-specific programs and services. The Strategy's second implementation plan, *Driving Action 2015–18*, outlines new priority actions and builds on ongoing commitments to improving outcomes for people with disability across the Strategy's six policy outcome areas. Additional areas of national co-operation include: NDIS transition to full scheme; improving employment outcomes for people with disability; improving outcomes for Aboriginal and Torres Strait Islander people with disability; and communication activities to promote the intent of the Strategy throughout the community.

In September 2016, the Disability Reform Council reaffirmed its ongoing commitment to the National Disability Strategy.

Sources: COAG (2011b, 2016b); DSS (2017c).

Table 5.2 **What the NDIS covers and what mainstream services provide**

	What the NDIS covers	*What mainstream services provide / what the NDIS does not cover*
Health	Support to enable a person with disability to undertake daily activities, including 'maintenance' supports (from clinically trained or qualified health practitioners) directly associated with the person's disability.	Access to health services, such as diagnosis and clinical treatment of health condition, as required by National Healthcare Agreement and Commonwealth Disability Discrimination Act.
Mental Health	Non-clinical supports that focus on the person's functional ability to undertake daily living.	Clinical support related to mental health and any residential care and rehabilitative care.
Early childhood development	Individualised support or early intervention, specific to a child's disability or developmental delay, targeted at enhancing the child's functionality to engage in daily activities.	Early childhood education and care needs, child and maternal health services and any supports clinical in nature.
Child protection and family support	Support for the child, family and carer as a direct result of the child's disability, to enable participation in the community.	Promoting the safety of children from abuse and neglect, and providing parenting programs, counselling and other supports for families.
School education	Supports related to the functional impact of a student's disability to undertake activities of daily living, such as personal care and transport to and from school.	Personalising learning and support related to educational attainment, including teaching, learning assistance, school building modifications and transport between school activities.
Higher education and vocational education and training	Functional support related to the student's disability to undertake daily activities, including personal care and transport to and from education.	Learning and support needs of students that primarily relate to their educational and training attainment, and transport between education, training and employment venues.
Employment	Assistance to take part in the workforce and support in the person's functional capacity to work, such as training in workplace relationships and communication skills.	Employment services to support people with disability to prepare for, find and maintain a job, and employers to hire people with disability in their workplace (e.g. workplace modification, training and funding assistance).
Housing and community infrastructure	Assist individuals with disability to live independently by building their capacity to maintain tenancy, such as home modifications for accessibility, specific to their disability.	Accommodation for people in need of housing assistance, access to housing and homelessness services and any previous infrastructure responsibilities.
Transport	Funding support to enable independent travel, including aids and equipment and training to use transport. Cover reasonable and necessary costs for those not able to travel independently.	Ensuring transport options are available to people with disability. Other parties are still responsible for transport infrastructure as part of universal service obligation, including managing disability parking.
Justice	Continue to fund the full NDIS support related to the person's disability impairment where the person is not serving a custodial sentence.	Meet the needs of people with disability in line with the National Disability Strategy and existing legal obligations, such as ensuring the system supports accessibility for people with a disability and a secure environment for those in prison.
Aged care	Those under age of 65 can choose to purchase support from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' costs.	Responsible for access to quality and affordable aged care and carer support. Cater for individuals aged over 65 years, unless they qualify to remain in the NDIS.

Source: COAG DRC (2015b).

Interfaces are not so clear at an operational level

At the operational level, the lines of responsibility between the NDIS and mainstream services are not so clear. The NDIA reported that during trial and transition it faced three key challenges in relation to mainstream supports, including:

- lack of clarity around some interfaces
- different understanding of mainstream obligations, by each jurisdiction and the NDIS
- difficulty in holding mainstream services accountable (sub. 161, pp. 59–60).

State governments also pointed to the need for further work on achieving greater clarity. For example, the South Australian Government said:

> There remains a lack of clarity in relation to roles and responsibilities across the NDIS and mainstream services in some areas. South Australia believes that there is still extensive work to be done in defining mainstream interface boundaries. (sub. 203, p. 6)

And the New South Wales Government said:

> Extensive further work is required by the States and the Commonwealth to scope, agree and communicate service boundaries. Any movement of boundaries (existing responsibilities) between the NDIS and other service systems should be implemented with associated resourcing considerations. (sub. 60, pp. 13–14)

A lack of clarity around responsibilities between the NDIS and mainstream services has the potential to impact on NDIS costs, and on the effectiveness and efficiency of service delivery in multiple ways, including scope creep; cost shifting from mainstream provision to the NDIS and vice-versa; gaps in service provision; inconsistent support access decisions; and duplication of services.

An added complexity is in-kind support arrangements (a program may have been agreed as in-kind but some people receiving the program may not be eligible for the NDIS and not all supports within the program may align with reasonable and necessary supports) (chapter 10).

There is some early evidence that interface issues are emerging. The NDIA reports some instances of possible cost-shifting, scope creep and services gaps, including:

- providers trying to extend the amount of therapeutic (health) interventions through use of NDIS funding
- reports that mainstream services are refusing entry to people who are likely to be eligible for the NDIS
- issues around a lack of accessible public transport options, particularly in regional, rural and remote areas, which means NDIS participants seek transport funding through the NDIS despite having the capacity to travel independently were transport options available (sub. 161, pp. 59–60).

State and Territory Governments also reported instances of cost shifting. The South Australian Government said:

> As policies and eligibility have been clarified over the trial/transition period, there are a number of emerging issues which are or are expected to result in costs for the state in areas which were originally assumed to be part of the scheme. … South Australia is keen to ensure that all appropriate costs are met by the NDIS to avoid any potential of states effectively paying twice for services. (sub. 203, pp. 7)

The ACT Government said:

> The ACT has experienced a cost pressure associated with the fact that what is 'in scope' for the NDIS has moved over time. (sub. 156, p. 9)

Some of the examples provided by the ACT Government include:

- a narrowing of the eligibility criteria for Early Intervention meant that some children who were deemed eligible for the scheme and have not implemented plans are being reviewed by the NDIA and referred back to mainstream services
- the lack of clarity from the NDIA about what is considered as parental responsibility and what is reasonable and necessary to fund student transport means that a tightening of scope by the NDIA will shift costs to states and territories
- the NDIA being insistent that supports for people with forensic disability where their behaviour manifests as a public safety issue is the responsibility of mainstream services. The ACT Government did not anticipate that it would be required to meet such costs, given that they relate directly to the participant's ability to live in the community (sub. 159, pp. 9–16).

And while many submissions to this study raised concerns about how the NDIS interface was working with mainstream services, particular concerns were raised in the areas of the justice system (box 5.6) and emergency and health services (box 5.7).

Box 5.6 Interface between the NDIS and justice services: views of study participants

Participants to this study expressed a number of concerns about the interface between the NDIS and mainstream criminal justice disability services. While there are specific NDIS rules that deal with the interface with the justice system (NDIS (Supports for Participants) Rules), there are some concerns that these rules are not clearly defined and that differences in interpretation will create inconsistencies. The Office of the Public Advocate, for example, said:

> On the intersection with the justice system, the COAG principles outline that the NDIS 'will continue to fund the reasonable and necessary supports'; a statement that is vague and subject to differing interpretations. Moreover, some of the responsibilities accorded to the justice system in the COAG principles have seldom been available in the pre-NDIS environment; for example, 'specific interventions to reduce criminal behaviours' and intensive case coordination — both of which are attributed to mainstream services — are not currently provided by the justice system and it is unlikely that they will be under the NDIS. (sub. 46, p. 2)

Participants also expressed concern that delineation between the NDIS and state and territory responsibilities is resulting in the withdrawal of some community justice programs and creating inconsistencies between jurisdictions and gaps in service provision. Disabled People's Organisations Australia submitted:

> There is an assumption that States and Territories are providing the appropriate supports to people with disability through the mainstream or their own specialist disability support systems. In some cases, States and Territories are entirely withdrawing funding and services for disability support while others are retaining a residual role in specialist supports. This creates inequity in programs within different jurisdictions. For example, NSW is ceasing its funding of specialist disability criminal justice programs based on the rationale that this should be the purview of the mainstream criminal justice system. (sub. 165, p. 11)

A further issue was the ability of people in custody to access NDIS support. Sisters Inside, for example, said:

> In our view, the unique and 'complex' needs of women in prison pose a significant challenge for the current NDIS model. We are concerned that most criminalised women will not be eligible for NDIS services. Even if eligible, many criminalised women can be expected to avoid the application process and services provided by mainstream (institutional charity) organisations. (sub. 16, p. 1)

In particular, access to disability services for people moving in and out custody is viewed as problematic. Neami National submitted that an:

> … issue occurs when participants move in/out of justice settings. For example, in preparation for discharge from a forensic mental health unit, extensive preparatory work and relationship building is provided through in-reach of community mental health disability support. This is not funded under the NDIS and will compromise the capacity of justice services to facilitate safe and timely discharge for people, again increasing overall cost pressures on the health and social care systems. (sub. 63, p. 9)

Similarly, Leanne Dowse, Melinda Paterson and Mike Sprange said:

> … as the NDIS implementation is only partially complete in NSW, it is hard to comment on how the interface between the NDIS and mainstream services has been working. What is clear has come from areas where trial implementations of the NDIS have occurred, such as in the Hunter region.
>
> In the area of Justice, there are some reports that the transition out of custodial sentences for people with disability who may be eligible for the NDIS, or even already in it, is problematic. It is likely that in relation to the mainstream area of Justice, many complex issues will arise in the interface. (sub. 114, p. 7)

Box 5.7 Emerging gaps in emergency and health services

Responsibility for funding emergency services

A gap in emergency response funding was identified by a number of study participants. For example, the ACT Government (sub. 156, p. 24) pointed out that there is currently no provision for emergencies, such as accommodation for:

- children with challenging behaviours who may not be able to live with their parents all of the time
- participants being discharged from a psychiatric inpatient unit
- participants unable to leave hospital without a modified or supported accommodation option.

It is unclear whether the NDIS or State and Territory Governments are responsible for funding this service. For example, in the ACT, the government has 'cashed out' on disability services related to emergency care (the ACT is expected to close its doors for 'Disability ACT' on 30 June 2017) under the expectation that the NDIS would fund these services. On the other hand, the NDIA has claimed that providing emergency accommodation falls under the state and territory responsibility of child protection, public housing and health sector respectively.

Based on the Commission's 2011 report, the intention was that crisis and emergency responses would be funded under ILC. However, ILC is yet to roll out and it is not clear whether it will provide such services.

Uncertainty in some health services

There are also cases where individuals are being turned away from specific state funded health services, and there seems to be uncertainty around who should provide these services.

- Audiologists report confusion around the funding of services for people experiencing tinnitus, with one practitioner being told that supports for tinnitus would no longer be funded by South Australia Health as this program would move over to the NDIS. However, young and adult clients with severe tinnitus are being advised that they are ineligible for the NDIS (Allied Health Professions Australia, sub. 37, p. 11).
- The Australian Physiotherapy Association (sub. 93, p. 10) reported feedback from consumers that rehabilitation services have 'closed their books' to NDIS package holders.
- The Australian Physiotherapy Association also noted cases of individuals being discharged early from hospitals:

  > … there are increasing incentives for 'early discharge' from public and private hospitals resulting from the introduction of the NDIS … There is little incentive, for example, for hospitals to ensure optimal pre-discharge functioning of a participant, compared with early hand-off and the transfer of the responsibility for achieving optimal functioning into the hands of the participant, their NDIS budget and community-based providers. (sub. 93, p. 10)

Where to from here?

It is too early to determine whether emerging problems in the interface between the NDIS and mainstream services are transitory or more long-term in nature. However, it is important that steps are taken to clarify NDIS boundaries and a process put in place to identify and address any service gaps, cost shifting, duplication and inconsistencies.

The first step is for State and Territory Governments to agree and finalise the boundaries between NDIS and mainstream services. As the New South Wales Government said:

> … at this early stage, NSW considers reviewing scheme boundaries by the PC to be of limited value given extensive work is still required by governments to define and agree boundaries. (sub. 60, p. 14)

A number of Administrative Appeals Tribunal cases have tested the boundaries of the NDIS (box 5.8), but given the narrow focus of these cases to date, their use in defining boundaries between services is limited. As more decisions are tested through the Tribunal, it can be expected that boundaries may be clarified. Importantly, however, the fact that a support is ruled to be best provided by a mainstream service does not in itself mean that the support will necessarily be provided.

Box 5.8 AAT Cases — whether a support is most appropriately funded by the NDIS

The following are examples of Administrative Appeals Tribunal cases that look at whether the requested NDIS support item is most appropriately funded by the NDIS or mainstream services. The cases have generally focused on specific claims for medical equipment and disability care.

- *Young and the National Disability Insurance Agency* [2014] AATA 401 — Young applied for a portable oxygen concentrator and insulin pump to be funded through the NDIS. The AAT found that the oxygen concentrator and insulin pump were clinical treatments and should be funded or subsidised under the health system.
- *McCutcheon and the National Disability Insurance Agency* [2015] AATA 624 — McCutcheon's NDIS support package did not include chiropractic care, which she appealed. The AAT found that the chiropractic treatment was related to McCutcheon's ongoing functional impairment and was therefore most appropriately funded by the NDIS.
- *Fear by his mother Vanda Fear and National Disability Insurance Agency* [2015] AATA 706 — On behalf of Fear, his parents applied for certain equipment (pulse oximeter and oral suctioning machine) as part of his individual support package under the NDIS, but they were not included in his plan. The AAT found that the oximeter and oxygen suction machines are more closely related to clinical treatment for Mr Fear's health and were the responsibility of the health system.

Interface disputes are an inevitable part of the transition process. Because of this, there needs to be a process to monitor interfaces, and prevent or resolve problems as they emerge.

The Commission considers that the most appropriate vehicle for the discussion and monitoring of mainstream services for this process is COAG. A standing item should be introduced through the COAG Disability Reform Council and at each COAG council that is responsible for services that interface with the NDIS, to discuss how the services interface with the NDIS.

The DSS suggested specific disability reporting across COAG Councils:

> Monitoring and reporting through COAG infrastructure could be strengthened by specific disability reporting across relevant COAG Councils, specifically on the effectiveness of mainstream systems in supporting all people with disability; and improving the interfaces between mainstream services and the NDIS.
>
> DRC could consider proposing this through its regular reporting to COAG, starting with the three agreed priorities for the *National Disability Strategy*:
>
> - mental health services outside the NDIS
> - health services for people with disability
> - over-representation and lack of support for people with disability in the criminal justice system (sub. 146, p. 28).

The *National Disability Strategy* should be strengthened to improve government accountability. There should be more detailed reporting around the boundaries of the NDIS and the implications for mainstream service provision. Specific commitments, key performance targets and outcomes should be set out. This should be pursued through review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreements. (An important commitment by governments under the Disability Reform Strategy was to use the review points of National Agreements and National Partnerships as an opportunity to assess their consistency with the aims and objectives of the Strategy.)

As the DSS said:

> Translating the National Disability Strategy into tangible results for people with disability, their families and carers is a major factor in successful implementation of the NDIS. (sub. 146, p. 5)

ILC and LAC can play a role in ensuring mainstream services are better informed about their roles and responsibilities.

DRAFT RECOMMENDATION 5.3

Each COAG Council that has responsibility for a service area that interfaces with the National Disability Insurance Scheme (NDIS) should have a standing item on its agenda to address the provision of those services and how they interface with NDIS services. This item should cover service gaps, duplications and other boundary issues.

Through the review points of National Agreements and National Partnership Agreements under the Federal Financial Relations Intergovernmental Agreement, parties should include specific commitments and reporting obligations consistent with the National Disability Strategy. The Agreements should be strengthened to include more details around how boundary issues are being dealt with, including practical examples.

5.4 Interface with aged care

An important issue in the design of the NDIS is the interface between the aged care and disability systems. As people with disability age, they are likely to experience age related conditions, such as increasing frailty, or the onset of age related neurological conditions (such as Alzheimer's). At the same time, a person may develop a non-age related disability later in life.

Under the NDIS, a scheme participant:

- under the age of 65 can choose to purchase support from an aged care provider and the NDIS will fully meet these 'reasonable and necessary' individualised support costs
- are free to remain in the NDIS once they turn 65, or they can exit the scheme and enter the aged care system
- ceases to be a participant when they enter a residential care service or start being provided with home based care on a permanent basis, but only after they turn 65 (DRC 2015b, p. 26).

There are incentives for people to stay in the NDIS

There are aspects of the design of the NDIS, and how it interfaces with the aged care system, that create incentives for people to stay in the NDIS after the age of 65, and encourage people nearing the age of 65 to apply for NDIS access (and have their needs met through the scheme, rather than through the aged care system).

There are different objectives and different supports

The NDIS and the aged care systems have different objectives.

The NDIS is designed to provide all eligible participants with a wide set of supports, while the aged care system rations places and the amount of government funding for each place.

- The NDIS is intended to support the independence of people with disability, the *Aged Care 1997 Act* (Cwlth) does not include independence or participation objectives.
- The NDIS aims to provide reasonable and necessary supports to participants, while the aged care system attempts to target limited resources to people within the system.

The NDIS is intended to provide each participant with reasonable care and assistance they need at each stage of their life. The scheme has a strong emphasis on contributing to the participant's independence and ability to participate in all aspects of life (including education, socially and economically). In addition, one of the objectives of the NDIS is to help participants enjoy the same rights as other people in Australia (NDIS Act s. 4(1)).

Aged care may require financial co-contributions. The NDIS does not.

While supports are provided at no cost to NDIS participants, means-tested co-contributions are a feature of the aged care system (My Aged Care 2017b). This means that there is a financial incentive for participants aged 65 years and over to remain in the NDIS, even where their needs could be better met through the aged care system. As noted by one participant (Name withheld, sub. 5, p. 1) as long as the market for providing services to NDIS participants is operating effectively, it is difficult to see why people would choose to transition from the NDIS to aged care.

That said, as noted by the DSS (sub. 146, pp. 14–15), 'for many with lifelong disability, it is unlikely that sufficient assets would have been accumulated for a means tested co-contribution to apply after the age of 65 years'.

However, means testing for aged care services is based on both income and assets, with co-contributions applying to people on an age pension — for example, the basic contribution for at home care costs is 17.5 per cent of the pension (My Aged Care 2017a). Contributions for residential aged care are higher.

It is too early to assess the cost implications

The Australian Government has agreed to fund the full cost of participants in the NDIS scheme aged 65 years or older. As the aged care system is also Commonwealth funded, this means that the cost of supporting older people falls to the Australian Government, whether they are in the NDIS or the aged care system. The additional costs to the Australian Government is the difference in the value of NDIS packages compared to the aged care costs that the same NDIS participants would otherwise have incurred.

If people aged nearly 65 join the NDIS, or those aged 65 or older elect to stay in the NDIS, there is a cost implication — the NDIS is more generous in support provided, and requires no co-contribution. As such people staying in the NDIS rather than moving to the aged care system is likely to result in higher expenditure for the Australian Government. It could also raise questions about equity.

Given the infancy of the NDIS, the interface between the scheme and the aged care system is yet to be tested. There are currently very few participants aged over 65 years in the scheme and the average support costs for this group are lower than expected (DSS, sub. 146, p. 14). However, the higher costs associated with the past few years of life and issues around the interface with the aged care system are unlikely to have materialised as the oldest participants in the scheme are 69 years of age (DSS, sub. 146, pp. 14–15). By 2019-20, however, there are expected to be around 15 000 scheme participants aged 65 years or older (chapter 2).

As part of the NDIS transition arrangements, the aged care system is implementing a new continuity of support program for people aged 65 and over — it is looking at who is

ineligible for the NDIS and who is currently in state specialist disability services. Insights from this program should help inform the aged care system in providing specialist disability supports (DSS, sub. 146). There should be ongoing monitoring as the scheme matures.

5.5 Interface with the National Injury Insurance Scheme

In 2011, the Productivity Commission also recommended a National Injury Insurance Scheme (NIIS) that would operate in parallel to the NDIS. At the time, the Commission considered it a priority to establish a no-fault lifetime care and support scheme for catastrophic injuries, as many Australians acquiring such injuries were receiving poor care and support because they were unable to find an at-fault party to sue.

Under the model proposed by the Commission, the NIIS was to fully fund health, rehabilitation and care and support costs for all newly acquired catastrophic injuries. As such, lifetime care and support needs of people with newly acquired catastrophic injuries would be met through the NIIS and not the NDIS. However, the care and support needs of people with existing catastrophic injuries, and not covered under any no-fault arrangements, would be met through the NDIS.

The NIIS, as proposed by the Commission, was to operate as a federation of individual state-based no-fault insurance schemes. Implementation of the NIIS is overseen by the Australian Treasury and has been undertaken across four streams — motor vehicle accidents, workplace accidents, medical treatment injuries and general accidents (occurring in the home or community).

The Commission, in 2011, recommended that the NIIS be in full operation in 2015, or before the full rollout of the NDIS. This was on the basis that there were well-established schemes in place that could form the blueprint for the design of schemes and the number of people affected was relatively small (around 1000 people a year) (PC 2011, p. 863). This has not happened. Of the four streams, motor vehicle accidents has been completed, and workplace accidents is in the process of being completed — a consultation Regulation Impact Statement has been released and progress is being made towards setting minimum benchmarks.

Progress on the other two streams, medical accidents and general accidents, has been slower. A discussion paper was released in 2015 for the medical treatment injuries stream (Australian Treasury 2016c); however, negotiations for the general accidents stream have not commenced. The DSS (sub, 146, p. 25) noted that over the short to medium term, the medical and general streams may not be implemented, with a number of implementation challenges identified for the medical stream.

As there is no agreement in place by the states and territories to commit to the funding for, or establishment of, the medical and general accident streams, anyone who acquires a

catastrophic injury from a medical or general accident will receive supports through the NDIS. This will have a direct impact on NDIS costs. As the DSS said:

> Contingencies are needed if the full NIIS is not delivered, as this would move costs onto the NDIS. … If the NDIS were to pick up responsibility the funding obligation would sit fully with the States, which have responsibility for implementing the NIIS. (sub. 146, p. 5)

The number of people entering the NDIS, who would otherwise be covered by the medical or general accident streams of the NIIS in any one year is expected to be relatively small — across both streams the Commission in 2011 estimated there to be around 400 people.

But over time, as new people enter each year, there is a cumulative effect. To illustrate, modelling undertaken by the NDIA suggests that the cost to the NDIS of the medical and general schemes not operating would amount to about $23 million in 2018-19, but would increase to about $226 million in 2025-26 and to around $1.3 billion in 2040-41 (table 5.3).

Table 5.3 **Medical and general accidents costs to the NDIS**
$ million

	2018-19	*2019-20*	*2020-21*	*2025-26*	*2030-31*	*2035-36*	*2040-41*	*2045-46*
Medical	1	3	7	33	71	121	186	271
General	4	19	42	193	417	712	1 098	1 597
Total	**5**	**23**	**49**	**226**	**488**	**833**	**1 284**	**1 868**

Source: NDIA modelling.

One of the key goals of the NIIS is to deter high-risk behaviour and reduce local risks that can contribute to accidents. For this reason, in 2011 the Commission argued that premiums and state and territory funding should be used to send price signals and encourage greater incentives for safety.

The Commission acknowledged that the appropriate funding source for no-fault coverage of catastrophic injuries following medical treatment is more complex than for other accidents. A key consideration is to build on existing incentives to minimise risk by:

- motivating the systematic collection and analysis of data that may decrease risks
- varying premiums depending on whether practitioners (or the health sector more broadly) follow best practice protocols and have the appropriate training and credentials (PC 2011, p. 877).

In terms of general injuries, accidents result from a number of causes, such as environmental factors (for example, maintenance of footpaths and safety of play grounds) and the nature of activity being undertaken (such as recreational activities). For this reason local governments (which are devolved powers by the states and territories) are in a better position to implement incentives to minimise the risk of accidents (such as proper signage

around dangerous areas) and are able to collect revenue reasonably efficiently to fund the NIIS, including a potential levy on local government rates.

Because the states and territories have greater control over implementing risk reducing programs (and therefore, indirectly, the costs of the NIIS), they should bear the costs of the NIIS if it remains only partially rolled out for an extended period. A number of participants pointed to the costs to the NDIS.

> Not proceeding with the medical or general streams of the NIIS will have a direct impact on the NDIS by increasing overall Scheme costs. … Any additional cost, not adequately funded by the States, is a risk to the Commonwealth. (DSS sub. 146, p. 26)
>
> The sustainability of the NDIS depends on a complete NIIS that, in providing no fault insurance for catastrophic injury, removes the significant cost drivers of these injuries from the NDIS. (Young People In Nursing Homes National Alliance, sub. 187. p. 4)
>
> Without the NIIS in place, further cost-pressure will be placed on the NDIS. (NDIA sub. 161, p. 113)

The Commission is seeking feedback on a mechanism to ensure that the states and territories bear the cost of participants who were intended to be covered by the NIIS.

INFORMATION REQUEST 5.1

The Commission is seeking feedback on a mechanism to ensure that the States and Territories bear the cost of participants who were intended to be covered by the National Injury Insurance Scheme.

6 Provider readiness

Key points

- Providers play an important role in meeting the needs and goals of National Disability Insurance Scheme participants, and improving their lives. However, the transition to a market-based system means that providers will need to make substantial changes to the way they provide disability supports. They need to become more efficient, innovative and responsive in the delivery of supports to participants.
- The supply of disability supports affects scheme costs. If there is insufficient supply, scheme costs are likely to be lower in the short term because individualised supports are underutilised, but higher in the long term as participants are unable to access the supports that can reduce their costs of care in the future.
- The National Disability Insurance Agency (NDIA) currently sets the maximum price of disability supports that can be charged by NDIA-registered providers. However, the responsibility to set prices may conflict with the Agency's other responsibilities, including maintaining financial sustainability and its market stewardship role. This potential conflict should be addressed in three stages, by:
  - introducing an independent price monitor to serve as a transparent 'check and balance' on the NDIA's pricing over the transition period
  - transferring the NDIA's power to set prices to an independent price regulator, who would also be responsible for deregulating the prices of supports
  - continuing independent price monitoring following price deregulation.
- While the market-based approach to providing disability supports will increase incentives for providers to deliver supports in areas previously undersupplied, there will still be 'thin markets', where there are few, if any, providers. Arrangements to deal with thin markets (including Provider of Last Resort arrangements) need timely and considered attention because shortages, less competition and poorer outcomes for participants may persist. While there is a range of ways to address access issues (including block-funding), ongoing public reporting, monitoring and evaluation of thin markets is crucial.
- Participants to this study also raised other potential barriers to supply — including moving to fee-for-service, administrative burdens, in-kind services and collaboration in the sector. While these are likely to be transitional issues, ongoing monitoring can ensure that they do not become entrenched or systemic issues.

The ability of the disability support sector to provide disability supports has a direct bearing on National Disability Insurance Scheme (NDIS) costs. If there are not enough providers and workers to deliver the supports allocated by the National Disability Insurance Agency (NDIA) to participants, this will lead to underutilisation of supports, and ultimately lower than expected costs to the scheme in a given year, and poorer outcomes for participants (and their families).

Costs should be considered from a long-term perspective. When reasonable and necessary supports are allocated to participants under the NDIS's insurance-based approach, the package of supports should minimise the long-term cost of care to the community. If these supports are not available, the costs of supporting participants may be higher in the long term — because of more services demanded through the NDIS, through other government services, or through informal carers. There are also costs to participants and their families from reduced wellbeing.

The loss in wellbeing of not being able to access supports for a person with disability will vary by the type of support. For example, not being able to find a carer to provide core supports (like an attendant carer to provide assistance to get out of bed and with personal daily activities) is likely to impose a higher cost on a person with disability than being unable to find a provider for community-engagement activities. Also, the use of the community-engagement support is likely to be contingent on being able to find someone to provide core supports, and vice versa.

The focus of chapters 6-8 is on how ready the market (providers, workers and participants) is to respond to such growth in demand, and how this will ultimately affect scheme costs. This chapter considers how existing and new providers are responding to the increased demand for supports under the NDIS. Section 6.1 provides a snapshot of the current state of the disability support sector and the expected growth required to meet the demands of the NDIS. Section 6.2 examines the pricing of disability supports in the context of market growth to date. Section 6.3 looks at where the market supply for disability supports could be limited and result in 'thin markets'. Section 6.4 discusses other transitional matters affecting provider readiness.

6.1 The disability support sector

People with disability have a range of different wants and needs (including personal care, therapy, and assistance with cleaning and mowing), which require a variety of supports. In turn, the cost of providing a range of services varies by region and the degree of competition. This means that there are a number of submarkets within the aggregate disability support market. As explained by one provider, there are particular characteristics of the disability support market that distinguish it from a traditional market.

> The disability support 'market' is not a normal or 'perfect' market in classical economic terms. It is about providing a range of customised supports, human and technological, paid and unpaid, to meet complex and often poorly-defined human needs and wants. Outcomes are often hard to measure and report. Information is unbalanced. Regional, rural and remote markets are 'thin'. The 'buyers' of services and their local situations are diverse and heterogeneous, not homogeneous. Many are vulnerable. (House With No Steps, sub. 104, p. 1)

It is within this context that the NDIS is driving market-based competition between disability support providers, at a time when the size of the aggregate disability support market needs to increase significantly to meet NDIS demand.

This includes:

- a shift away from a block-funded, welfare model of support to a fee-for-service, market-based approach
- an increase in funding for the sector from about $8 billion in 2015-16 to $22 billion by 2019-20 (SCRGSP 2017)
- assessing and meeting the reasonable and necessary needs of about 475 000 people by 2019-20 (chapter 2)
- about 70 000 additional workers (or about 20 per cent of all new jobs created in Australia) in the three-year transition period to full scheme (Bonyhady 2016, p. 5; chapter 7).

As put by the NDIA:

> In the first year [of transition], to meet projected Scheme demand, growth in supply needs to be around eight per cent. By the second and third year respectively, growth must reach 30-40 per cent, although … the supply needed to meet funded participant demand varies depending on location. (2016k, p. 8)

The market for disability supports is diverse and difficult to characterise in general terms. There is a range of different markets for people with disability. Some providers specialise in providing supports for those with specific disability, while others specialise in providing particular types of supports (such as accommodation or therapeutic supports). Others provide a much broader service. NDIA 2016k, p. 8)

The data on disability support providers are patchy. The most comprehensive data were collected by Martin and Healy in 2010. More recent work by National Disability Services (NDS) and Curtin University's Not-for-profit Initiative contains data on provider characteristics and financial performance.[21]

Notwithstanding the data limitations, a few broad points can be made.

- Many providers are small. About 40 per cent of disability service outlets employed 10 or fewer disability workers (Martin and Healy 2010, p. 122). The NDS estimated that about 58 per cent of providers are either small or very small (with a turnover of less than $5 million) (Gilchrist and Knight 2017, p. 10).
- About 80 per cent of disability providers are not-for-profit (NDS 2016, p. 7).
- Most providers do not exclusively provide disability services. About 57 per cent of providers surveyed by the NDS provided services in other areas, such as aged care, mental health and homelessness (NDS 2016, p. 13).

[21] The National Disability Services' (NDS) State of the Disability Sector Report 2016 is based on the fourth wave of the National Business Confidence Survey of 549 disability service providers, of whom 486 were NDS members and 63 were non-members (NDS 2016, p. 7). The NDS has also undertaken a financial benchmarking project for disability services (NDS nd).

How will the sector need to change under the NDIS?

While a lack of data prevents a complete evaluation of the current state of the sector, envisioning how the future disability sector will look under the NDIS is even more difficult. Some of the supports required by participants will be provided by existing providers who expand, while others will be provided by new entrants. However, it is not certain:

- how many providers will be needed — and the proportion of new and existing providers
- what the proportion of for-profits, not-for-profits and government service providers will be
- whether there will be greater specialisation by disability, type of support, or both
- how long it will take for these changes to occur.

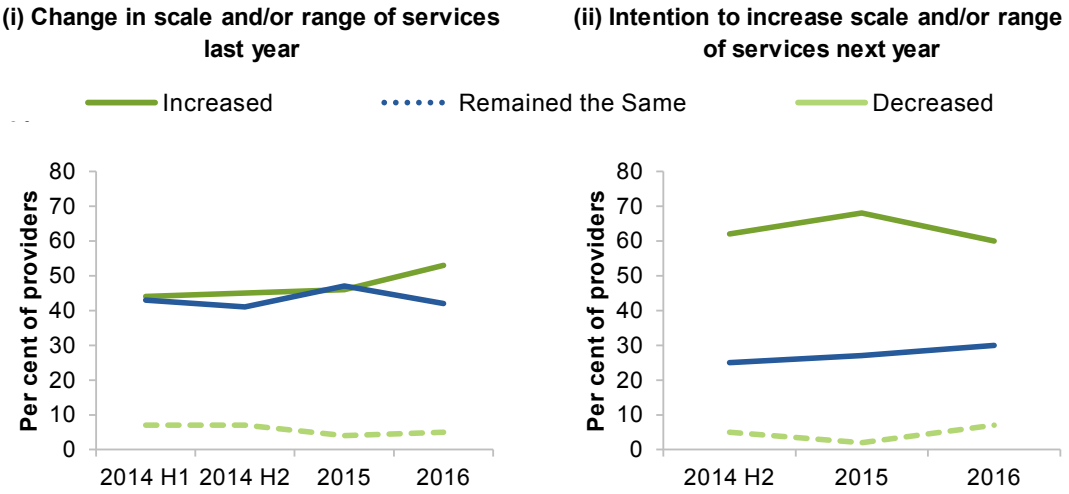
This uncertainty is reflected in estimates on the number of providers needed under the NDIS. The ANAO (2016, p. 68) estimated that between 13 500 and 40 000 providers will be needed by the end of the transition period in 2020. Therefore, understanding how existing providers are responding to, and whether new providers are entering, the NDIS market is important.

The NDS survey of providers gives some insight into how existing providers are responding. The majority of providers surveyed said that they expanded their services last year, and that they intend to expand further next year (figure 6.1). Providers reported increasing their services particularly in the areas of therapy, early intervention, and planning and coordination supports (NDS 2016, p. 11), but the amount of additional supports is unclear. However, some providers also reported plans to reduce or stop supplying services in other areas, and that they are entering new markets (outside of the disability support sector) (NDS 2016, pp. 12–13). The financial position of providers is also variable, and in turn, the strength of existing supply.

It is more difficult to ascertain the size, scope and number of new providers who are entering the market in response to the NDIS. Data are available on the number of providers *registered* with the NDIA to provide supports under the scheme, which includes both existing and new providers (figure 6.2).

While registrations increased by about 30 per cent between the December 2016 and March 2017 quarters, about 54 per cent of registered providers are yet to provide a service, and the top 25 per cent of registered providers currently account for about 80-90 per cent of the value of payments made by the NDIA for participant supports (NDIA 2017o, pp. 38, 41).

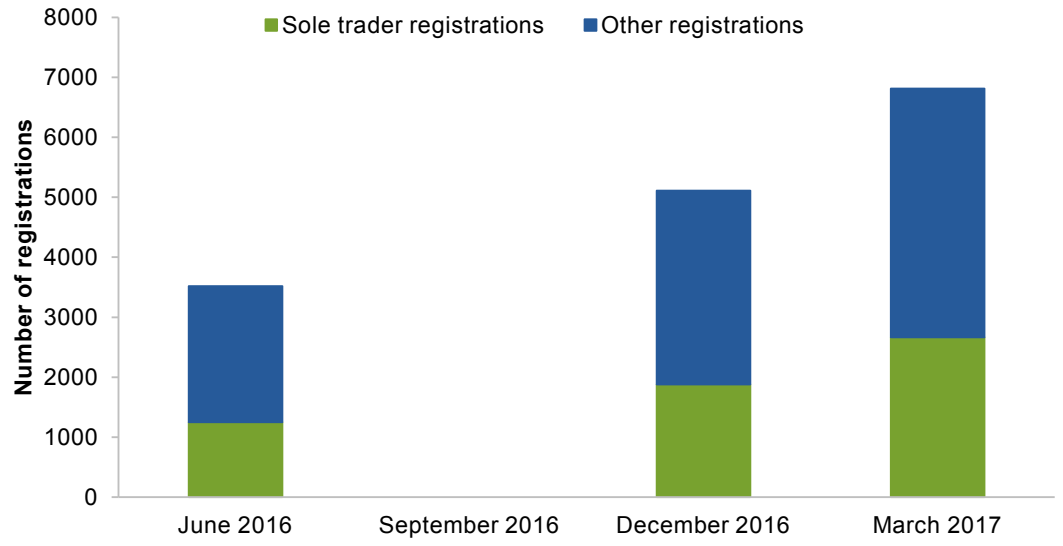
Figure 6.1 **Providers' response and intention to increase supply[a]**



[a] H1 and H2 refer to the first half and second half of the calendar year respectively.

Source: Gilchrist and Knight (2017, p. 16), who surveyed 492 respondents.

Figure 6.2 **Cumulative number of NDIA-registered providers by quarter[a]**



[a] Data for September 2016 are unavailable.

Sources: Commission estimates based on NDIA (2016t, 2016u, 2017o).

This is consistent with NDS data, where 77 per cent of providers surveyed had registered, but only about half had provided services under the NDIS (Gilchrist and Knight 2017, p. 5). One explanation could be that some providers are registering to provide services ahead of the NDIS rollout in their location (NDIA 2017o, p. 41; DSS, sub. 146, p. 36).

Growth in registrations of those providing therapy supports — usually allied health professionals — has been strong, and accounted for 54 per cent of the increase in registrations in the quarter ending 31 March 2017 (NDIA 2017o, p. 40).

While the scale of market growth to date is uncertain, many providers pointed to two challenges to developing the market for disability supports:

- the effect of price controls for supports set by the NDIA
- concerns that some markets will be too small to be profitable for providers to supply.

The next two sections examine these concerns in turn.

6.2 Pricing of disability supports

In a mature market, the choice and control that participants exercise will increasingly be the main factor driving the price of disability supports. Allowing the market to determine the price of supports is an important tenet of the NDIS, as it will contribute to both participant outcomes and the financial sustainability of the scheme.

However, there is a need for the temporary regulation of prices in the disability support sector, as recommended by the Productivity Commission in its 2011 *Disability Care and Support* inquiry (box 6.1).

Box 6.1 Why regulate the price of disability supports?

Governments have historically regulated the price of human services (PC 2016, p. 35), including disability care and support services, on the grounds of equity and efficiency. Absent price regulation, the use and provision of disability supports may be below socially optimal levels for a number of reasons, including ineffective competition and abuse of market power (NDIA 2017a, p. 5).

In particular, there may be too few providers in the market, which is a real risk in the disability support sector. Early data indicate a market concentration of more than 80 per cent in some disability service sub-markets (NDIA 2016p, p. 32, 2016w, p. 29, 2016aa, p. 38; DSS, sub. 146, p. 38). This may result in prices that are too high, and limited access to services for some disadvantaged groups. Others have noted the need to maintain price controls in the foreseeable future, as it may take at least a decade for the new market for NDIS disability supports to develop (ANAO 2016, p. 54; AONSW 2017, p. 5; DSS, sub. 154, p. 39).

The Commission in 2011 recommended that an early — albeit temporary — task for the NDIA was to set efficient prices to allow providers to recover the costs of service provision (including adequate returns for capital investment), and in turn, ensure the supply of disability supports (PC 2011, pp. 51, 412–414). While the NDIA has set prices since the beginning of the NDIS trials in July 2013, the Agency indicated that it does not plan to do so in the long term.

> During transition, the market stewardship role of the Agency will be more active; to facilitate development of the marketplace and as a catalyst for basic market infrastructure. This includes … setting prices and pricing policy …
>
> The setting and reviewing of NDIS prices is a significant market-intervention initiative … for most submarkets, it sees this [price-setting] as a temporary measure to support the marketplace. In the long-term, the NDIA will not set prices to the extent it does now and will instead allow the marketplace to determine the price of supports. (NDIA 2016k, pp. 18, 26)

An important principle of price regulation is that it should not persist unnecessarily, have excessive scope, nor shape the market — such as by benefiting some providers or participants over others.

How are prices set?

The NDIA sets the total value of a participant's support package as part of the planning process (chapter 4). Participants can only purchase supports from NDIA-registered providers if they want the Agency to manage their plan (chapter 8). These supports are subject to a maximum price set by the NDIA — 'a price cap'. Given that about three-quarters of participants are currently subject to these price caps (NDIA 2017o, p. 21), price controls have considerable scope to affect market development.

The NDIA walks a fine line in setting prices.

> The NDIA risks unnecessarily disrupting existing markets through setting prices inaccurately. If price limits are set too high (relative to an efficient benchmark) providers will not face adequate incentives to review practices and operations in an effort to be more efficient. As a result, participants, and the Scheme in general, would not get value for money from expenditure on supports. On the other hand, if price limits were set too low, providers would be

> unable to recover even efficient costs. This could result in a significant share of providers leaving the sector and/or a lack of new investment in disability services. (NDIA 2016r, p. 10)

This is reflected in the rationale of price caps, which is to:

- ensure 'value for money' for participants — as the price of supports may be bid up too quickly in the absence of price caps in the period after funding is allocated to participants, but before the disability support sector grows sufficiently to meet the increased demand
- encourage the market supply of disability supports by giving providers sufficient incentive to grow and enter the NDIS market (NDIA 2016s).

There are also trade-offs associated with price controls. While fixing prices causes scheme costs to be lower in the short term, it may slow the development of the market. Conversely, the deregulation of prices could mean higher short-term costs, but potentially lead to faster growth of the market in the long term.

The NDIA currently sets price caps using a 'reasonable cost model', which seeks to 'define the direct cost elements at a rate that is sufficient to cover the efficient costs of a reasonable quality support provider at a point of time' (NDIA 2014a, p. 2). Prices are intended to reflect an estimate of what the long-term 'efficient' price would be in a competitive, deregulated market, *plus* an additional margin to reflect both the cost and time needed for existing providers to transition to a market-based system, and to entice new providers to enter the disability support market (transitional pricing). To do this, the reasonable cost model makes a number of assumptions about the cost of providing supports, which vary by the support in question (box 6.2).

Prices are currently set by annual reviews conducted by the NDIA. The price review for 2017-18 was recently completed, with prices effective from 1 July 2017 (NDIA 2016a). This price review included an examination of the evidence and methodology used to set prices, with a focus on attendant care (NDIA 2017a, p. 8). The Agency also considered changing the nature of price information provided to firms by introducing 'price bands', which would consist of two components: a benchmark price that reflects the efficient costs of providing a reasonable and necessary level of care, and a price cap *above* the benchmark price reflecting the maximum price that can be charged under the NDIS (NDIA 2017a, p. 17).

Regulating prices is always difficult — regulating a market that is still developing and undergoing significant change is even harder, as the past may offer less guidance to regulators than in a mature market, and there is an increased risk of disruption caused by regulated prices. Prices are also only one of many factors that affect the willingness and ability of providers to supply disability supports.

Box 6.2 The NDIA's reasonable cost model used to set price caps

The reasonable cost model (RCM) uses a range of assumptions that have been developed in consultation with the disability support sector to determine the price cap for a given support type under the NDIS. These price caps are intended to inform providers about the efficiency levels that should be targeted under the market-based system. To date, price caps have included an additional premium to reflect the costs of transitioning existing providers into the scheme, and to give new providers an incentive to enter the sector.

One support subject to a price cap is the cost of an hour of attendant care — one of the most common supports provided under the NDIS. The RCM assumes the following conditions for an hour of attendant care provided in 2016-17.

- The hourly rate of pay is based on the *Social, Community, Home Care and Disability Services Industry Award 2010* pay point 2.3 for employees and 3.2 for managers or supervisors. Pay rates depend on whether the hour worked is on a weekday (6am-8pm or 8pm-12am), Saturday, Sunday, or a public holiday.
- Employees are employed on a full-time or permanent part-time basis. No allowance for shift work or other allowances are included. Leave entitlements are ten days of paid personal leave; four weeks of paid annual leave at 17.5 per cent leave loading; and 17.98 per cent of employees achieve long service leave of 8.67 weeks.

In terms of other costs, including 'on-costs', the RCM assumes:

- loadings for location (18 and 23 per cent for remote and very remote areas respectively) and the complexity of client needs (about 6 per cent)
- that carers spend 95 per cent of paid time with clients, and that managers spend 90 per cent of time with clients, or dealing with client matters. A manager is expected to supervise 15 employees (for standard needs clients)
- that providers operate with a corporate overhead equal to 15 per cent of total salary, management and non-client facing expenses. There is an additional payment for provider travel costs for travelling between clients (maximum 20 minutes).
- superannuation is 9.5 per cent of total salary costs, and workers' compensation insurance is 4 per cent of total salary costs
- a profit margin of 5 per cent of total costs, as well as an additional margin for the transition pricing period.

The RCM, under these assumptions, results in a price cap of about $42 for an hour of attendant daytime weekday care in metropolitan New South Wales, Victoria, Queensland and Tasmania. About a third of this price is for on-costs.

Most of the assumptions and methodology of the model were initially developed in consultation with National Disability Services; however, the parties did not agree on what assumptions were appropriate for the future efficient price (NDIA and NDS 2014, p. 16). Many providers who made submissions to this study argued that the price caps resulting from the RCM are inappropriately low (box 6.3).

Sources: NDIA (2016l, 2016m, 2016n, 2016o, 2016s, 2017a).

However, prices are also important because they affect participant choice and control. What participants want and need should ultimately be the main driver of prices — something that can be most effectively and efficiently achieved in a market *without* price

controls. This is because price caps constrain quality, variety, innovation and ultimately reduce the benefits to participants. It is therefore important that prices are not regulated where it is unnecessary to do so.

Prices affect who providers choose to supply. Although it is difficult to get a complete picture as the scheme is still early in the transition period, a number of providers submitted to this study that they were unable to provide services for participants with complex needs at the prices derived from the reasonable cost model (Anglicare Australia, sub. 157, pp. 11-12, 19; CMHA, sub. 11, pp. 5, 13; Leadership Plus, sub. 128, pp. 3-4; NDS 2017c, p. 4; United Voice, sub. 118, p. 12; VCOSS, sub. 176, pp. 20-21) — an unintended consequence of assumptions in the model of a single complexity loading, base salary rate and supervisory requirements. As put by the Brotherhood of St Lawrence:

> The existing fixed pricing structures pose some problems for both participants and service providers because they fail to take into account the circumstances of activities. By setting a single price, the provider does not have the option to charge less or more for a tailored service. This has the unintended consequence of reducing the choice and control of people with disability. (sub. 189, p. 20)

NDIS transition data tend to suggest greater underutilisation of supports for those with complex needs (as proxied by level of function). While this could indicate problems with plans or participant readiness to navigate the NDIS (chapter 8), many study participants indicated that those with complex needs were experiencing significant difficulties with finding providers willing to provide services to them.[22]

Some concerns about prices may reflect a general inefficiency by providers or a reluctance to change business practices. While a number of study participants raised concerns about the adequacy of prices to provide quality supports (box 6.3), the NDIA submitted that some providers may be finding it difficult to become more efficient under the new fee-for-service model.

> Some providers have raised concerns that NDIS price levels are too low, particularly for personal care and community supports, but have generally not supported these arguments with clear evidence. Other providers have suggested that current price levels are appropriate. These contradictory views within the provider population might be evidence that some are struggling to adjust to a funding model that is based on market principles. There is also evidence of a wide variation in operating costs under pre-NDIS approaches where efficiency was not a key consideration. It also might reflect changes in volume as well as the extent of cross-subsidisation of services that previously existed.
>
> The NDIA effort to set maximum prices has incorrectly been taken by many in the sector to authorise an 'NDIS price' for their services, which is often inflated above actual costs. (sub. 161, p. 101)

[22] Including: ACT Government (sub. 156); Anglicare Australia (sub. 157); Belinda Jane (sub. 80); Disability Services Australia (sub. 9); Disability Services Commissioner Victoria (sub. 35); National Disability Services (sub. 51); Scope Australia (sub. 72); and Victorian Government (sub. 174).

Given that the most recent price review by the NDIA has only just concluded (with new prices to take effect on 1 July 2017), the Commission has not made any findings or recommendations about the adequacy of prices at this stage.

Box 6.3 Study participants' views on NDIS price caps

Many providers gave anecdotal evidence to the study about the NDIS price caps being too low to provide services, with a particular focus on the price cap for an hour of attendant care. Estimates of the shortfall between what was needed against what the cap offered varied considerably.

- House with No Steps (sub. 104, p. 3) indicated a shortfall of about 10 per cent.
- Belconnen Community Service Board (sub. 39, p. 1) indicated a shortfall of between 10.5 and 16.0 per cent.
- Cohealth (sub. 50, p. 11) indicated a shortfall of 98 per cent for those with mental health needs.

The Commonwealth Ombudsman provided an anecdote in relation to wages relative to other care sectors.

> … at a recent consultation a provider told us they could bill around $10 per hour more for providing in-home domestic assistance for aged care clients than they could for providing the same service to an NDIS participant. They suggested it was difficult to understand the rationale for this difference and said it created a risk that service providers would focus their service provision on areas that were more financially sustainable, leaving NDIS participants with even fewer choices. (sub. 137, p. 14)

While these anecdotes are helpful, data and evidence on how the overall market is responding to price caps are limited.

A survey by National Disability Services in partnership with Curtin University found that 67 per cent of respondents reported that they were worried that they would not be able to provide services at the prices being offered under the NDIS. And 46 per cent advised that to provide services at the prices being offered by the NDIA, they would have to reduce the quality of service (NDS 2016, p. 19). Although 55 per cent of disability support organisations reported making a profit, only 40 per cent of respondents budgeted to make a profit in 2016-17 (NDS 2016, p. 14).

Another report applied assumptions in the pricing model that it considered to be more representative of what could be achieved by disability support providers. It found that the price cap on an hour of attendant care would have to increase by approximately 13 and 25 per cent for providers to continue to provide care of a reasonable quality (Samaritans Foundation, in Anglicare Australia, sub. 157, att. 4, p. 1).

Should the NDIA set prices?

Regardless of the effectiveness of the NDIA's price caps to date, a question that needs to be asked is whether the NDIA should be setting prices. Even though it is an independent statutory agency, the NDIA's roles of funder and purchaser of supports, market steward and guardian of financial sustainability mean that it has a potential or perceived conflict when setting prices.

Typically, agencies such as the NDIA are not placed in such a position when managing human services provision. This was noted by the ANAO in its audit of the performance of the DSS' and NDIA's management of the transition of the disability services market.

> … the NDIA's dual roles in the market as both a funder or 'purchaser' on behalf of governments, and as a price 'regulator' presents a conflict of interest which needs to be transparently managed. In other (largely public-provided) sector transformations such as the establishment of the national energy market, governments have progressively taken steps to establish independent pricing regulators, for all or part of the market's operations where public interest concerns remain. In a similar human service delivery market, the Aged Care Financing Authority provides independent advice to government on funding and financing matters.
>
> In the context of entities' analysis of NDIS market arrangements, and advice to governments' on the NDIS market design, the ANAO could find no evidence that the implications of these dual market roles for the NDIA had been actively examined. (2016, p. 30)

This concern was shared by the DSS (sub. 146, p. 39), who suggested that while the NDIA is best placed to continue to set NDIS prices in the short term, consideration should be given to prices being set by an independent pricing authority in the medium term (ideally within the next five years). The New South Wales Government (sub. 60, p. 8) queried whether prices should be set by the NDIA, when the independent regulation of prices has assisted market development in other sectors. The Victorian Government (sub. 174, p. 19) also emphasised the need for prices to be set independently.

Is there a better way to set prices?

A fundamental tenet of the NDIS is for prices to be driven by the market in the long term. While price caps are only meant to be transitional, if set inappropriately, there is the risk that the NDIA's pricing decisions 'make the market', rather than allowing the market to develop in a way that reflects the needs (and goals) of participants. To avoid this outcome, price controls need to be evidence-based, set transparently and determined independently.

Evidence and transparency are essential

As the NDIS disability support market is still developing, the evidence base needed to determine the appropriate price controls is limited. This is reflected in the NDIA's approach, which includes consultation with the disability support sector.

> In the roll-out phase of the NDIS, the NDIA is adopting a cautious approach to price controls in the absence of information on the competitiveness of markets for supports. (NDIA 2017a, p. 5)
>
> Price control decisions are informed by significant input from market stakeholders through regional forums, targeted workshops, individual discussions and responses to discussion papers. (NDIA, sub. 161, p. 100)

This approach is consistent with the Office of Best Practice Regulation's recommendation that the NDIA:

> … continue to make its decisions about the setting of reference prices transparent, continue to work with the NDS to collect information on the costs of providing supports, and continue to monitor the impacts of reference prices on existing providers. (2015, p. 43)

There is some evidence that the NDIA has responded to market circumstances and feedback. For example, the NDIA increased price caps for personal care and community supports by about 10 per cent in 2014 and 2015 at some NDIS trial sites (ANAO 2016, p. 47).

However, some providers argued that they have had no real opportunity to provide feedback on pricing decisions. For example, House with No Steps (sub. 104, p. 4) said that there was a 'lack of real consultation by the NDIA with service providers', and that they had never been formally consulted on any matter (including prices), despite being one of the largest providers nationally.

> Our frustration is that this pricing is relatively easily and transparently modelled in an Award environment. Such modelling, if publicly shared, would move the discussion from the inadequacy of a 'black box' number to an informed discussion around cost drivers such as staffing mix, management spans of control and overhead levels. We understand such modelling has been carried out by the NDIA and independent actuaries and, if so, do not understand why the output of those modelling exercises has not been made public or reflected in NDIA pricing. (sub. 104, p. 3)

These frustrations extend to a lack of usable information about prices needed to provide meaningful feedback.

> The NDIA's process for pricing services of various kinds has been difficult for non-government stakeholders to understand or contribute to … Providers have also been largely unable to provide detailed advice in response to any consultations either during or subsequent to the RCM's development. To build the NDIA's evidence base for 'a market price' for psychological services, Mental Health Australia asked the NDIA to check the assumptions in the model with providers, but to our knowledge this did not occur. (Mental Health Australia, sub. 155, p. 22)

Concerns about a lack of transparency and consultation appear to be shared by many others (not just providers) — including the Health Services Union (sub. 132, p. 10), the ACT Government (sub. 156, p. 27) and the ANAO (2016, p. 13). As part of its most recent price review, the NDIA said that it had received feedback from stakeholders that there was:

> … a lack of transparency on the assumptions and methodology used to calculate price controls (which could affect discussion about how price arrangements relate to other parts of the NDIS, as well as debate about the price controls themselves). (2017a, p. 7)

To address this lack of transparency, the NDIA released additional information about pricing as part of the latest pricing review (NDIA 2017a). That said, the price-setting process remains largely opaque. Submissions to the price review process are not made public, nor is it clear how the material is used. Details about the operation of the RCM are not in the public domain.

The lack of transparency around prices is at odds with the practice of independent price regulators in other sectors.[23] It is also inconsistent with the Commission's 2011 recommendation that the NDIA's recommendations to change prices should be transparent, if the Agency is to set prices (PC 2011, p. 412). Transparency is important to impose discipline and public accountability in setting prices, as well as to increase credibility and certainty of price signals, which assists with forward planning and investment by providers. It also creates greater incentives for new providers to enter the disability support market, and helps build community confidence that the prices for supports are fair and reasonable for providers, participants and taxpayers. A lack of transparency can erode this confidence, and put the scheme at risk.

An independent price regulator

The transition period of the scheme represents an opportunity to resolve concerns about the NDIA's perceived conflict of interest and lack of transparency in price regulation. It is also an opportunity to provide greater certainty to providers about how and when price deregulation will occur, which is a key milestone in moving to a market-driven approach.

The Commission considers that prices for disability supports should be deregulated in three stages. In the first stage, the NDIA would maintain its role of price regulator, and an independent price monitor would be introduced with responsibilities, including to:

- examine how the market is responding to price caps set by the NDIA
- review the NDIA's price caps based on the available evidence, including submissions made to the NDIA's price reviews, and making comparisons with prices in other care sectors (including aged care)
- report publicly on its assessment of the NDIA's price controls with regard to market development and participant outcomes.

This monitor should be put in place immediately to serve as a 'check and balance' on the NDIA's pricing over the crucial transition period. The monitor would improve transparency on how price caps are set, and in turn, lead to greater accountability to participants, providers and the wider community.

The second stage is to shift the NDIA's price-setting powers to a regulator that is an independent statutory authority — an approach consistent with the evolution of other markets for consumer-directed care, such as in the aged care sector. This would allow the NDIA to focus on its core responsibilities of delivering and administering the NDIS; remove any potential conflict of interest; and help address concerns about a lack of transparency in price regulation.

[23] For example, aged care (Aged Care Pricing Commissioner), electricity and telecommunications (Australian Competition and Consumer Commission), minimum wages (Fair Work Commission) and hospitals (Independent Hospital Pricing Authority).

At this time, the Commission envisions that the independent price monitor would be best placed to take over these pricing powers, as it would have developed the knowledge and expertise necessary to understand the disability support market.

The body tasked with price regulation for scheme supports (including the NDIA while it remains the price regulator) should, among other things:

- collect and publicly report data on providers' characteristics and costs — public reporting of this data would provide a benchmark for providers, inform public debate about prices, and facilitate relevant research by external parties
- communicate with disability support providers, participants and the NDIA to transparently set prices at regular intervals, with sufficient time for providers to phase in price changes
- periodically review and publish its price model for transitional and efficient prices in a transparent and comprehensive manner
- send granular and targeted price signals — that is, provide prices at the state and territory level, with an expectation that prices could be set at a more disaggregated regional level where possible
- assess and recommend — on the basis of transparent consultation and evidence — when prices for particular NDIS supports in each region should be deregulated, and evaluate whether there is a need for price controls. To enable efficiencies to be driven by the market wherever possible, the price regulator should presume that it is appropriate for prices to be deregulated — that is, to only have price controls when there is clear evidence that unregulated prices are likely to lead to inflation that would harm participants.

Pricing of NDIS disability supports should be transferred to the independent body by 1 July 2019. This is important for providing certainty to the sector of a transparent pricing regime. There is also an expectation that price regulation will be required for some supports over the medium to long term.

The third and final stage of deregulation will occur when the price of a given disability support is deregulated, but is still subject to subsequent monitoring. The independent price monitor would maintain an ongoing watch on pricing, collect data, and publicly report on emerging market issues that affect the purchasing power of scheme participants. The pricing role of the independent regulator would gradually diminish (and revert to a monitoring role) as the market develops over time.

DRAFT RECOMMENDATION 6.1

The Australian Government should:

- immediately introduce an independent price monitor to review the transitional and efficient maximum prices for scheme supports set by the National Disability Insurance Agency (NDIA)
- transfer the NDIA's power to set price caps for scheme supports to an independent price regulator by no later than 1 July 2019.

The body tasked with price regulation for scheme supports should:

- collect data on providers' characteristics and costs. This should include appropriate funding to continue the business characteristics and benchmarking study currently undertaken by National Disability Services and Curtin University
- determine transitional and efficient prices for supports at a state and territory level
- comprehensively review and publish its price model on an annual basis. This review should be transparent, have public consultation, be evidence-based and evaluate the effectiveness of prices in meeting clearly-defined objectives
- assess and recommend when to deregulate prices for supports, with particular regard to the type of support and region, on the basis that prices should only be regulated as narrowly, and for as short a time, as possible.

6.3 Thin markets

The market-based model for disability supports is designed to encourage the provision of more supports that people with disability want and need than under previous arrangements (PC 2011, pp. 111–156). However, there are still going to be cases when the disability support market remains too small (in terms of the number of providers or participants) to support the competitive provision of services. This outcome is known as a 'thin market'.

There are a number of negative consequences of thin markets. Insufficient supply may lead to higher prices, less variety, lower quality services and unmet demand. In the disability support sector, thin markets can result in poor participant outcomes, increased demand for mainstream services, and greater pressure on informal carers. Scheme costs are also affected — while they may be lower in the short term (due to underutilisation of supports), they may be higher in the long term if participants are not receiving the right supports at the right time. For these reasons, governments often need to — and do — intervene in thin markets to ensure the supply of disability supports for people with disability.

When will thin markets arise in the NDIS?

Thin markets can arise in places or for particular disability supports when demand is limited and the cost of supply is high. The NDIA and COAG Disability Reform Council

both noted that thin markets are most likely to occur in rural and remote areas, and for specialised supports, such as aids and equipment (DRC 2015a, p. 19; NDIA 2016k, p. 15). Participants in this study also identified access problems for particular groups of people with disability, including some participants:

- living in outer regional, remote or very remote areas[24]
- with complex, specialised or high intensity needs, or very challenging behaviours, such as those with psychosocial disabilities[25]
- from culturally and linguistically diverse (CALD) backgrounds (ECCV, sub. 31)
- who are Aboriginal and Torres Strait Islander Australians (GIFSA, sub. 13; OPG of the Northern Territory, sub. 143; VACCHO, sub. 162; and Northern Territory Government, sub. 205)
- who have an acute and immediate need (crisis care and accommodation) (Anglicare Tasmania, sub. 145, pp. 46–47).

Given the early stage of the transition, it is difficult to tell where thin markets may be diminishing, growing or persisting under the NDIS. Even when thin markets do occur, it is not necessarily the case that the NDIS is responsible for them. Thin markets were a feature of disability support arrangements previously, as well as in many other human services (PC 2011, pp. 115–156, 2017). What is important is that the appropriate and timely policies are put in place to minimise their incidence and impact on participants and providers. This is especially the case as the interface with other mainstream services evolves (chapter 5). Thin markets will remain a feature of the provision of some disability supports under the NDIS (box 6.4).

[24] Including: the ADFO (sub. 180); Cheryl McDonnell (sub. 79); Commonwealth Ombudsman (sub. 137); Deaf Australia (sub. 183); Early Childhood Intervention Australia NSW/ACT (sub. 190); GIFSA (sub. 13); Mental Health and NDIS Facebook Support Group (sub. 8); MTHCS (sub. 6); Northern Territory Government (sub. 205); OPA Victoria (sub. 46); OPG of the Northern Territory (sub. 143); Queensland Advocacy Incorporated (sub. 115); RDAMR (sub. 12); and South Australian Government (sub. 203).

[25] Including: Carers Australia Victoria (sub. 131); Department of Health (sub. 175); DSA (sub. 9); and Leadership Plus (sub. 128).

Box 6.4 Evidence of thin markets under the NDIS

Thin markets for disability supports have long been an issue for some groups and in some regions. The structure of these thin markets means that many will persist under the National Disability Insurance Scheme (NDIS). This is particularly the case for people with disability who live in rural and remote areas, and early evidence from the scheme appears to confirm this.

- The NDIA (2016c, p. 34) deemed there to be supply risks for therapy supports (a specialised support) to be more acute in regional areas in southern New South Wales.
- The DSS (sub. 146, p. 37) said that there was early anecdotal evidence of thin markets for personal care support, participants with complex needs, early childhood and employment supports.
- A National Institute of Labour Studies survey found that unmet demand was experienced more by NDIS participants living in rural and remote areas in the Victorian trial site and for older NDIS participants, particularly those living in regional areas (Mavromaras, Moskos and Mahuteau 2016, p. xi).
- In some service regions, the increase in the value of support packages is forecast to grow more quickly than the growth in participants (NDIA 2016p, pp. 10–12, 2016aa, pp. 10–12). This could reflect a lack of supports and more unmet demand for these participants.
- In South Australia, almost one-third of NDIS participants are expected to reside outside of Adelaide (NDIA 2016y, p. 25); however, the NDIA observed that there was a lack of provider choice in remote and very remote areas in South Australia, with participants often dependent on a key support worker (NDIA 2016y, p. 26).
- Participants in the Barkly region in the Northern Territory had the third highest level of unutilised funding — 41 per cent in 2014-15, and 64 per cent in 2015-16 (NDIA 2017m, p. 29). However, underutilisation may be due to a number of factors other than unmet demand (chapter 2).
- In the Northern Territory, there appears to be a shortage of supports for physical disabilities. As at 30 June 2016, only one per cent of active registered providers in the Northern Territory provided physical wellbeing services, but 27 per cent of participants with an approved plan in the Barkly trial region were identified as having a physical disability (NDIA 2017m, pp. 10, 22). The NDIA noted that:

  > Given the much higher level of physical disability in the Territory as compared to … [Victoria and New South Wales], the number of providers registered to provide physical wellbeing supports appears to be low. (2017m, p. 21)

How can thin markets be minimised?

One of the challenges of addressing thin markets is that while they share some common characteristics, often they have very specific and different causes. A 'one-size-fits-all' approach will not to be feasible or effective. A more tailored response that considers the complexities of dealing with the wide variety of thin markets is required, taking into account issues such as the presence of CALD and Aboriginal and Torres Strait Islander

communities; quality of infrastructure; weather events and population density.[26] In practice, it means that standardised approaches to pricing may not be effective to encourage supply in some thin markets. This is reflected in the diversity of options that can be used to address thin markets (box 6.5).

There are costs associated with government intervention to minimise under-provision of disability supports in thin markets. In addressing thin markets, it is necessary to balance the trade-off between providing cost-effective service provision, and providing as flexible a service as possible to enable participant choice and control.

The NDIA's recently published Rural and Remote Strategy (NDIA 2016x), and Aboriginal and Torres Strait Islander Engagement Strategy (NDIA 2017b) both reflect the need to provide disability supports in a way that allows for as much choice and control for participants as possible, and to enable innovative methods of service delivery.

Such an approach is also reflected in the Bilateral Agreement between the Northern Territory and Australian Governments on the transition to the NDIS, as the Northern Territory has historically faced particular challenges in providing human services due to thin markets (PC 2017). It was agreed that the Northern Territory's approach to the transition would be guided by the following principles:

- place-based, tailored solutions to planning, market development, access to services and risk management
- a coordinated, client-centred, and tailored approach to the operating model in remote communities, informed by existing effective frameworks that maximise access, engagement and management of risk for individuals
- culturally competent engagement and professional practices
- local planning, market development and risk management strategies informed by timely and appropriate data (Australian Government and Northern Territory Government 2016, p. 4).

[26] For example, scheme participant density in the Northern Territory (except the Darwin urban service region) in 2020 is expected to be less than five participants per 100 square km (NDIA 2017m, p. 14). Despite remoteness price loadings, some providers in Queensland also reported to the NDIA that recent new providers were concentrated in major population centres such as Townsville, Cairns and Mackay (NDIA 2016w, p. 33). The Commonwealth Ombudsman (sub. 137, p. 16) also noted that some existing providers who specialise in providing services for CALD and Aboriginal and Torres Strait Islander people with disability may not be able to make the transition, due to registration barriers and insufficient cash reserves to transition to fee-for-service.

Box 6.5 Different approaches to address thin markets

There are a number of measures that could be used to mitigate the risks of thin markets, including:

- partial or full block-funding to commission or procure services (PC 2011, pp. 521–523). Goldfields Individual and Family Support Association (sub. 13, p. 12) said that removing block-funding would likely result in an 'almost complete loss of services on the very remote Lands.' Many study participants said that block-funding is the most efficient way to ensure that needs are met (Centacare Brisbane, sub. 44; Australian Blindness Forum, sub. 48; Cohealth, sub. 50; and Anglicare Tasmania, sub. 145)
- sharing of infrastructure, knowledge, skills and experience among providers
- facilitating bulk-purchasing arrangements by participants — for example, by pooling of participants' funds (Mallee Track Health and Community Service, sub. 6; PC 2017)
- more collaboration, coordination and integration of services, particularly with local and mainstream service providers — to avoid supply gaps or duplication (CADR 2014, p. 15; RACGP, sub. 200). Providing more hours of support coordination in participants' packages should also be considered, particularly for those with complex needs (Alzheimer's Australia, sub. 10, pp. 9–10). Brain Injury SA (sub. 116, p. 14) emphasised the need for effective coordination of services between State (and Territory) and Australian Government providers
- use of community- or place-based services (PC 2017) — including greater use of the local workforce where possible
- greater use of information technology, including videoconferencing, telehealth and other technologies, particularly for therapeutic supports (NDIA 2016z, p. 28; APA, sub. 93; Amaze, sub. 160)
- the NDIA providing more detailed information on market demand (and unmet demand) to encourage providers to enter thin markets
- cultural training, education and awareness programs (Brain Injury SA, sub. 116; Commonwealth Ombudsman, sub. 137) — including greater funding of translators and interpreters (Goldfields Individual and Family Support Association, sub. 13; Cohealth, sub. 50; SDN Children's Services, sub. 73; and Companion House, sub. 84)
- more support and respite care for informal carers (chapter 7)
- greater engagement with the local community to build trust and relationships.

What is being done to address thin markets?

Based on the experience of the NDIS trial sites (particularly the Barkly trial in the Northern Territory), the NDIA said that it would consider a range of approaches to mitigate the risk of thin markets, including:

- active and deliberate cross-government collaboration — including the use of locally-based workers, and educating the community about the interface between health services and disability supports
- leveraging established community organisations (such as those already operating in health, aged and community care sectors) who may also deliver disability services

- supporting a provider to access supports from business councils, Indigenous Business Australia, or any other organisation in the Aboriginal and Torres Strait Islander business capacity-building sector
- using the hub and spoke model (also known as scaffolded support) — where generalist providers provide support in the rural or remote community, and where needed, can collaborate or seek oversight from an advanced practitioner or specialist centre, either through a visiting clinic or telepresence
- working with existing mainstream providers to expand their services to better meet the needs of participants — such as plan management services by local accounting services and re-purposing underutilised infrastructure (sub. 161, pp. 105–106).

These approaches rely heavily on the commercial decisions of providers (such as the type of workforce, the decision to deliver disability services, and service delivery business models). They also appropriately reflect an attempt to make the market-based, consumer-driven approach succeed where possible — with more interventionist alternatives a last resort.

The NDIA (sub. 161, p. 106) noted that 'some providers are thinking creatively about supply in thin markets', including by diversifying into associated areas to provide additional business income, and forming business relationships between urban and remote businesses.

While the details of how providers are to be encouraged to supply thin markets are not yet clear, the Commission understands that the NDIA and DSS are jointly developing a more detailed Market Intervention Framework to address thin markets, which is being negotiated with each jurisdiction (NDIA 2016k, p. 15, 2016x, p. 26). This framework will be released later in 2017.

Given that the NDIS is already in the transition phase, there is a risk that thin markets will persist or worsen in the absence of timely strategies and intervention by the NDIA. There is a growing need for the NDIA to clarify and implement practical measures to mitigate the risks to participants associated with thin markets, particularly with the withdrawal of in-kind supports by governments (DSS, sub. 146, p. 37).

Interventions need to be tailored to the specific circumstances of each case — such as user characteristics, the broader service landscape, resource constraints and effects on the wider community (PC 2017). The diversity of user needs also means that a 'one-size-fits-all' solution will not be effective in addressing access issues. As a result, it is inappropriate to automatically default to block-funding, direct commissioning or mainstream services (particularly acute or primary health care services). While it is likely that block-funding will be needed in some cases (PC 2011, pp. 521–523), care must be taken to avoid crowding out competition.

Regardless of the approach chosen, there will be a need for strong market stewardship (PC 2017), and collaboration between the Australian, and State and Territory

Governments, given the latter's knowledge and experience as funders and providers to date. Addressing thin markets requires a whole of government approach and community involvement.

As noted by the Commission in 2011, it will not always be possible to match the price, quality and range of services in the major cities (PC 2011, p. 529). Some participants may need to travel (and in some cases, move) to metropolitan areas to access highly specialised services. This highlights the need for complementary services, such as transport to access specialised disability care, to be provided either in a participant's plan or outside of the NDIS where appropriate (chapter 5). Improving access for participants in thin markets is a key objective of the NDIS, but it is an ongoing task requiring constant vigilance, monitoring and evaluation (box 6.6).

DRAFT FINDING 6.1

In a market-based model for disability supports, thin markets will persist for some groups, including some participants:

- living in outer regional, remote and very remote areas
- with complex, specialised or high intensity needs, or very challenging behaviours
- from culturally and linguistically diverse backgrounds
- who are Aboriginal and Torres Strait Islander Australians
- who have an acute and immediate need (crisis care and accommodation).

In the absence of effective government intervention, such market failure is likely to result in greater shortages, less competition and poorer participant outcomes.

Box 6.6 Addressing thin markets requires data and ongoing public reporting

Mitigating the effects of thin markets (and informing associated funding arrangements) will require more transparent identification, reporting and evaluation of thin markets than at present. Planning, evaluation, monitoring and feedback systems (as well as commissioning practices) are discussed in the Commission's current inquiry into Human Services. Specific key performance targets and indicators (both outputs and outcomes) need to be developed, and the relevant data collected, to ensure the equity, effectiveness and efficiency of disability supports and thin market strategies. This was recognised by the Joint Standing Committee on the NDIS for services in rural and remote areas, which recommended that:

> … all options to develop a market that provides choice and control for participants in rural and remote areas be explored, and that any additional funding for disability in the Northern Territory to any provider is conditional on measureable increases in service provision. (2015, p. 78)

The Northern Territory Government also emphasised the need for more granular data.

> The availability of more granular data is particularly important to enable monitoring of the Scheme's roll out in remote regions and thin markets – where the NDIS market-based model is most challenging to implement. Detailed regional level data is also important to inform service providers to enable localised market growth and development (e.g. client base, size of market, and service provider gaps). (sub. 205, p. 3)

As a starting point, the type of information that could be collected in the monitoring of thin markets (including through Local Area Coordinators and current feedback mechanisms in the NDIS) could supplement current reporting to COAG under the National Disability Strategy. In particular, reporting in each thin market could better reflect similar measures reported by the Commission as part of the National Disability Agreement, including:

- participation rates — such as the number of eligible participants; the severity and nature of disabilities; and other participant characteristics. The Joint Standing Committee on the NDIS (2015, pp. 62–67) noted a lack of data for participants who are from culturally and linguistically diverse backgrounds, as well as for Aboriginal and Torres Strait Islander Australians
- access or support use by participants — including utilisation rates; the number of providers, workers and supports; as well as market concentration
- appropriateness of supports — for example, whether supports were delivered in a culturally and linguistically respectful manner in accordance with the NDIA's Aboriginal and Torres Strait Islander Engagement Strategy
- quality of services — such as reporting the satisfaction rate of participants and carers, and any complaints under the NDIS Quality and Safeguarding Framework (and State and Territory Government quality and safeguard regulations in the interim)
- cost per unit of output — including government and NDIA contribution per participant, and forecasts of future costs per participant. This would also be consistent with the insurance-based approach of the scheme
- participant outcomes — such as choice and control; economic or social participation; and use of other services by people with disability (including mainstream services and informal support) (SCRGSP 2017, p. 15.1-15.39).

Timely and ongoing data collection is particularly important as the NDIA's online platform (eMarketPlace) is still being developed (chapter 8).

What if there is no market? The Provider of Last Resort

The NDIA does not directly supply individualised supports to participants, but there are times when it may take a direct role to ensure that services are provided. This might occur in very specific and exceptional circumstances when providers are unwilling or unable to supply disability supports under NDIS policy settings, for example, when:

- participants cannot access disability supports — there is no provider, or the only external provider is likely to fail in circumstances that would leave participants at risk (such as in remote locations)
- supports are not available at reasonable prices — this might be true for participants with highly complex needs or challenging behaviours, or in emergency situations when supports are needed at short notice
- it is difficult to verify that external providers are genuinely achieving good quality outcomes for participants or their carers
- there are significant economies from combining or coordinating several services together, and where the government has an advantage in supplying the package of services ('economies of scope') — this might apply to participants who are Aboriginal and Torres Strait Islander Australians, where governments might have to deal with multiple levels of disadvantage (housing, health, education, urban amenity, employment, transport and disability) (NDIA 2016k, pp. 26–27; PC 2011, p. 409).

The principles that should govern provider of last resort (POLR) arrangements were considered by the Commission in 2011. The Commission noted that POLR needed to be subject to the same regulatory oversight and monitoring as other providers in the scheme, and that block-funding of providers should only be used when fee-for-service was proven to be infeasible to ensure the supply of supports (PC 2011, pp. 523–526).

The Commission also emphasised the need for POLR arrangements to be contestable and at arm's length from the commissioning body, and when block-funding is judged to be the preferred method, that the NDIA should develop standardised tendering, contracting, reporting and acquittal requirements in order to reduce compliance costs (PC 2011, pp. 523, 528). Importantly, it is not the role of the NDIA to support failing providers in thin markets, but to ensure the supply of disability supports for participants in the most effective and efficient way.

The POLR arrangements for the NDIS are still being developed by the NDIA, but appear consistent with the Commission's views in 2011 (box 6.7). However, the delay in formalising these arrangements is resulting in uncertainty for both participants and providers.

The NDS stated that POLR arrangements under the NDIS are:

> … currently poorly articulated and are inadequate. This needs to be addressed, ideally through the NDIA establishing emergency response agreements with a number of disability support providers across the country. (sub. 51, p. 16)

Box 6.7 The NDIA's provider of last resort arrangements

What is the provider of last resort (POLR)?

As a market steward, the NDIA is responsible for POLR arrangements. When there is a significant risk of insufficient market supply; when no provider is available; or in the event of provider failure (for example, if the *only* local provider for a range of disability support services in a remote community goes into administration), the NDIA may directly commission and procure disability supports for scheme participants. Triggers are likely to include:

- insufficient, volatile or uneven supply — in a particular geography, market segment or service type, potentially due to lack of scale or providers being active in that market
- evidence of inappropriate use of market power — for example, constraints to competition or lack of consumers exercising choice
- insufficient quality at a reasonable price
- benefits for greater return on investment from arrangements other than individual commissioning.

A provider contracted as a POLR will need to meet agreed quality standards and ensure that services are delivered in an appropriate and culturally competent way. The provider may also need to leverage existing infrastructure. The NDIA considers POLR arrangements to be a highly interventionist form of market intervention.

Who is responsible for the POLR?

As the transition leads to full scheme, the NDIA will lead an integrated response jointly with the States and Territories. In the interim, the States and Territories lead as POLR, and will continue to do so for providers who they fund during transition (except for the Northern Territory, where the NDIA is responsible for ensuring POLR services even in the transition period pursuant to Schedule K of the Northern Territory Bilateral Agreement). The Agency noted that identification and response to such market failure will require collaboration among all NDIS stakeholders.

What does the POLR involve?

The POLR framework forms part of the NDIA's broader *Market Intervention Framework*. Both are currently being developed by the NDIA and DSS, and negotiated with each jurisdiction. It is expected that in 2016-17, the NDIA will agree to POLR processes, and that by 2018-19, there will be a maturity of POLR capabilities, to potentially include a range of response options, such as panels in relevant jurisdictions or submarkets capable of providing emergency capabilities at extremely short notice.

Sources: NDIA (2016k, 2016x).

Some guidance about POLR arrangements has been included for scheme participants in the Northern Territory. In the Bilateral Agreement between the Australian and the Northern Territory Governments on the transition to the NDIS, it was agreed that the NDIA would

be responsible for ensuring that POLR services are in place for all participants in the Northern Territory (Australian Government and Northern Territory Government 2016, p. 1, Schedule K). The bilateral agreement also includes principles on how these arrangements are to work (risk, transparency, person-centred approach, non-exclusivity, barriers to entry, supply of services and end of service arrangements) (Australian Government and Northern Territory Government 2016, p. 2, Schedule K). It also stipulated that 'solutions will be established to avoid inappropriate default to the acute medical system as the provider of last resort' (Australian Government and Northern Territory Government 2016, p. 2, Schedule K). Some have commented that this detail has not been sufficient to ensure that POLR arrangements are in place (and what they would entail).

> The State Committee is further concerned the POLR [provider of last resort] commitment is behind in its conceptual and operational planning in line with the rollout schedule and ambiguous to members on what these provisions mean in terms of their own business planning and existing services.
>
> We ask that urgent attention be given to clarify the POLR aspect of the NT Bilateral Agreement so as to further mitigate the risk of market failure. (TEAMhealth, sub. 102, p. 22)

The Northern Territory Government (sub. 205, p. 6) said that it is working with the NDIA to develop the POLR framework, which once developed, could have broader application nationally. The need for greater clarity on how POLR and thin market arrangements more generally are to be put into practice is increasing, particularly as governments change their involvement in providing disability and mainstream supports (chapter 5).

The Commission is seeking feedback on when particular measures should be used to provide services in thin markets, when POLR arrangements should be used, and any other information on ways to address thin markets.

INFORMATION REQUEST 6.1

In what circumstances are measures such as:

- *cross-government collaboration*
- *leveraging established community organisations*
- *using hub and spoke (scaffolding) models*
- *relying on other mainstream providers*

appropriate to meet the needs of participants in thin markets? What effects do each have on scheme costs and participant outcomes? Are there barriers to adopting these approaches?

Under what conditions should block-funding or direct commissioning of disability supports (including under 'provider of last resort' arrangements) occur in thin markets, and how should these conditions be measured?

Are there any other measures to address thin markets?

6.4 Other factors affecting provider readiness in transition

The NDIS is a new system for existing providers, and is creating a new market for all participants and providers in the disability support sector. And there are several transitional issues affecting the sector's supply response. These include:

- challenges faced by providers who were previously block-funded
- administrative burdens associated with the scheme
- the effect of supports that are provided 'in-kind' by governments to the scheme
- the scheme's effect on collaboration among providers.

Moving from block-funding to fee-for-service

As detailed in table 1.1, providers received government funding *before* providing certain supports in 'bulk' to participants prior to the NDIS. This usually took the form of lump sum payments for each participant under annual contracts that were paid three months in advance (AONSW 2017, p. 7). Providers now claim reimbursement from the NDIA *after* providing individualised supports to scheme participants. The majority of support items are based on per hour, or 'per instance' of service provided (NDIA 2016l, 2016m, 2016n, 2016o).

Providers face significant challenges to adapt to the new fee-for-service model, and some may not be able to make the transition. Providers bear increased financial risk (such as from non-payment and late payment) and in turn, have a greater need for cash reserves, making it harder to maintain liquidity and solvency (DSS, sub. 146, p. 37). The NDS (2015, p. 17) stated that 'the majority of not-for-profit disability service providers report insufficient cash flow required to transition to the NDIS.' Providers will incur specific fixed costs to restructure and adapt their business to the NDIS market. Costs may relate to unit pricing, IT, accounting, marketing and the provision of individualised supports.

While these costs are likely to be significant given the scale and nature of the required changes (particularly for small providers, and there are many of them in the disability support sector (box 6.8)), they are better addressed by the price received for supports than the payment method (PC 2011, p. 520). In general, the need to cover fixed costs is not a reason for government intervention (PC 2011, p. 523). Fixed costs are also likely to be a transitional issue for a number of reasons.

- The introduction of innovative payment systems by some financial intermediaries may reduce some of the financial risks of the fee-for-service model and help providers adapt to the new system (Eyers 2017).

- Price deregulation will help providers recover their fixed costs, as prices will more accurately reflect the cost of supply, and fixed costs will be driven by consumer preferences (PC 2011, p. 520).
- Providers may be able to use different pricing methods to efficiently recover fixed costs (such as discounts for regular users, or for periods where demand is lower) (PC 2011, p. 521).
- The experience of providers in comparable and adjacent sectors in the economy (including aged care) that moved from block-funding to fee-for-service as part of consumer-directed care reforms also suggests that adjustment can and will take place in the medium to long term. As the NDIA observed:

  > Similarly, aged care providers are undergoing their own reforms related to consumer-directed-care and many businesses are leveraging this experience to build services and products relevant for the disability market. (2016aa, p. 5)

Box 6.8 Small providers can face big challenges to transition

A feature of the disability support sector is that many providers are small (Martin and Healy 2010, p. 122). National Disability Services estimated that about 58 per cent of providers are either small or very small (with a turnover of $5 million or less) (Gilchrist and Knight 2017, p. 10). And about 39 per cent of NDIA-registered providers are individuals or sole traders (NDIA 2017o, p. 38). Small providers may have less capacity to make the transition to the NDIS than larger providers. For example, they face challenges from:

- proportionately higher fixed costs of operating in the NDIS, especially as they must incur new marketing and systems costs
- achieving economies of scale or scope, with total costs spread more thinly across smaller hours of support, particularly with the shift to more individualised or tailored supports.

The scale of these challenges may be inferred by the amount of merger and acquisition activity in response to the challenges of being a small provider. Merger activity and restructuring in the sector provides some indication that this may be the case (NDS 2016, p. 17), although it is unclear whether this has led to an actual increase in services or substantially reduced competition.

The Commission heard that some providers are delaying making changes to their business model and planning decisions (including investment) because of uncertainty and lack of clarity, particularly about the timing of price deregulation and the withdrawal of in-kind services (ANAO 2016, p. 32). About 75 per cent of providers surveyed by the NDS felt that 'the policy environment is uncertain' (NDS 2016, p. 19). One provider surveyed by the NDS commented that:

> The uncertainty around 'how much we will be able to receive' once NDIS is implemented in our region means that the climate for any investment is too uncertain, because we cannot make a reliable business plan. (NDS 2016, p. 10)

The Office of Best Practice Regulation also noted that:

> … ongoing engagement with providers when developing reference prices and maximum prices, particularly for key supports, should help providers during the transition to a fee-for-service based system of disability care. (2015, p. 49)

Better information and communication by the NDIA would assist, as will independent price monitoring (recommendation 6.1).

Administrative burdens

There are a range of regulatory and other costs to provide supports. As the NDIA (2016k, p. 9) noted, there are 'high costs to enter the marketplace'.

Regulatory costs include those to register with the NDIA, and costs associated with ensuring quality and safety of supports. These include professional registration (in the case of specialised services, like therapeutic supports), working with children checks, and police checks. These costs are necessary to ensure safe and high quality support provision for NDIS participants. The recently developed NDIS Quality and Safeguarding Framework (which will only apply to NDIA-registered providers) aims to provide a nationally consistent set of regulations on what providers need to do to provide disability supports (chapter 9). Increased regulatory consistency across jurisdictions should mean lower costs for some providers.

Concerns were also raised by a number of study participants about the NDIA's online payment system and communication issues with the NDIA. As Catholic Social Services Australia said:

> Though CSSA [Catholic Social Services Australia] member agencies have been preparing for transition to the NDIS for a long time, the dysfunctionality and un-preparedness of the NDIA has severely affected its capacity to deliver sustainable services through the NDIS. Complex and ongoing issues with the portal (including the system being taken down for weeks at a time with very little notice) means that providers are finding it very difficult to access the funds for services provided. These cash flow issues have restricted providers' ability to invest, innovate and even operate (for example one agency providing significant disability services in a trial site had $1 million 'stuck' in the portal in December 2016). This has led to cash flow issues and providers withdrawing due directly to pricing or lack of payment. (sub. 166, p. 9)

The problems associated with the online portal have been examined in some depth by others (ANAO 2016, pp. 62–71; Conifer and McKinnon 2017; PwC 2016), and were recognised by the NDIA (sub. 161, p. 119). The Agency indicated that it is reforming its processes to improve the 'provider pathway', including registration and payment arrangements, and is also delivering tailored information sessions for providers.

> The NDIA is working to improve the quality and amount of information available to providers in all elements of the provider pathway (awareness, commercial assessment, registration process (including the impacts of the move to the national arrangements being led by DSS),

service planning and delivery, payment and claiming outcomes) so that providers are better placed to meet expectations and develop their service offer under the NDIS. (sub. 161, p. 102)

Payments to providers need to be timely so that innovation, entry and the supply of supports are not hampered.

Competition and in-kind services

Under Bilateral Agreements between the Australian, and State and Territory Governments, government funding of the NDIS is a combination of services and cash contributions, with the proportion differing by jurisdiction.

This means that Australian, State and Territory Government programs under existing block-funding arrangements ('in-kind services') continue to exist to ensure continuity of supply in the short term. In practice, this means that governments may continue to remain a service provider,[27] or block-fund a provider to deliver services. Most in-kind services are to be phased out through transition and replaced by cash contributions, though the timing of this varies by jurisdiction (NDIA 2016v, p. 71).

The withdrawal of in-kind services is consistent with the NDIS objective of a more competitive, consumer-driven and market-based system, with services to be delivered by a wider range of private providers. Governments will no longer provide or procure disability services except in limited circumstances, such as in thin markets and under POLR arrangements (section 6.3).

However, there are concerns that the continuation of in-kind services in the meantime may adversely affect the transition by existing providers, market entry (PC 2017), the quality of supports (PDA, sub. 38, p. 13) and overall scheme costs. Providers may also delay adapting to the fee-for-service model due to ongoing block-funding under in-kind service arrangements (Mavromaras, Moskos and Mahuteau 2016, p. 45; NDIA, sub. 161, p. 102). In addition, providers may have less incentive to provide or increase services if they are effectively foreclosed from meeting demand for the entire market due to in-kind services.

> … large parts of the marketplace are subject to in-kind arrangements and therefore, not immediately available to prospective providers … (NDIA 2016k, p. 7)

The risk of deterring private providers may be higher in regional or remote areas, and other thin markets, where governments may be the main provider with few actual or potential competitors.

> Mr Croker from Keep Moving, was concerned that because the NT Government was the only entity that was able to provide services across all of the region, this left his organisation

[27] Host jurisdictions are also likely to provide services in monitoring the overall integrity and effectiveness of the *NDIS Quality and Safeguarding Framework*. For example, approval of restrictive practices by providers will continue to be managed through current State and Territory government processes (DSS 2016c, p. 17).

> effectively in competition with the NT Government and begged the question of 'How do you compete as a private enterprise against government departments?'. (JSCNDIS 2015, p. 68)

Some in-kind services also cannot be bundled by the NDIA and can only be priced as individual line items (JSCNDIS 2015, p. 33), often at prices higher than the NDIA's price caps (NDIA, sub. 161, p. 101). This limits the potential efficiencies and pro-competitive benefits of allowing providers to bundle supports due to economies of scale or scope, and price discrimination.

As in-kind services restrict the development of the disability support market and place upward pressure on scheme costs, they should be phased out as quickly as possible (chapter 10, recommendation 10.3). At the same time, it will be important to monitor and respond to any service gaps arising from cashing out of in-kind services — particularly if they result in or exacerbate thin markets (section 6.3). This is likely to occur when in-kind services comprise a large share of the market. For example, about 45 per cent of disability support accommodation services are provided in-kind in South Australia (South Australian Government, sub. 203, p. 16).

Even if in-kind services are phased out, governments may still provide some disability supports under the NDIS and therefore have an impact on competition. Private providers need to be able to compete with governments on a level playing field to ensure the most efficient provision of disability supports to scheme participants (also known as 'competitive neutrality'). Greater clarity by governments about the application of competitive neutrality in the disability support market would assist in achieving this outcome (PC 2017).

Collaboration in the disability support sector

Some disability supports are provided using collaborative and co-operative arrangements. Some providers were concerned that the increased competitive pressures of a market-based system will reduce collaborative activity (and the associated benefits), and therefore lead to a potential erosion of 'social capital'[28] (Alzheimer's Australia, sub. 10, p. 15; Anglicare Australia, sub. 157, p. 13; and CMHA, sub. 11, p. 14). This could increase provider costs and lead to the withdrawal of some services.

A National Institute of Labour Studies survey found that the introduction of the NDIS had made providers more guarded and that less information was shared due to commercial considerations (which may undermine provider networks), although some collaboration among providers was continuing to occur. One provider who was surveyed commented that:

> I think that's been a sad sort of aspect of the NDIA. When you create a competitive marketplace it's very hard, you know, those old networks that we would have been a part of and shared ideas and things like that have kind of broken down a little bit. (Mavromaras, Moskos and Mahuteau 2016, p. 45)

[28] The relationships and trust that underpin the functioning of society (PC 2010, p. XIX).

Not-for-profit providers may experience lower volunteering and fundraising contributions due to public perception of their perceived greater 'commercial' focus and competitive behaviour, and that the NDIS is fully-funded (ABF, sub. 48, p. 14; Australia Scope, sub. 72, p. 25). The NDS said that:

> Providers are beginning to report that fundraising is dropping as donors believe that the NDIS will provide all people with disability with all the supports they need. This is clearly a misunderstanding but seems to be becoming more pervasive. (sub. 51, p. 14)

While these contributions may be retained within the disability sector (either redirected to other providers or spread more thinly across all providers), they could also be transferred to other human service sectors, and therefore be lost from the disability support sector.

Conversely, providers may have greater incentives for collaboration in order to increase flexibility and responsiveness to participant demand in an increasingly competitive funding environment (NDS and CADR 2015, p. 13). Collaboration may allow providers to offer services at a greater range of times and locations, and achieve economies of scale or scope that would otherwise be difficult to achieve (particularly in thin markets and for small providers). Market stewards (and regulators) need to monitor such arrangements closely to ensure that collaboration does not reduce competition, efficiency and participant wellbeing.

NDS data indicate that in 2015-16, the majority of providers surveyed collaborated to advocate for the sector (68 per cent) or for clients (62 per cent), and had agreements to refer to provide services to clients (55 per cent), despite increased competition for both workers and clients (NDS 2016, p. 17). This appears to be broadly in line with previous results, where providers reported that they were forming alliances and joint working relationships with other organisations to offer services at a greater range of times and locations (NDS 2015, p. 38; NDS and CADR 2015, p. 13). Collaboration would also be consistent with the objectives and mission of not-for-profit providers, which typically promote the interests and wellbeing of NDIS participants. As noted by Centacare Brisbane (sub. 44, p. 3), the degree of collaboration and cooperation between providers under the NDIS will depend on the maturity, interests and skills of each party.

On balance, collaboration is a voluntary and valuable activity undertaken by not-for-profit providers that produces intangible benefits, but has tangible costs when removed. The mixed evidence on the degree of and incentives for collaboration in a more competitive environment suggests that the net effect will depend on whether the increased efficiency of providers offsets the higher costs associated with reduced social capital. The Commission has previously noted that for the not-for-profit sector, efficiency and effectiveness are central to maximising community wellbeing (PC 2010, p. 18).

While it is difficult to assess the change in collaboration (particularly when there are price caps and lack of data), based on the available evidence to date, some collaboration may continue to exist in the NDIS, and will be primarily determined by provider efficiency.

Separating transitional issues from structural issues is difficult

The disability support market is undergoing significant change. The way that participants, providers, workers and governments interact with the demand and supply of supports means that it is difficult to be certain about which challenges faced by providers are transitional, and which may become more entrenched or systemic. This is especially as the NDIA is already responding to some problems faced by providers.

The importance of choice and control for participants means that a diverse range of providers will be necessary for participants to achieve the best outcomes from the scheme. The Commission is seeking further feedback on barriers to new providers entering the market, and existing providers expanding their provision of disability supports. The Commission is also interested in approaches that will promote greater market innovation and responsiveness to demand.

INFORMATION REQUEST 6.2

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

7 Workforce readiness

Key points

- The disability care workforce will need to roughly double from its 2014-15 level to meet the increased demand for National Disability Insurance Scheme (NDIS) supports. Such workforce growth will mean that about one in five new jobs forecast to be created in Australia over the transition period will need to be in disability care. While the disability care workforce has grown considerably over the transition period to date, it is unlikely to meet this target under current policy settings.
- There are a number of challenges to growing the disability care workforce. These include: finding carers to meet high participant demand at particular times of the day; ensuring that there are enough qualified carers to provide a reasonable quality of care (including allied health professionals); and increasing rates of retirement of workers from the sector as they age. There are also regional challenges. In some areas, the workforce will need to more than double to meet demand.
- Policy changes that would help to address some of the workforce shortages over the transition period include:
  - taking advantage of the preference of many workers in the disability care sector to work more hours
  - relaxing the rules on informal carers providing paid care to participants, especially in remote and regional areas
  - using a targeted approach to immigration to address persistent skill shortages.
- The way that respite services are provided under the NDIS — requiring participants to include it in their plans, and being subject to caps on the amount of respite — could be creating a disincentive for providers to supply these services. This may reduce the ability of participants' family members and friends to provide informal care. A lack of respite and informal care will increase demand for formal carers and scheme costs.
- There needs to be a clearer delineation of roles and responsibilities for developing workforce policy for a more coordinated response to meeting the workforce needs of the NDIS in the future. Building the evidence base on the number of workers in the sector, their conditions and working arrangements would be a sound investment to develop more effective workforce policies in the future.

As discussed in chapter 6, the state of the disability care market's readiness to deliver National Disability Insurance Scheme (NDIS) supports will affect scheme costs. Market readiness will depend on, among other things, whether there are enough workers to provide NDIS supports.

As recognised by the National Disability Insurance Agency (NDIA), any workforce shortages are a risk to the scheme.

> A major concern for the NDIA is that the speed in growth of demand cannot be met by a commensurate speed in growth of supply. The availability of workforce is a significant factor in the ability of the market to supply the needs of people with disability. (sub. 161, p. 95)

While workforce shortages will have a direct effect on scheme costs, the pricing policies of the NDIA will also have an effect on workforce growth and scheme costs. For example, without price regulation (in the short term), increased competition for care workers could bid up wages and increase scheme costs. However, with price regulation, it may be difficult to build up the workforce fast enough. This could lead to unmet demand for participants, which will put a brake on scheme costs, but could undermine the objectives of the scheme by restricting access to supports that are regarded as reasonable and necessary.

This chapter examines the question — can the disability care workforce grow quickly enough to supply the increasing demand for services under the NDIS? Section 7.1 looks at the current state and characteristics of the disability care workforce. Section 7.2 discusses the size and scope of the workforce that will be needed when the NDIS is fully rolled out. Section 7.3 examines policy options for developing the workforce, and ways to reduce the number of workers required to provide NDIS supports.

7.1 The current disability care workforce

The disability care and support workforce is diverse. It includes disability support workers that provide daily care and allied health professionals that provide specialised care. As the NDIS is rolled out, the size and scope of the workforce will increase further — both to cater for more participants, and to embrace new roles driven by the market-based system as participants exercise greater choice over their supports.

To understand how the workforce will need to change requires an understanding of what it looks like now. It is difficult to measure the disability care workforce by itself, as it is classified with aged care in regularly published statistics (box 7.1). With this in mind, a number of broad conclusions about the disability (and aged care) workforce can be drawn:

- disability care workers are older than the workforce in general (figure 7.1) — about one fifth of workers are aged 55 and older (NDS, sub. 51, p. 9)
- about 80 per cent of employees in the disability care sector are women (compared to about 46 per cent of employees for all occupations)[29]
- about 60 per cent of employees in the disability care sector work part time (compared to about 30 per cent of employees for all occupations)[30]

[29] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

[30] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

- the majority of workers in the disability care sector hold a certificate-level qualification (figure 7.2).

Box 7.1 Measurement issues: the disability care workforce

Data on workers in Australia are collected regularly by the Australian Bureau of Statistics based on the of industry of operation (the Australia-New Zealand Standard Industry Classification (ANZSIC)) and the occupation of the worker (using the Australia-New Zealand Standard Classification of Occupations (ANZSCO)) (ABS 2006, 2013). However, neither of these classifications are well suited to identifying those working in the disability care sector, or those working in disability care roles.

For example, the most disaggregated — that is, the level of finest detail — ANZSIC classification that includes disability carers is '8790 Other Social Assistance Services', which also includes aged care assistance services, marriage guidance services, and the operation of soup kitchens. In ANZSCO it is '4231 Aged or Disabled Carer', which again combines aged and disability carers together. Neither of these are ideal for analysing the state of the disability care workforce.

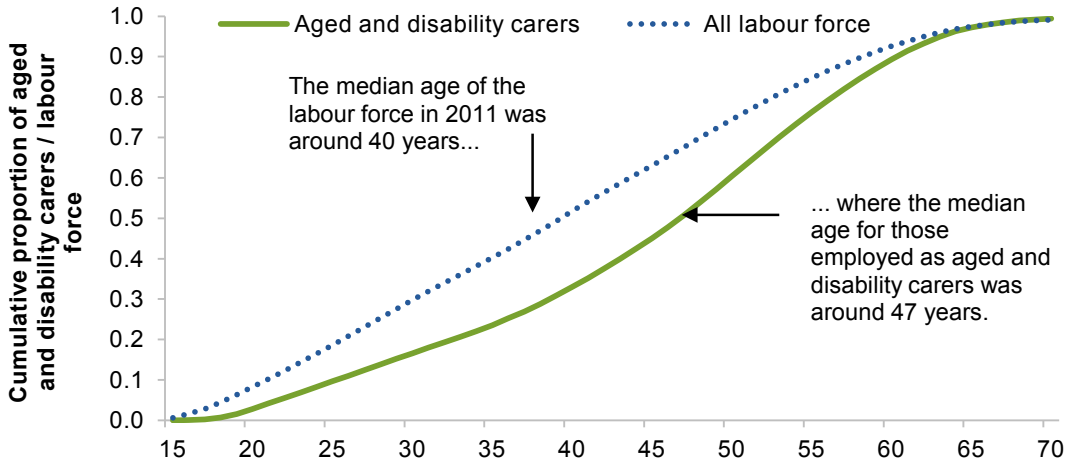
Allied health professionals that work in the disability support sector are similarly hard to identify, as it is difficult to distinguish between those that may provide services occasionally or those that provide them full time to people with disability. The classification of allied health professionals is also contentious and subject to revision.

> There is no one definition which prescribes the disciplines considered as allied health. At the meeting of the Council of Australian Governments in July 2006, agreement was reached to establish NRAS [the National Registration and Accreditation Scheme] for health professionals, beginning with the ten professional groups registered in all jurisdictions, of which seven fall under the allied health banner: chiropractic care, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology. … A further four allied health professions joined NRAS on 1 July 2012: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists. … Other allied health professions that are not included under NRAS, but are considered in the Commonwealth's health workforce policy planning, include: Audiologists, Counsellors, [Dieticians], Exercise physiologists, Music therapists, Nutritionists, Pathologists, Social workers, Sonographers, Speech pathologists. (Department of Health and Ageing 2013)

Other studies, including the Commission's inquiry into *Disability Care and Support* (PC 2011), relied on 'one-off' surveys and alternative data sources to better understand the disability care workforce. This included a detailed survey by Martin and Healy (2010). This survey remains the most specialised data source for the disability care sector workforce, though is now becoming dated. A forthcoming survey on the disability care workforce may also help solve some unaddressed measurement issues (Cortis nd).

Figure 7.1 **People working in the aged and disability care sector are older than the labour force in general[a]**

2011

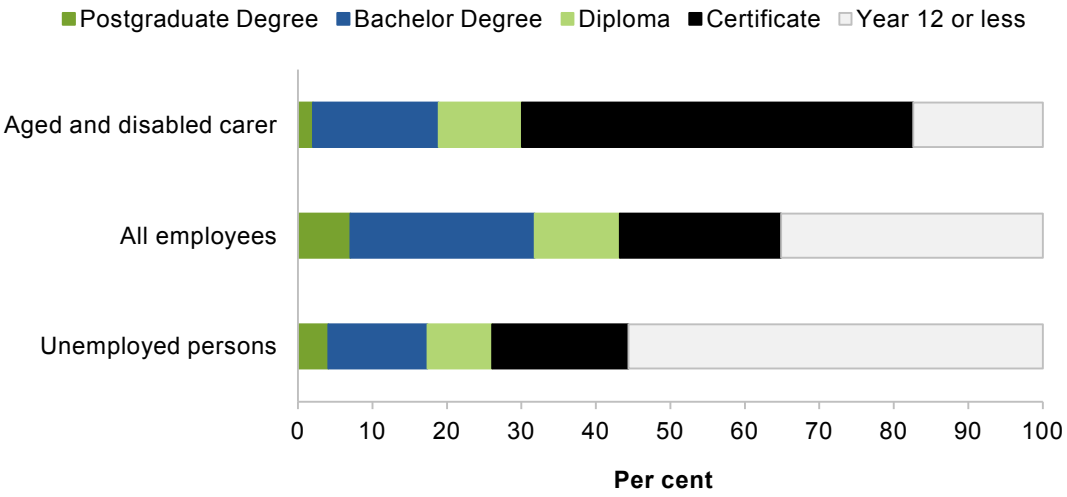


[a] Based on ANZSCO code 4231 'Aged or Disabled Carer'.

Source: Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census).

Figure 7.2 **People employed in aged and disability care roles are more likely to hold certificate-level qualifications[a]**

Highest level of educational attainment, 2016



[a] Aged and disability care roles based on ANZSCO code 4231 'Aged or Disabled Carer'. The Bachelor Degree category includes postgraduate certificate and diploma qualifications.

Source: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016).

7.2 What will the size of the workforce need to be by scheme roll out?

While estimates of the number of workers required to deliver supports allocated through the NDIS vary, the consensus is that the workforce will need to increase by between 60 000-90 000 full-time equivalent employees (FTE) — or roughly double in size:

> The workforce will need to increase from approximately 73 600 full-time equivalent (FTE) workers, to an estimated 162 000 FTE workers. (DRC 2015a, p. 19).
>
> The workforce opportunities and challenges as a result of the introduction of the NDIS are very significant. It is expected that the NDIS will generate between 60 000 and 70 000 new jobs on a full-time equivalent basis over the next three years. This represents about 20 per cent of the total number of new jobs forecast to be created in Australia over this period. (Bonyhady 2016, p. 5)

The NDIA's market position statements indicate that about an additional 70 000 FTE workers will be needed from 2015-16 to 2019-20 (NDIA 2016c, 2016p, 2016w, 2016y, 2016z, 2016aa, 2017m).

The evidence to date — admittedly at the very early stage of transition — indicates that the workforce is growing quickly, but not fast enough to meet the overall growth target. For example:

- data collected on the workforce by National Disability Services (NDS), a peak body for disability care providers, indicates that the number of workers in the sector is growing at a rate of about 12 per cent each year (NDS, sub. 51, p. 9)
- the number of people employed in aged and disability care occupations increased by about 27 per cent between 2015 and 2016 according to ABS Labour Force data.[31]

Neither of these sources are on a FTE basis. Based on the proportion of part-time to full-time positions, halving the rates of reported 'headcount' growth allows for a rough approximation of the FTE growth targets. As such, both figures are well short of the average annual growth rate of 18 per cent in FTE employees required to meet the expected workforce needed for the scheme.[32]

Data on allied health professionals, albeit patchy and reported in a period early in the trial phase, also indicate that growth rates in FTE employees are slow (table 7.1). Clearly, there are considerable challenges emerging in scaling up the workforce to meet the needs of NDIS participants.

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[31] Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2015 and May 2016).

[32] Commission estimates based on NDIA (2016c, 2016p, 2016w, 2016y, 2016z, 2016aa, 2017m)

Table 7.1 **The number of registered allied health professionals[a]**
2014

Allied Health Category	*Number registered*	*Average hours worked per week*	*FTE equivalent per 100 000 population*	*Average annual growth rate in FTE per 100 000 population (%)*
Psychologists	31 489	32.7	87.4	1.3[b]
Physiotherapists	27 011	34.7	83.3	2.1[b]
Occupational therapists	16 757	33.1	52.2	3.2[c]
Chiropractors	4 902	32.8	15.8	1.3[b]
Podiatrists	4 316	36.2	16.1	4.0[b]
Dental prosthetists	1 223	38.8	4.9	-2.6[b]
Aboriginal and Torres Strait Islander health practitioners	322	40.7	1.2 (76.4 based on Aboriginal and Torres Strait Islander population)	4.4[d]

[a] Only selected allied health professions shown from National Registration and Accreditation Scheme data (box 7.1). No data available for speech therapists and dieticians. [b] 2011 to 2014. [c] 2013 to 2014. [d] 2012 to 2014.

Sources: Commission estimates based on ABS (*Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, 2001 to 2026, Cat. no. 3238.0, series B); AIHW (2014a, 2014b, 2014c, 2014d, 2014e, 2014f, 2014g).

Challenges to reaching the workforce target

While estimates of FTE employees are helpful for providing an overview of the growth required, they mask a wider variation of supply and demand at a more disaggregated level. There are many different workforces that will provide services for NDIS participants, and the challenges — and policy responses to address those challenges — to each will vary. A better way is to consider the disability care workforce across 'role and region'.

- Role covers the types of workers needed to fulfil a NDIS participant's needs, which in turn will depend on individual choice, disability and other family circumstances. In turn, this translates to the skill mix of workers needed, and in turn, the mix of general carers, allied health professionals, and other workers required.
- Region covers the different number and growth in workers required in different locations.

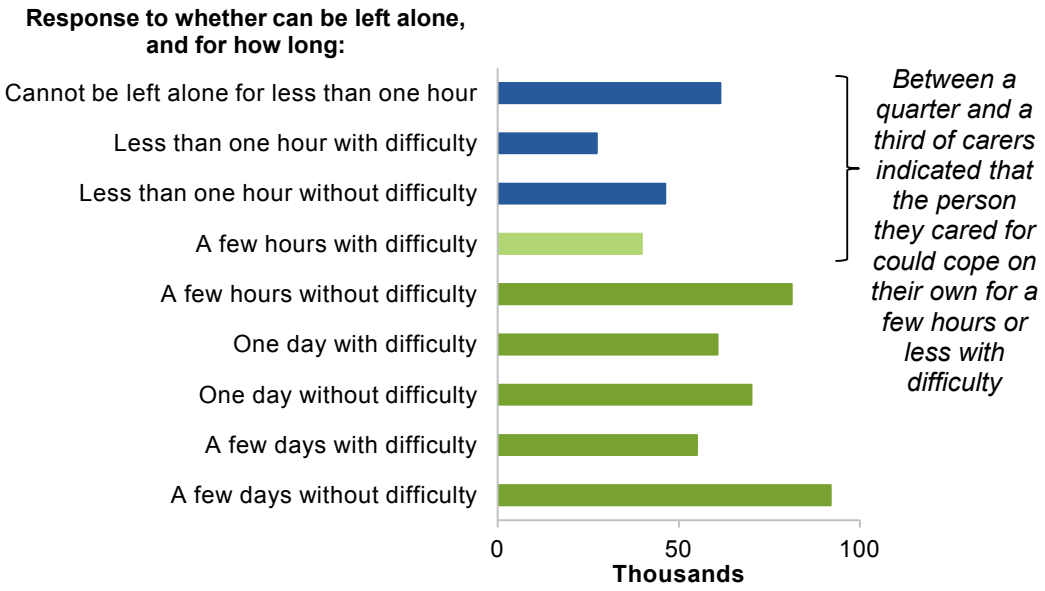
Role challenges

Peak hours

Disability carers are often required for only a few hours per day at 'peak times' — when there is high demand for carers in early mornings and evenings to help people with

disability get in or out of bed, showered and fed (Physical Disability Australia Ltd, sub. 38, p. 11). This is reflected in the Survey of Disability, Ageing and Carers, which indicates that about three-quarters of people with severe or profound disability require attendant care for a few hours a day before encountering difficulties (figure 7.3).

Figure 7.3 **Amount of care required before recipient has difficulties[a]**
2015



[a] Based on the response by the carer for those with severe or profound disability aged 15 years or more.

Source: Commission estimates based on ABS (*Disability, Ageing and Carers Australia: Summary of Findings, 2015,* Cat. no. 4430.0, table 42).

This means that there are times of the day when more carers are needed than on average, which would require a greater headcount than the FTE figures suggest. This has implications for how 'flexible' the workforce needs to be. As the NDIA said:

> Participant demand for care often occurs at 'peak times' or high demand periods which may include 7-9am (breakfast) and 4-8pm (bathing and mealtime) with less demand at late morning or mid-afternoon. This poses challenges for the sector to develop more mature rostering and staff management practices which are emerging in some areas. (sub. 161, p. 98)

One way to address this challenge is to make greater use of a more casualised workforce. This could provide the labour needed in those hours of greatest demand. However, there are also some impediments to such an approach, including:

- minimum shift requirements under the Social, Community, Home Care and Disability Services Industry Award, and the cost of casual loadings and penalty rates for working less desirable hours (such as those outside ordinary hours of work)
- quality concerns, such as whether NDIS participants want a different carer for each instance of care, and issues of reliability of casual labour (Cortis nd, p. 6)

- whether there is the supply of casual labour to allow such an approach
  - this includes the attractiveness to work on a casual basis for prospective workers, and the risk that more experienced and better qualified workers may seek permanent jobs elsewhere given the disincentives associated with less secure work (Independent Inquiry into Insecure Work in Australia 2012, pp. 20–21).

Qualified staff in general

The quality of care provided to NDIS participants will depend, in large part, on the quality and skills of the workers providing disability supports. For many roles, formal qualifications are important, if not mandatory, to provide supports. For other roles, formal qualifications are less important. The available evidence suggests that the 'average' level of formal skills in the disability care workforce will decline over the transition period of the NDIS (box 7.2).

This raises the question — is a formal qualification the most important or necessary characteristic to secure employment as a disability support carer? A survey of firms specialising in disability support by the Department of Employment (2014, pp. 2, 5) found the evidence to be mixed.

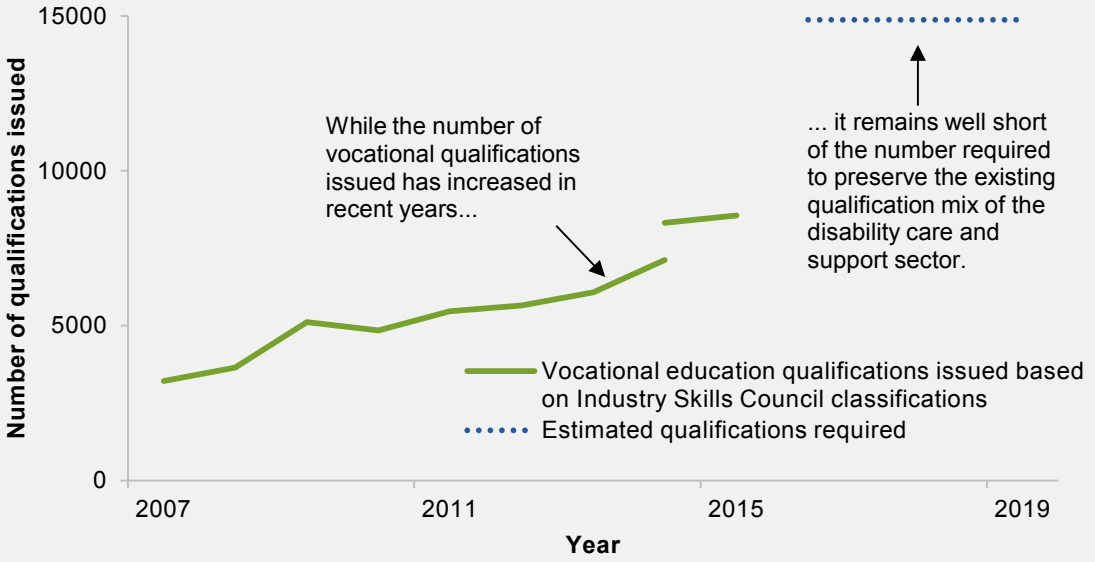
- 89 per cent of providers said that 'personal qualities' were 'important or very important' in terms of the characteristics sought; this compared to 70 per cent for 'relevant experience' and 47 per cent for 'relevant qualifications'.
- 89 per cent of firms said that their minimum requirement for employment was a certificate-level qualification. However, 26 per cent of firms indicated that they regularly employed unqualified workers, suggesting this requirement was not as binding a constraint for some firms.

This mixed story was also reflected in evidence provided to the Commission's 2011 inquiry into *Disability Care and Support*. While some providers argued that a minimum standard or qualification should be mandated for disability support staff, others said that formal qualifications sometimes fell short of providing 'work ready' employees, and that on-the-job training was far more important (PC 2011, p. 740).

Box 7.2 Not enough new trainees to maintain formal qualifications[a]

People employed in aged and disability care roles are more likely to hold a formal qualification than the workforce in general. The most common level of qualification for disability and aged care workers is a certificate III or IV. The number of people completing a qualification against expected workforce targets provides a measure of how the qualification mix of the workforce may look by the end of the National Disability Insurance Scheme transition.

The National Centre for Vocational Education Research dataset on vocational education outcomes (VOCSTATS) indicates that, if workforce targets are met, there will be a smaller proportion (than currently) of workers holding a certificate-level qualification. The figure below shows that about 50 000 certificate or diploma level qualifications were issued in the nine years between 2007 and 2015, while about another 60 000 qualifications would be necessary in the four years between 2016 and 2019 to preserve the same distribution of qualifications observed in the 2011 census.



This indicates that the proportion of workers holding certificate-level qualifications in disability care related studies will fall over the transition period. However, it is not clear what mix of qualifications will be necessary for all National Disability Insurance Scheme participants.

a Estimate is derived by subtracting the expected and current midpoint estimates of FTE disability care and support workers from the NDIA's market position statements and multiplying by a scaling factor of 0.85 to apply the proportion of full-time equivalent workers with a certificate or diploma qualification. This yields a result of 59 500 additional qualified workers, which when apportioned over 4 years requires 14 875 new qualified workers per year. Vocational qualifications are identified using Industry Skills Council classifications that include the term 'disability' in their title (specifically, codes CHC20599, CHC30302, CHC30408, CHC30799, CHC40202, CHC40302, CHC40308, CHC40312, CHC40799, CHC50102, CHC50108, CHC50799, CHC60102, CHC60108, CHC60112, CHC60799). Note that these data are presented in terms of qualifications awarded rather than qualifications used on a full-time equivalent basis. The break in series reflects changes in concordance between previously offered qualifications and current qualifications.

Sources: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016) and VOCSTATS (http://www.ncver.edu.au/resources/vocstats.html), extracted on 15 March 2017.

In practice, the benefits of a formal qualification depend in large part on the role that a disability care worker is employed in, and the client's needs. The NDIS will also mean that many workers will need to learn additional skills in the market-based environment for disability supports.

> The NDIS differs considerably from previous reforms as it moves away from 'block funding' programs to a 'fee for service' model. Earlier reforms had little effect on frontline workers. But now workforce models are changing. Frontline workers need to have an understanding of sales, customer service and the ability to work within financial constraints as well [as] being able to adapt and customise service delivery in a person centred model.
>
> Conversations are being held in the sector regarding formal qualifications and whether they are necessary. Some organisations are recruiting workers with no experience and no formal qualifications, with new staff undergoing customised organisational training only. For other organisations, formal qualifications are a pre-requisite. This brings opportunities for a diverse workforce. (Queensland Alliance for Mental Health, in VICSERV & CMHA 2017, p. 46)

It seems reasonable to conclude that the lack of certificate-qualified workers will affect some firms and present a challenge to meeting the workforce target of the NDIS, but the evidence is too limited to say which areas will be most disadvantaged. Also, participants may prioritise attitude and aptitude, and choose to employ less qualified staff who better suit their needs.

Qualified allied health professionals

Allied health roles are very different to attendant care roles. Allied health professionals specialise in a range of different areas, and hold higher level qualifications relative to the disability support workforce in general.

> Allied health professionals are generally educated in the university sector with bachelor degrees, usually three to four years duration. However, in a development common to other health professions, there is an increasing move to postgraduate degrees, for example an initial generic undergraduate science degree followed by a Masters in an individual discipline. (Department of Health and Ageing 2013)

Formal qualifications are almost always a requirement for allied health professionals to practice, which means building up qualified staff can take much longer than for other roles. Constraints in this regard were recognised as part of the *NDIS Integrated Market Sector and Workforce Strategy*.

> It is estimated that the highest rate of increase in the demand for disability workers will be for allied health professionals. The disability sector will need to work closely with related community service sectors, particularly health and aged care, to ensure the demand for allied health professionals is met.
>
> To support the sector and enhance the supply of allied health professionals to the disability sector, the Commonwealth and jurisdictions will work with the sector, education authorities, and professional bodies to ensure that professional education prepares graduates adequately to work in the NDIS. At the same time, to encourage allied health professionals to choose the

> disability sector, the Commonwealth will work with these same stakeholders to strengthen the sector's capacity to provide high-quality placements and support continuing professional development for allied health workers. (DRC 2015a, p. 20)

If the allied health professional workforce does not build quickly enough, then this could lead to unmet demand for participants. It could also lead to a substitution away from using professionals carers to using more general workers instead. This has already been reported in the evaluation of the NDIS, along with the effect this has had on the quality of care provided.

> A perception was expressed in the wave 1 interviews that the pricing structure of the NDIS would bring change to the role of allied health professionals through encouraging the increased use of non-professional staff. By wave 2 a de-professionalisation of the disability workforce was more commonly being reported, with increasing numbers of allied health assistants in the sector. Concerns were raised about the ability and skills of these workers to provide more complex supports and the impact this could have on the quality of care and outcomes for participants. (Mavromaras, Moskos and Mahuteau 2016, p. 48)

And as put by one of the providers interviewed in that study:

> We have employed a number of inexperienced people, but I believe that's starting to backfire … Just the inexperience and the lack of knowledge on how to work with behaviours or understand confidentiality, or things like professional distance and all those types of things. And we're sending inexperienced people out to work individually with people with disabilities. (Mavromaras, Moskos and Mahuteau 2016, p. 48)

Evidence presented to the Commission provides another mixed story about supply and demand for allied health workers in the NDIS. On the one hand, the number of providers registered to deliver allied health services to NDIS participants has grown strongly (NDIA 2016v, p. 44), and in line with the expected number needed by the end of the transition period. However, many who have registered are not yet providing services to scheme participants. This makes it difficult to determine if they are registering in advance of the NDIS rollout or have changed their mind about delivering services.

Many disability service providers indicated that there are a number of allied health roles that are moderately or extremely difficult to fill. For example, more than half of the firms surveyed by National Disability Services indicated that they had experienced difficulties recruiting speech therapists and occupational therapists (NDS 2016, p. 38). The *Intermediate Review of the NDIS* also identified persistent shortages in the provision of speech pathology, occupational therapy and psychology supports (Mavromaras, Moskos and Mahuteau 2016, p. 32), though supply to those who needed such services had increased. As one staff member of the NDIA in the Intermediate Review put it:

> The NDIS has worked twofold. It's increased the amount of service available so people can see other OTs [Occupational Therapists] outside of what they would have been able to. But there's an increased demand. The increased demand is way above the increase of services. (Mavromaras, Moskos and Mahuteau 2016, p. 54)

Some service providers and peak bodies expressed concerns about whether there will be enough allied health providers for NDIS participants, and the consequences for sectors (box 7.3).

Box 7.3 Difficulties faced finding allied health workers

Matthew Burrows:

> The workforce is a wicked problem. … To think that we, as service providers, can just advertise for and employ that many qualified staff (eg therapists) in such a short time is just misguided. Let alone the considerations of balancing a commercial and compassionate culture during this transition time.
>
> At entry to the NDIS in 2012-13 the employment market for therapists relied heavily on internationals supported to work domestically on 457 visas. By 2016-17 the training institutions had geared up and graduates now make up a steady portion of the new recruits. But there remains a gap and that gap is being filled from the full employment market being accessed elsewhere. Australia only has so many therapists and their entry into the NDIS employment field means they are exiting elsewhere. (sub. 7, pp. 3–4)

Disability Services Australia:

> Professional staff, in particular Psychologists and Speech Pathologists are generally difficult to attract (especially in Regional areas) in a very competitive marketplace. This has driven the need to implement creative sourcing strategies such as the hiring of interns for a short term solution. We have also seen significant wages growth in the allied health professions due to labour shortages. (sub. 9, p. 9)

Australian Physiotherapy Association:

> Our members have suggested that increasing the NDIS workforce to that which is projected as being required will not be possible in the current policy settings. They have advised us that demand for services has already stripped supply of providers. (sub. 93, p. 16)

Allied Health Professionals Australia:

> Current demand for services is already exceeding the available supply of allied health providers and there is no evidence of short term changes to this workforce shortage. (sub. 37, p. 16)

A lack of allied health professionals represents a risk that supports of appropriate (and necessary) quality may not be available to some NDIS participants. The time it takes to train an allied health worker — both in terms of formal qualifications and on-the-job training — means that it may be too late to prepare the necessary allied health workforce without either diverting them from other caring sectors, or to seek skilled migrants to fill the workforce gap in the short term. Both approaches involve costs.

An ageing workforce and population presents a greater challenge

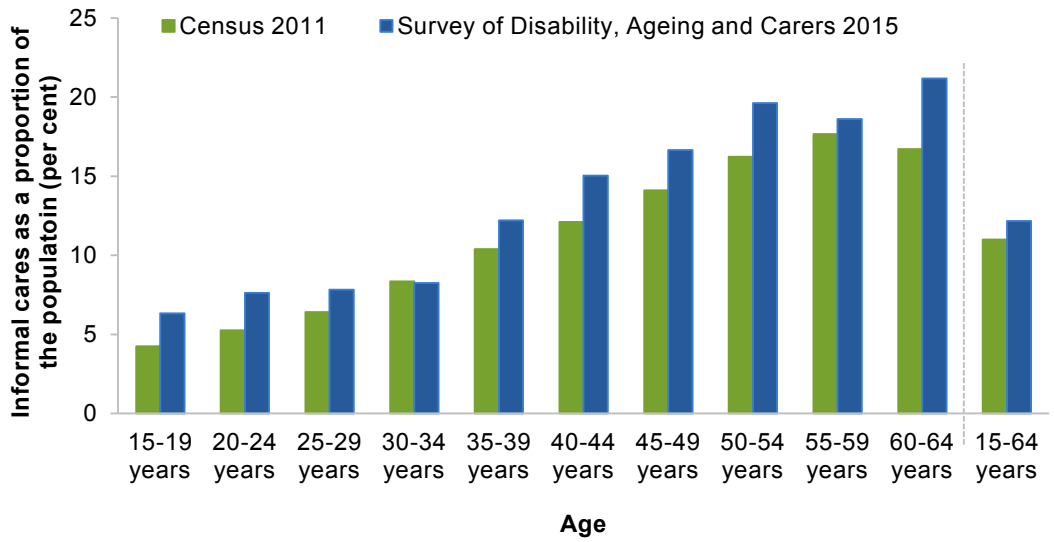
Australia has an ageing population, and this is reflected in the increasing average age of:

- formal carers employed to look after people with disability (figure 7.1)
- informal carers who look after friends and family with a disability
- the general population, which will affect the on demand for carers more broadly.

As noted above, the average age of carers employed in the aged and disability care workforce is higher than for the general workforce. The average age of people employed in aged and disability care is about 47 years, and more than 30 per cent are above the age of 55 years (figure 7.1).[33] An increasing proportion of the care workforce is likely to retire in the coming years, with the average retirement age of those employed in the personal care and assistance occupations being about 55 years in 2014-15.[34] Only about half of those working in disability care intend to still be working in the sector in five years' time (Cortis nd, p. 24).

Informal carers are also ageing. The trend since the 2011 Census has been an increasing proportion people aged 50-64 years providing care for others (figure 7.4). The ability for informal carers to continue providing this care as they age is likely to diminish. As the degree of informal care a NDIS participant receives affects the amount of formal care supports that they are allocated, this suggests that as informal carers age, there will be greater calls on the NDIS to provide more supports and this will require a larger formal workforce.

Figure 7.4 **Informal carers are growing older**



Sources: Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census; *TableBuilder,* Survey of Disability, Ageing and Carers 2015).

The ageing population also means that there will be more intensive demand for carers. While aged carers are not perfect substitutes for disability care workers, there are some roles that cross over, and about one-fifth of disability care providers also provide aged care

33 Commission estimates based on ABS (*TableBuilder Basic,* 2011 Census).

34 Commission estimates based on ABS (*Retirement and Retirement Intentions, Australia, July 2014 to June 2015,* Cat. no. 6238.0, unpublished data).

(NDS 2016, p. 13). This means that even if new carers are trained, they may not be necessarily attracted to the disability care sector as the aged care sector expands. As Disability Services Australia said:

> There is no doubt that as Baby Boomers retire from full time work there will be an overall impact on a range of employment sectors. Whilst there may be some potential for retirees to take on casual disability support or mentoring roles, the ageing population will also create an increase in demand for aged care workers, in direct competition with the recruitment for workers in to disability roles. (sub. 9, p. 9)

Even if the disability sector attracts workers from the aged care sector, there could still be implications for scheme costs. For example, if the quality of aged care services falls as a result of workforce shortages, there could be a stronger incentive for NDIS participants to remain in the scheme past the age of 65 years.

The role of wages in growing the workforce

Most of the payments from the NDIS will be spent on wages, given the labour-intensive nature of disability care. While price caps will have an impact (chapter 6), this is likely to mean more money will be available for workers. From a policy perspective, the question is whether this money will be sufficient to induce more workers to provide disability supports. This depends on how competitive the disability care market is, how responsive care workers are to wages, and in turn, why people work in the disability care sector.

Analysis conducted prior to the introduction of the NDIS suggests that pay is not the primary motivation to work in disability care. For example, a study of community service employees undertaken in 2009 found that only 16 per cent of employees were attracted to work in the disability services sector primarily for the remuneration (Martin and Healy 2010, p. 135). A desire to help others and a desire to do something worthwhile were far more important motivations (nominated by 76 and 68 per cent of workers, respectively) (Martin and Healy 2010, p. 135). As put by one disability support worker:

> I love this industry. It's not about coming into work, doing an 8 hour shift and leaving. It's so much more than that. For some people we can be their eyes, their ears or their hands. (United Voice, sub. 118, p. 2)

However, there is evidence that suggests that higher rates of pay may help to retain workers in disability care roles and to attract new workers to the sector. Just over half of employees who left a disability support provider surveyed by the Department of Employment (2014, p. 17) said that they left for a position that had 'better pay and conditions', and that about 60 per cent of firms used increased remuneration as a means to improve retention. Given the ageing workforce, higher wages to keep workers from retiring may prove to be one of the scheme's strengths, notwithstanding the effects of the NDIA's price controls.

Overcoming the perception that caring jobs do not lead to fulfilling careers may be necessary to enough workers to provide NDIS supports. As noted in the *NDIS Integrated Market, Sector and Workforce Strategy*:

> To meet the increased demand for disability workers, including allied health professionals, it will be necessary to assist suppliers to promote the disability sector nationally as a career. (DRC 2015a, p. 20)

A number of study participants noted that caring roles are seen as unattractive due to the nature and remuneration of the work.

> The nature of the work of disability support staff may not in itself be attractive enough to appeal to many school leavers and those looking for a career change in later life. The work itself can be highly complex and carry significant risk, especially when supporting people with severe challenging behaviours or people with complex medical support needs. Greater provision for training support staff is vitally important at present, providers are limited in the amount of training that can be provided due to cost pressures. (Macarthur Disability Services, sub. 57, p. 8)

> The NDIA has observed over the course of trial and transition that caring jobs are often poorly valued. Common reasons cited for a lack of retention (Department of Employment survey of Personal Care Workers 2014, National Aged Care Workforce Census and Survey) include the low conditions of work and physical and emotional toll of the job. This is regrettable. (NDIA, sub. 161, p. 97)

> That caring roles are poorly [valued] is not perception, it is reality. Caring jobs are poorly valued. Pay rates are mostly minimal. Good or exceptional performance of the role is rarely valued financially. (Autism Aspergers Advocacy Australia, sub. 178, p. 26)

The longer term responsiveness of labour supply to conditions under the NDIS is hard to determine. The nature of the data makes it difficult to understand the number and hours worked by employees of disability care providers. The unprecedented scale of workforce growth required combined with a new market-based approach also mean that historical data on wages and work patterns are less useful to estimate the future. The interaction with other care sectors — especially aged care — will also important. More data will need to be collected to make meaningful wage policy when it comes to NDIS workers.

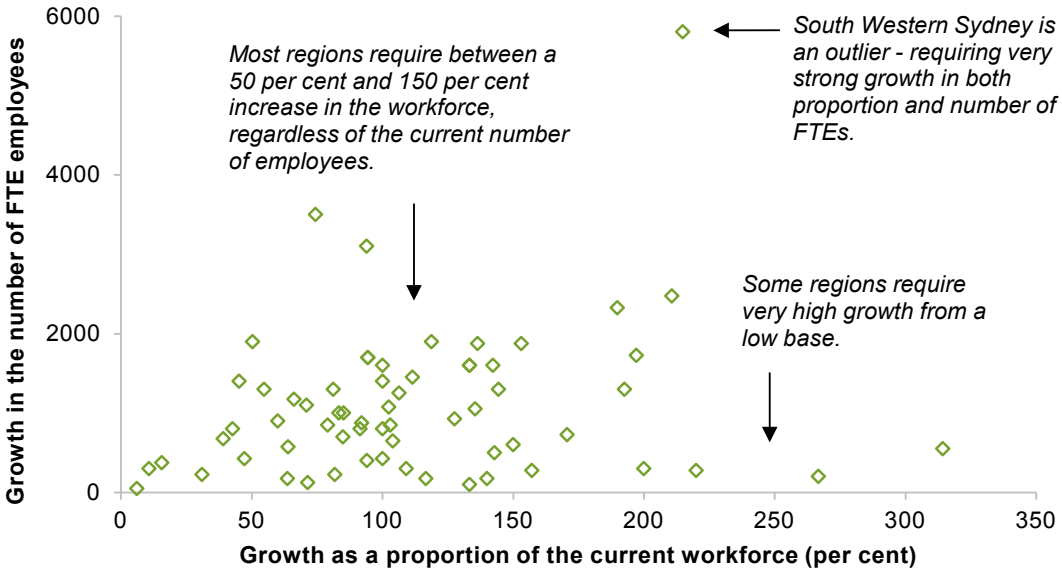
Regional challenges

The disability care workforce needs to double in aggregate, but the scale of growth required in individual regions varies between as little as 5 and over 300 per cent (figure 7.5).[35] Most regions will need to grow their disability care workforce between 50 and 150 per cent. While some of the percentage increases are large, many are based on a very low number of workers to start with. This is especially the case in rural or remote areas where a few workers can represent a doubling of the disability care workforce.

[35] Regions are groups of local government areas, which are the geographical basis for the NDIA's market position statements.

Figure 7.5 **Variation in growth required in different regions[a]**

Each dot represents the growth in the amount of FTE employees needed relative to the current situation, both in terms of the number and proportion, between 2015-16 and 2019-20.



[a] The NDIA's market position statements provide a range of estimates for the number of FTE disability workers at present and what will be needed in the future. To derive these estimates for growth, the midpoints of each range are used. No data are available for Western Australia. Regions are groups of local government areas.

Sources: Commission estimates based on NDIA (2016c, 2016p, 2016w, 2016y, 2016z, 2016aa, 2017m).

Some of the challenges associated with thin markets in remote areas are discussed in chapter 6, but it is worth noting that there are several regions within metropolitan areas where the required growth is about 200 per cent:

- South Western Sydney, where about an additional 5800 FTE workers are needed (growth of 215 per cent)
- Southern Melbourne, where about an additional 2400 FTE workers are needed (growth of 211 per cent)
- Beenleigh, where about an additional 2300 FTE workers are needed (growth of 190 per cent)
- Brimbank Melton, where about an additional 1700 FTE workers are needed (growth of 197 per cent).

These data, as published, do not capture the mix of roles within the FTE positions. For example, they do not distinguish between the hours of care provided by an in-home carer as opposed to those provided by an allied health professional. All of this emphasises the need for policies that seek to mitigate workforce shortages to have a focus at a regional

level, where different policy responses may be more appropriate across different regions and roles.

The bottom line?

The scale of workforce growth required, combined with challenges related to worker roles and regional variation, means that the NDIS workforce targets are unlikely to be met by 2020. As the Intermediate Review of the NDIS noted:

> While the NDIS had led to an increase in the supply of disability supports, the Scheme had also led to an increase in a demand for services (and particularly therapy services); NDIA staff concluded that overall, demand now exceeded supply. (Mavromaras, Moskos and Mahuteau 2016, p. 54)

The trends to date show that providers are already responding to workforce shortages by using less skilled labour. In some cases, this may compromise the quality of care received by participants and could become more widespread as the NDIS is fully rolled out. This, in turn, will reduce the effectiveness of the NDIS, compromise its insurance principles (and increase long-term costs), and in some cases, be a risk to participants' wellbeing.

It is more difficult to make an assessment of how far the workforce will develop beyond the transition given the uncertainties about how yet-to-be implemented policies will affect the supply and demand for workers (such as the implementation of the NDIS Quality and Safeguarding Framework, outcomes from future price reviews, and the implications of the NDIS's market intervention framework).

DRAFT FINDING 7.1

It is unlikely that the disability care workforce will be sufficient to deliver the supports expected to be allocated by the National Disability Insurance Agency by 2020.

7.3 What can be done to improve workforce readiness?

The challenges confronting the readiness of the workforce, if left unaddressed, could create short-term and long-term risks to the sustainability of the scheme and the wellbeing of participants. In the short term, a lack of qualified workers may mean that less qualified staff are used to deliver supports, or there will be unmet demand. This, in turn, erodes the benefits of the insurance approach over the longer term, meaning that the costs to support participants will be higher than necessary.

However, some of these challenges can be addressed relatively quickly, or alternative arrangements employed to mitigate their effects.

Getting the right balance between strategy and action

The responsibility for funding sector and workforce development was allocated to the Australian Government as part of the 2012 *Intergovernmental Agreement for the National Disability Insurance Scheme Launch* (ANAO 2016). The Department of Social Services (DSS) has responsibility for many roles in developing the disability care workforce to meet the needs of the NDIS, including: coordinating and facilitating responses to workforce shortages; coordinating with other Australian Government agencies to build workforce supply; and developing a coordinated response in particularly challenging areas — such as the demand for allied health professionals (Independent Review of the Readiness of NDIS for Transition to Full Scheme 2016).

Australian Government initiatives to foster disability care workforce readiness have focused primarily on a range of frameworks and principles that have been developed in consultation with the NDIA (table 7.2). These have been designed to provide guidance on how the workforce is to develop.

Such a strategic approach to developing a market — especially one so ground-breaking as the NDIS — was appropriate for the trial period. However, as the scheme begins to build up over the transition period, there needs to be more practical implementation of the strategic objectives, particularly to develop the workforce. Relying on strategic policies alone is leading to uncertainty among providers.

> Several strategies have been published (Assistive Technology, Rural and Remote, Market and Workforce). They provide directions but are light on implementation detail. For these strategies to inform the planning and investment decisions of service providers, they need to be underpinned by clear publicly-available plans. (NDS in ANAO 2016, p. 32)

Table 7.2 **Many strategies affect workforce development**

Entity	*Strategy*
NDIA (2013, 2016h)	2013–16 Strategic Plan and 2015–21 Corporate Plan
NDIA (2015b)	Assistive Technology Strategy
NDIA (2016x)	Rural and Remote Strategy
NDIA (2017b)	Aboriginal and Torres Strait Islander Strategy
NDIA (forthcoming)	Provider of Last Resort Strategy
NDIA (forthcoming)	Market Intervention Framework
COAG DRC (DSS 2016c)	Quality and Safeguards Framework
COAG DRC (DRC 2015a)	Integrated Market, Sector and Workforce Strategy
COAG DRC (DSS 2017c)	National Disability Strategy 2010-2020
DSS (2015)	Sector Development Fund Strategy and Operational Guidelines
DSS (2017b)	Integrated Plan for Carer Support Services

The Australian National Audit Office (ANAO), when it examined the market transition under the NDIS, found that the *Integrated Market Sector and Workforce Strategy* lacked the details necessary for the transition.

> While establishing a national approach to the market transition, the Strategy does not provide a clear basis for coordinated actions, as it does not commit jurisdictions to specific deliverables, with agreed timeframes, accountabilities and milestones. DSS advised the ANAO that 'detailed timeframes and accountabilities will likely be captured in a bilateral context going forward, recognising the unique characteristics in each jurisdiction in terms of the market and workforce.' …
>
> Further detail about how the Strategy is to be operationalised, including specific actions and timeframes, would assist stakeholders, particularly service providers who need to make investment decisions. In July 2016, DSS advised the ANAO that it intends to develop a Strategy 'action plan' for 2016-17 and into the future. Publishing this action plan, including key priorities and initiatives, timeframes and milestones, may help to address stakeholder concerns. (ANAO 2016, p. 32)

The Sector Development Fund (SDF), which is funded by the Australian Government with $146 million to support the NDIS market transition between 2012-13 and 2017-18, includes workforce development as one of its objectives. The DSS administers the SDF by allocating grants to organisations and governments to address areas of identified need. However, in its evaluation of the SDF, the ANAO (2016, p. 34) found that the approach to grant-making had not followed the objectives outlined in the strategic documents themselves, and that greater evaluation of SDF projects was necessary . More recently, funding to boost the workforce was allocated as part of the 2017-18 budget.

> The Government will assist service providers in rural, regional and outer suburban areas to provide the workforce required to meet the expected growth in the disability and aged care sectors arising from the introduction of the National Disability Insurance Scheme and an ageing population by investing $33.0 million over three years from 2017-18. (Australian Treasury 2017a, p. 145)

Some State and Territory Governments have already taken action in response to workforce concerns. For example:

- The New South Wales Government spent $5 million to supplement its 'industry development fund', which provides a range of resources for firms to transition to the NDIS and includes materials regarding workforce development (NDS 2017b; Nucleus Group 2015)
- The Victorian Government (sub. 174, p. 18) spent about $26 million (supplemented in part by the Sector Development Fund) on its *Keeping Our Sector Strong* policy, which has the goal of 'developing and growing the disability workforce over the transition to full scheme'
- The South Australian Government has sought independent advice about likely workforce needs at a more detailed level, and has provided grants as part of its *Provider Readiness Program* (SA DCSI 2017)

- The ACT Government has invested in market development, and made a number of direct grants to provider organisations, including some using SDF monies (ACT Directorate of Community Services 2016).

While it is understandable that State and Territory Governments want to address potential workforce shortages, there is a risk that fragmented workforce policies may lead to duplication or unnecessary programs at a time when the scheme can least afford it. As a union that represents many disability carers said:

> Unclear delineation of market development and stewardship responsibilities between the National Disability Insurance Agency (NDIA), the Commonwealth Department of Social Services (DSS) and the States and Territories has resulted in no substantive progress on a workforce development strategy focusing on attraction, retention, skills or quality. (Health Services Union, sub. 132, p. 4)

While the COAG Disability Reform Council has taken steps to clarify responsibilities, the Commission considers that further refinement is necessary. The 'big tent' approach to workforce development remains appropriate, but the responsibilities of different parties should be made public.

- State and Territory Governments should have more responsibility for workforce development issues over the transition period. They have the best experience of where historically unmet need has been and the approaches best suited to solve such issues in particular jurisdictions.
- The Australian Government should retain oversight of the scheme and focus on areas such as tertiary education and immigration, and how increased demand affects and interacts with other care sectors, in particular aged care.
- The NDIA is best placed to provide more information to governments in the form of actuarial and scheme data collected to provide more granular detail on where supply gaps are emerging, or likely to emerge.
- Providers should also be regularly consulted by governments about emerging workforce policy issues, such as where the incentives of the scheme may be affected by other laws and regulations, like minimum standards, conditions of State and Commonwealth awards, and training and development.

The workforce development responsibilities of State and Territory Governments will be less as the NDIA fully rolls out and replaces their existing disability support programs. However, State and Territory Governments should remain 'in the tent' when it comes to workforce policymaking given the interaction between the NDIS and other mainstream services. The Commission seeks feedback on the best way for governments and the NDIA to manage these responsibilities as the scheme rolls out.

DRAFT RECOMMENDATION 7.1

The roles and responsibilities of different parties to develop the National Disability Insurance Scheme workforce should be clarified and made public.

- State and Territory Governments should make use of their previous experience in administering disability care and support services to play a greater role in identifying workforce gaps and remedies tailored to their jurisdiction.
- The Australian Government should retain oversight of workforce development, including how tertiary education, immigration and aged care policy interact and affect the development of the workforce. In doing so, the Australian Government should pay particular attention to immigration policy to mitigate workforce shortages over the transition period.
- The National Disability Insurance Agency should provide State and Territory Governments with data held by the Agency to enable those jurisdictions to make effective workforce development policy.
- Providers of disability supports should have access to a clear and consistent mechanism to alert those tasked with market development about emerging and persistent workforce gaps.

INFORMATION REQUEST 7.1

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

An evidence-based approach to workforce policy is needed

A lack of data makes it difficult for policymakers and market stewards to properly exercise direction and support to the sector for it to develop sustainably. The existing data do not lend itself to measurements of specialisation, or differentiation of caring roles (such as between aged and disability care). Nor is it straightforward to examine labour supply and wage outcomes. This means that tasks that are simple for other industries — like identifying the response in labour supply to an increase in wages — are impossible to undertake with any degree of certainty. As the DSS said:

> A significant limitation to assessing the NDIS market readiness is the availability of market and workforce data. DRC has agreed Market Key Performance Indicators to monitor NDIS market performance and identify emerging market risks and, as the Scheme matures, will assist the NDIA with identifying risk requiring intervention. (sub. 146, p. 34)

These key performance indicators will be drawn from scheme data, which will provide a richer dataset on providers and participants. However, the nature of the data means that it will be less well suited for measuring workforce growth and gaps over the transition period

and over the longer term. The Commission considers that the evidence base on the NDIS workforce needs to be commensurate with the importance of the scheme itself.

More data need to be collected on the supply and demand of disability care workers. On the demand side, the NDIA's market position statements provide the necessary information on when and where workers will be needed, and should be updated regularly. On the supply side, the Australian Bureau of Statistics should be funded to collect policy-relevant data on the disability care workforce.

DRAFT RECOMMENDATION 7.2

The National Disability Insurance Agency should publish more detailed market position statements on an annual basis. These should include information on the number of participants, committed supports, existing providers and previous actual expenditure by local government area.

The Australian Government should provide funding to the Australian Bureau of Statistics to regularly collect and publish information on the qualifications, age, hours of work and incomes of those working in disability care roles, including allied health professionals.

There is some scope to expand the supply of carers in the short term

One short-term policy to bolster the workforce is to make better use of existing disability carers. About 20 per cent of current aged and disability care workers express a desire to work more hours, half of whom wanted to work full-time (figure 7.6). This confirms the observation made by Martin and Healy (2010, p. 146), that frontline disability care workers 'generally wanted a substantial increase of 10 or more hours' of their weekly workload.

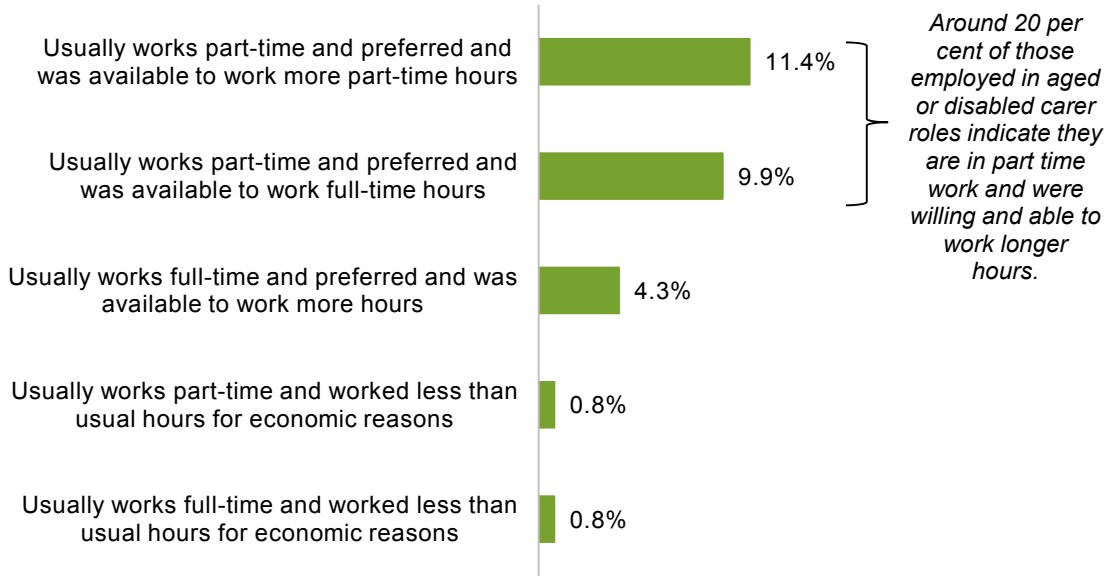
However, a desire to work more hours, does not mean an outcome of working more hours if policy settings and preferences of workers do not align. As put by the South Australian Government:

> Offering additional hours and more full time positions is an effective strategy to increase the size of the workforce, capitalising on the use of existing skilled workers and potentially offering greater security for some, particularly in the short term. However, this should also be balanced with being an employer of choice and offering flexible work arrangements to retain skilled workers in the sector. SA would therefore be interested in analysis being conducted on what level of inducement is provided by the flexibility of work arrangements that part time employment provides. (sub. 203, p. 14)

The Commission agrees, and considers that building the evidence base is key to identifying and addressing further impediments to making the most of the existing workforce. There may also be impediments to working additional hours arising from the price caps set by the NDIA, an issue that would form part of an independent pricing monitor and pricing regulator's duties to assess and respond to, if necessary (chapter 6).

Figure 7.6 **Aged and disabled carers express a desire to work longer hours[a]**

Per cent of aged and disabled carers, based on ANZSCO definitions, 2016



[a] Residual are those who are not underemployed (about 72 per cent of aged and disabled carers). 'Economic reasons' include being stood down or there not being enough work available.

Source: Commission estimates based on ABS (*TableBuilder,* Education and Work, May 2016).

Some informal carers may be able to provide additional care

Workforce shortages will mean that some people with disability will have to continue for some time yet to rely on their informal carers. But there are three constraints on informal carers providing additional hours of care:

- declining ability to care (especially in the case of ageing informal carers)
- other commitments (such as paid employment, or the need to engage in paid work)
- lack of respite.

In terms of the first point, and as mentioned above, the increasing age of informal carers means that there will be many carers who are unable to provide additional care. The most striking example are ageing parents of adult children with disabilities. Many ageing parents contributed to this study (box 7.3). It is clear that their capacity to offer additional care is extremely limited, and should not be relied upon.

Box 7.3 Many parents are currently the 'provider of last resort'

Rosa Miot:

> The NDIS is crucial to my future. I have a 40 year old daughter with an intellectual disability. I have been her full time carer all of her life. … However, I am now 70 years old and I will need the NDIS to provide her with the ongoing supports she will need to be able to remain living in the community as she has done all her life. I would like to be able to concentrate on my own life and health needs and not be overburdened with the caring role. (brief sub. 134)

Evelyn Ware:

> My husband and I are 89 and 82 years old respectively and have a daughter aged 55 with autism and intellectual disability. Although living in the community she requires a considerable amount of support with budgeting, health matters, cooking and general management of her life. … once we are unable to provide the assistance we are now providing she will need to have more support from NDIS, or go into supported accommodation as her disability prevents her from living independently in the community. (brief sub. 137)

Pat van der Beek:

> Our intellectually disabled son is 41 years old this year and my husband and I are 73 and 72 respectively. When the NDIS rolls out in our area in July, we are hopeful that we will have additional resources to enhance his life. His siblings are busy with their own families, careers and lives in general and there is no certainty that they will be able (or willing) to provide the necessary support for their brother when we no longer can. … While we are currently both in reasonable health, there is obviously no guarantee this will continue; inevitably, our son will be without our support in the later years of his life. … We have genuinely done our utmost to give him the best possible life to this point and welcome the introduction of the NDIS which we hope will enhance his future while also lifting some of the responsibility from our shoulders. (brief sub. 70)

However, for others the constraint is less to do with ability and more to do with the forgone wages that caring entails. Alleviating these constraints may allow informal carers to support family members with disability for longer and more intensively.

The simplest option is to allow the payment of informal carers through NDIA-managed plans. The NDIA's operational guidelines do not allow family members to be paid as carers except in exceptional circumstances. Specifically, the NDIA (ndd) 'will not fund a family member to provide personal care or community access supports unless all other options to identify a suitable provider of supports have been exhausted'. In practice, this has been interpreted to mean that family members who are paid to provide supports do not reside at the same location as the participant (NDIA 2014b, p. 5; Queensland Advocacy Limited, sub. 115, p. 15).

Due to slower than expected workforce growth, the Commission considers that it is appropriate for the guidelines concerning payment for informal care to be relaxed over the transition period for core supports (as these supports are critical to the wellbeing of a participant). Specifically:

- any requirement that the paid informal carer not reside at the same location as the participant should be removed

- the need to 'exhaust' all options to identify suitable providers should be more clearly defined, and linked to the NDIA's own data about the number and nature of providers in a region.

It is appropriate for such supports provided by informal carers paid by the NDIS to be reviewed regularly in light of market development, as well as issues about quality, safety and the longer-term objective of the scheme to relieve the burden on informal carers. There are also potential benefits for those in thin markets, including for Aboriginal and Torres Strait Islander participants where a greater use of informal carers could be more culturally appropriate in some circumstances.

> Peak representative group the First People's Disability Network argues there is an existing workforce in many Aboriginal and Torres Strait Islander communities because family members provide support informally. Giving resources to people already providing informal support may help fill capacity gaps in a culturally appropriate way. Additionally, area or community-based cooperatives could be used to develop capacity in Aboriginal and Torres Strait Islander communities. (AONSW 2017, p. 15)

A separate price for the supports provided by informal carers should be determined by the body tasked with setting prices for NDIS supports (chapter 6). It could reflect the opportunity cost of wages or welfare payments forgone, but should, generally speaking, be lower than that of the base hourly wage set in the NDIA price list for formal carers. The methodology used to determine the carers payment could also form a basis for setting the price of supports provided by informal carers.

There remain some administrative difficulties. Carers employed by participants are subject to the same laws about superannuation, occupational health and safety, industrial relations and workers compensation insurance. These arrangements should be the responsibility of participants and their families.

DRAFT RECOMMENDATION 7.3

The National Disability Insurance Agency's (NDIA) guidelines on paying informal carers who live at the same residence as a participant should be relaxed for core supports for the period of the National Disability Insurance Scheme (NDIS) transition. Such payments should be:

- accessible under clearly defined and public guidelines, which make reference to worker shortages in the relevant market using the NDIA's information about providers and supports in the participant's region
- set at a single rate determined by the NDIS price regulator in a transparent manner
- reviewed by the NDIA as part of plan reviews.

Respite plays an important role in facilitating informal care

Respite services can also help informal carers care for longer. A number of submissions to this study argued that respite services are not well catered for in NDIS supports. Specifically:

- the prices for short-term accommodation under the NDIS, which is used for respite, are too low to be sustainable (Cerebral Palsy Alliance, sub. 163, att. 1, p. 4) — an issue of price caps set by the NDIA for some supports (discussed in chapter 6).
- there is a lack of respite supports for family members (Carers Australia Victoria, sub. 131, pp. 37–38).

The shift towards participant-driven demand means that there are few avenues for informal carers to be assured of respite care. For informal carers to receive NDIS-funded respite care, it must form part of a participant's plan. While this maximises choice and control for the participant, it can lead to inappropriate levels of support for informal carers (National Mental Health Commission, sub. 153, p. 4), especially as some block-funded supports for carers are withdrawn. As Anglicare Sydney said:

> … carer needs and supports are not formally recognised as part of NDIS packages. There is no formal assessment of the needs of the carer, no funding package for the carer and no guarantee of involvement in the assessment of the care recipient's needs. … With the closure of carer-specific support services, Anglicare is concerned that carers will no longer receive the same amount of support, let alone improved levels of support, under the new system. (Kemp et al. 2016, p. 10)

The supports for respite under the NDIS are made up of several different options, most of which place a cap on the number of respite days provided per year. These caps have attracted criticism, with some providers claiming that they make the provision of respite services commercially unviable, including for participants with particularly complex needs or challenging behaviour (Cerebral Palsy Alliance, sub. 163, att. 2, p. 1). Some families also indicated that the respite offered in plans is insufficient (Carers ACT 2015, pp. 1–3).

Broader support for carers, including information and linkage about respite, is also to be provided under the DSS' *Integrated Plan for Carer Support Services*, which is yet to be fully implemented. A gap is emerging for respite services both within and outside the NDIS as the scheme transition occurs.

A lack of respite may mean that informal carers are unable to support family members and friends who are NDIS participants. This, in turn, will require more formal and costly supports in their place. It was for this reason that the Commission in its 2011 *Disability Care and Support* inquiry recommended that the needs of carers be considered as part of a participant's individualised supports (PC 2011, p. 340).

However, it is less clear whether a quantity cap (as well as a price cap) for respite services is warranted, and whether it is in the best interests of participants, providers and the

community over the transition period of the scheme where *all* carers are needed. The Commission is seeking further information on these issues.

INFORMATION REQUEST 7.2

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

Greater use of skilled migration has costs and benefits

While reducing underemployment for general care workers may bolster supply of some workers, there is practically negligible underemployment in allied health professions.[36] For such workers, the long lead time to train them means that shortages could persist over the shorter term, and potentially beyond the end of the NDIS transition period.

An option to meet a shortfall in the short-term is to make greater use of skilled migrants, which was proposed by the Commission in its 2011 inquiry (2011, p. 721). The Commission considers that the existing policies and regulations for using skilled migrants is appropriate to meet the needs of the NDIS over the transition period, if required.[37] The flexibility of using staff employed on visas over a few years is also of value to the scheme, as participants may have changing preferences over a similar time period.

That said, it should be recognised that using skilled migrants is not an immediate solution. Like any new worker, there is a period of on-the-job training required to become proficient in providing services, and in the case of allied health, it will still be necessary for sufficient mentoring to occur. These issues touch directly on setting the appropriate prices for supports over the transition period to enable a sufficient margin for such training to occur — an issue for the independent price regulator discussed in chapter 6.

36 Commission estimates based on ABS (*TableBuilder*, Education and Work, May 2016).

37 Commission estimates based on ABS Census data from 2011 indicate that about 10 per cent of those working in a group of allied health professional occupations (based on the ANZSCO classes relating to dieticians, optometrists and orthoptists, health therapy professionals (not further defined), occupational therapists, physiotherapists, podiatrists, speech professionals and audiologists) were born overseas and arrived in Australia after 2000, suggesting that avenues for skilled migration are possible. Analysis by the ABS found that the second most commonly reported industries of Skilled Program migrants' employment was in the Health Care and Social Assistance industry division, which includes carers and some allied health professionals (ABS 2010). It is too early to tell if recently announced changes to skilled migration visas (Dutton and Turnbull 2017) may impact on this flexibility.

Not all participants to this study agreed that greater use of skilled migration is an appropriate approach to workforce shortages. For example, Allied Health Professions Australia, while agreeing that skilled migration is one way to increase the number of qualified allied health professionals, said that the time spent to acclimatise skilled migrants to Australian conditions was as intensive as training someone locally.

> … skilled migrants are unlikely to be familiar with local health and social systems and services and may not have specialised skills as required to provide appropriate support to many participants. As a result these skilled migrants are likely to have skills and knowledge at a level that is closer to entry level allied health professionals and requiring mentoring and support. Experience suggests that significant time is required for overseas-trained graduates to learn to navigate the complex interaction of systems and understand the various parties involved in providing support. These factors mean that there will need to be significant investment to ensure that skill[ed] migrants can provide services of equivalent quality and AHPA [Allied Health Professions Australia] submits that it may be more effective to pursue alternatives such as incentivisation of Australian graduates and other workers. (sub. 37, p. 18)

The Commission considers that the time taken to train someone to understand Australian conditions is likely to be shorter than the time taken to achieve the formal qualifications to practice in the first place. This is particularly the case in the transition stage, when the time to train new staff is limited.

Another objection raised was in relation to the precarious nature of skilled migration visas, and that it should not be viewed as a substitute for training local workers. As put by the Australian Services Union and the Disabled People's Organisations of Australia:

> Any migrant worker scheme for the NDIS should provide permanent migration and only be considered after there has been local labour market testing. The NDIS provides a significant opportunity to address high levels of unemployment for many people, including people with disability. While we do not support a precarious, exploitative 457-style visa scheme for NDIS workers, we do support the development of a comprehensive workforce plan to retain and attract new workers locally. (sub. 198, p. 2)

The Commission agrees that skilled migration is a policy response that should focus on meeting the shortfall in specific roles (rather than as a general measure to address all shortages), and considers that more clearly delineating workforce development responsibilities among governments would provide a better platform to train and develop local workers. However, given the risk of shortages in the transition period, greater use of skilled migration appears to have more benefits than costs at present. As previously put by the Commission:

> Overall, the role of immigration as a source of labour must balance the impacts on wages and other strategies for eliciting domestic supply of workers, and the reality that significant labour shortages are still likely, especially during the rapid growth in disability supports during the establishment phase of the NDIS. In that vein, immigration should mainly address acute and persistent shortages. (2011, p. 720)

What remains to be seen is whether the shortfalls persist over the longer term, which is when further review and consideration should be given to changes to workforce

development and immigration policies. This could be facilitated as part of the expected future reviews of the NDIS, including the regular reviews by the Joint Standing Committee on the NDIS.

New technology may reduce demand for workers

A number of submissions to the study indicated that greater use of technology could reduce the need for some disability care workers, and so mitigate a potential shortfall. Understanding the extent that technology could be 'labour-saving' is difficult: the market for disability supports is undergoing major change, and what NDIS participants will demand is still unclear. That said, there is a range of emerging technologies that could significantly reduce the need for workers. As put by the NDIA:

> Technology may reduce the need for formal and informal care as innovations allow participants to partake in more daily living tasks:
>
> - Incorporating smart design into Specialist Disability Accommodation has the potential to reduce reliance on person-to-person supports. For instance, smart alert systems may enable participants to operate their homes better without or with less assistance;
> - The expansion of innovative transport services such as car-sharing into accessible transport options may provide more efficient ways for people with disability to access modified vehicles compared to private ownership; and
> - Creating communities of support and effective use of telepresence technologies for the delivery of paid supports may assist informal carers to maintain and develop their care with the reassurance that they can seek advice or assistance when needed. Communities of support may also help reduce the expectation that therapy/ interventions can only be undertaken in a clinic or practitioner's premises and thus support the NDIA expectation of a diverse workforce.
>
> Appropriate use of assistive technologies (including suitable monitoring/ alert systems) can reduce dependence of participants on carers for routine tasks and appointments (e.g. getting a drink or going to the toilet), and permit care and interventions to target activities or periods that require skilled human input (e.g. preparing a meal or intervention to manage a period of muscle spasm).
>
> Technology advances and innovation in service sectors similar to the disability support sector demonstrate potential future uses of technology:
>
> - Evidence from dementia research has shown that appropriate use of location triggered alerts/alarms can enable greater freedom for people who may wander, without increasing (even lessening) the burden on carers. Similarly, such technologies can also offer protection for carers dealing with participants out of hours or with at risk behaviours; and
> - Recent reports on the use of robot monitors in homes of the elderly to predict falls. While this particular instance is in an aged care setting, there are clearly applications in this technology applicable to disability support services. (sub. 161, pp. 98–99)

Other participants highlighted the values of providing care remotely through 'telepractice' (Allied Health Professions Australia, sub. 37, p. 17; The Shepherd Centre, sub. 107,

pp. 14–15; Speech Pathology Australia, sub. 136, p. 47), which reduces the need for service providers to travel.

Given the scheme is in the early period of transition, it is difficult to tell what technologies will emerge and what effects they will have on the need for workers. The Commission will examine these issues, as well as other impediments to participants making the use of emerging technologies, including issues about internet access and access to telepractice supports in NDIS plans in preparing the final study report.

8 Participant readiness

Key points

- How ready participants are to make the most of their National Disability Insurance Scheme (NDIS) plan will depend on a number of factors, including: an individual's capacity; their network, informal carers and peers; the assistance provided under the NDIS; how ready the market is to provide supports; and the complexity of the scheme.
- Some participants (as well as their carers and families) are finding the NDIS difficult to understand and interact with, particularly in the context of the scheme being a new way to allocate and supply disability supports. Some transitional issues are also making it harder for participants to navigate the scheme.
  - If participants are unable to interact well with the NDIS, then the benefits of the scheme will not be fully realised. This has consequences for the lives of participants and the financial sustainability of the NDIS.
- Supports are provided to some participants to increase their capacity to navigate the scheme and implement their plans — including through support coordination, which makes up about 4 per cent of committed supports (for plans after 30 June 2016). There may be ways to improve the efficiency of support coordination, including through complementary actions directed at building participant readiness.
- The National Disability Insurance Agency is currently responding to participants' concerns about the online portal (through which participants manage and organise payment for supports). It is also developing the eMarketPlace to provide timely information to participants to help them find and purchase supports from disability support providers. The eMarketPlace is critical to supporting participant decision making.
- Intermediary services, which can help participants manage different elements of their plans, can also help to reduce the transaction costs and complexity of the scheme for participants. At this early stage of the scheme rollout, the extent of any barriers to entry for intermediary services is unclear, as well as whether additional safeguards are required to regulate their operations.

The readiness of participants to make the most of their National Disability Insurance Scheme (NDIS) plan is key to the success of the scheme. Understanding how ready participants are to enter the NDIS; to get the plans that they need; to find their supports; and, if they desire, to self-manage their own affairs, is directly linked to the intended outcomes of the scheme.

Participant readiness also has a direct bearing on costs. If people with disability are unable to navigate the scheme, this will lead to lower participation in the scheme and underutilisation of supports. Both outcomes will reduce scheme costs in the short term, but may lead to higher costs (both inside and outside of the NDIS) over the longer term.

This chapter examines participant readiness by looking at how readiness to navigate the NDIS can be considered, and the supports available to participants to assist them to use the scheme (section 8.1). It then discusses options for improving participant readiness (section 8.2). Issues relating to participant engagement in the planning process are discussed in more detail in chapter 4.

8.1 What is participant readiness?

Participant readiness should be considered in the context of the changes that the NDIS is driving for people with disability. Participants are moving from a scheme where they had little choice and control over their supports to a new system, where they have greater opportunities to exercise choice and control. While this empowers participants to take greater control of their lives, it also brings with it challenges that they may have never faced before. This includes: thinking about the best way to achieve their goals; shopping around for providers; and managing more administrative and financial tasks than previously. And they must do this while the scheme is still rolling out and as the disability support market is changing. A study participant said that:

> Telling people they have choice and control, does not give them the skills to find appropriate service providers, which are much harder to find when they are full and simply tell people to go somewhere else if they are not happy with something. There is no information anywhere on how people can choose providers, what to look for in them, the sorts of questions to ask and what sorts of things you might want to consider. Equally when providers are all full, then what options are there. (Belinda Jane, sub. 80, p. 10)

There will be some degree of 'learning-by-doing' as participants spend more time in the NDIS and become more accustomed to the scheme. But at this point in time, it is clear that participants need help to become well-informed consumers who are able to make decisions that provide cost-effective outcomes. This was recognised by the COAG Disability Reform Council.

> … many people with disability will not have had the opportunity to exercise choice. Some people with disability may require additional support to effectively exercise informed choice, especially those with high and complex needs. (2015a, pp. 14–15)

Broadly speaking, there are two main aspects to participant readiness:

- the capacity of participants (and informal carers who they may have to assist them) to navigate the NDIS — including their ability, willingness, skills and resources
- the complexity of the NDIS — including interactions with the National Disability Insurance Agency (NDIA), Local Area Coordinators (LACs) and providers to secure and purchase supports. The more complex the scheme, the more skills that participants require to engage with it.

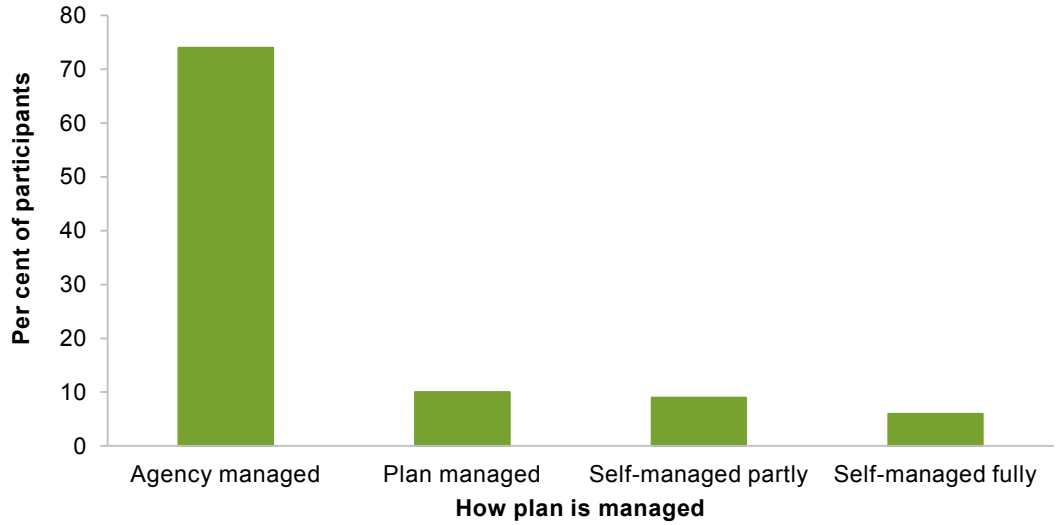
As such, there are two levers that can be used to improve participant readiness: developing the skills (and capacity) of participants, and reducing the complexity of the scheme. While

both approaches have costs and benefits, they are not mutually exclusive, but interdependent and complementary.

What assistance is there for participants?

NDIS participants have access to a range of resources to help them navigate the scheme, and to exercise choice and control over their disability supports. Participants have a range of options in relation to managing their plans (box 8.1). Most participants in the transition period to date have chosen to use a NDIA-managed plan, rather than using a third party or managing their plans themselves (figure 8.1).

Figure 8.1 **How NDIS participants are managing their plans**
For participants joining the scheme between 1 July 2016 and 31 March 2017



Source: NDIA (2017o, p. 21).

Box 8.1 Managing the funding for supports under a participant's plan

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) allows a participant to choose how to manage their funding for supports. Management of funds is defined as:

- purchasing the supports identified in the plan (including paying any applicable indirect costs, such as taxes, associated with the supports)
- receiving and managing any funding provided by the Agency
- acquitting any funding provided by the Agency (s. 42(1)).

A participant with an approved plan (or one that is being prepared) may make a request that funding be managed wholly, or to a specific extent, by one of the following:

- the participant — this is known as 'self-management'
- a registered plan management provider nominated by the participant
- the National Disability Insurance Agency (NDIA)
- the plan nominee nominated by the participant or the CEO of the NDIA (ss. 42(2) and 43).

The NDIS Act does not permit self-management of funds in some circumstances, including when:

- the participant or the plan nominee is an insolvent under administration (s. 44(1))
- self-management would present an 'unreasonable risk to the participant' (s. 44(2)(a)). This is prescribed by the *National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth), which includes a range of factors relating to the participant's legal capacity and decision-making ability that the CEO of the NDIA must consider in making the determination (s. 44(3)(a), rr. 3.7 and 3.8)
- the NDIS Rules have prescribed matters that must not be managed by a participant (s. 44(2)(b)).

If a participant does not make a plan management request, the plan is to be managed by the registered plan management provider specified by the NDIA, or by the NDIA itself (s. 43(4)). If this occurs, the CEO of the NDIA 'must, so far as reasonably practicable, have regard to the wishes of the participant in specifying who is to manage the funding for supports under the plan' (s. 43(5)).

General assistance is available for all participants

General assistance to implement and manage a plan is available for all NDIS participants, including via LACs, Information, Linkages and Capacity Building (ILC), and plan managers (sometimes referred to as intermediaries).

LACs link participants to the NDIS, and to information and support in the community. They also work with the local community to make it more inclusive for people with disability. LACs can also help participants understand the NDIS and implement their plan. This involves helping participants to:

- find and start receiving the supports that they need

- self-direct or self-manage their plan
- find mainstream and community services.

However, LACs are still being rolled out. The nature of their services also means that they assist participants with less complex needs (NDIA, sub. 161, p. 107).

ILC-funded projects focus on community inclusion, and making sure that the community becomes more accessible and inclusive for people with disability. This includes:

- personal capacity building — making sure that people with disability and their families have the skills, resources and confidence that they need to participate in the community, or access the same kind of opportunities or services as others
- community capacity building — making sure that mainstream services or community organisations become more inclusive of people with disability (NDIA 2017h).

ILC was not part of the NDIS trial period, but will be progressively rolled out across the country (chapter 5). The NDIA has provided grants to organisations to carry out activities in the community, with further funding rounds open in the second half of 2017 (NDIA 2017h).

Participants can also choose to use an external plan manager for some or all of their supports. A plan manager can take on a range of different tasks for the participant, allowing the participant to effectively 'outsource' the tasks that they feel least comfortable with managing, and in turn, reduce the administrative burden on participants. For example, plan managers can coordinate payments between the participant, provider and the NDIA, but participants retain choice and control over their supports. Plan managers can also take a larger role, such as searching and securing providers to meet a participant's needs — effectively acting as an agent for the participant.

Specialised support coordination is available for some participants

Some participants, including those with complex needs or less capacity to actively manage their affairs, can receive a range of 'support coordination' items as part of their plan. These include: support connection; coordination of supports; participant training in planning and plan management; and specialist support coordination. Support coordination is determined in the same way as any other support in a plan — based on what is reasonable and necessary for the NDIS to provide in meeting a participant's needs or goals.

In practice, support coordinators provide more intensive assistance to help a participant understand their plan, and to help them choose and connect with providers — effectively a more personalised and in-depth service than what LACs would provide (NDIA ndc, nde). Between July 2016 and March 2017, about 55 per cent of scheme participants had some funding for support coordination included in their plans (NDIA 2017o, p. 21).

Other groups can also provide assistance to participants

While LACs, ILC, plan management and support coordination are all provided under the umbrella of the NDIS, there are other groups and representatives who can offer assistance to NDIS participants. These include Disability Support Organisations (DSOs) and peer support groups, advocacy organisations, and trustees. These groups currently play, and will continue to play, an important role in assisting participants and their families to make the most of the NDIS.

DSOs are community organisations that facilitate disability peer support groups, which allow scheme participants and their families to share their experience, information and knowledge with others about issues associated with disability and the scheme (including helping people think about their goals and the supports that they might need). Peer support groups can also provide information on how best to find and arrange supports, and connect with community activities.

Funding through the Australian Government's Sector Development Fund was allocated to 18 DSOs to facilitate up to 20 peer support groups over the life of the project (NDIA 2015c, p. 80). However, peer support groups are also forming naturally (without funding) as the NDIS rolls out (for example, the Mental Health and NDIS Facebook Support Group (sub. 8)).

Advocacy for people with disability (including NDIS participants) can be defined as having an independent person (without a conflict of interest) directly speaking, acting or writing on behalf of the interests of an individual or group. There are a number of different models of disability advocacy, including:

- systemic advocacy — this is aimed at bringing about systematic improvement in policy and practice, and removing discriminatory barriers for people with disability
- individual advocacy — this involves upholding the rights of individuals with disability by working on discrimination, abuse and neglect (DSS 2016b, p. 2).

Advocacy may extend to helping participants find supports; however, it is currently not funded through the NDIS, but shared between the Australian,[38] and State and Territory Governments (except for South Australia). There are also a small number of disability advocacy organisations that are not funded by government (DSS 2016d, p. 2). The Department of Social Services (DSS) is currently reviewing what an updated National Disability Advocacy Program should look like, and how it should work (including funding) in a NDIS environment (DSS 2016d, p. 2). To reflect this, the COAG Disability Reform Council's terms of reference was recently amended to include a review of

[38] National Disability Advocacy Program (NDAP) agencies based in the NDIS sites may have additional roles, such as assisting people through the planning and internal review processes with the NDIA. Australian Government funding has been provided via the NDIS Appeals program to support people with disability who seek an external review of the NDIA's decisions through the Administrative Appeals Tribunal. Funding to current providers of the NDAP has been extended until 30 June 2018 (DSS 2016b).

advocacy arrangements, including roles and responsibilities, by 31 October 2017 (COAG 2017, p. 3).

Trustees can also help participants manage their affairs. For example, public trustees, established by State and Territory Governments, aim to ensure that all members of the community (including people with disability) have access to financial management services in the event that their capacity to make decisions is affected. Public trustees can make decisions on behalf of the person with disability in the best interests of that person (known as 'substitute decision making'), taking into account their needs and views. The *National Disability Insurance Scheme Act 2013* (Cwlth) also allows the CEO of the NDIA to appoint a public trustee as a participant's nominee in order to make decisions on planning and actioning supports.[39]

Navigating the NDIS is difficult for some participants

Some scheme participants are finding it difficult to understand and interact with the scheme, and to exercise choice and control over their supports. Study participants said that they are finding it difficult to understand plans; find, negotiate and coordinate supports with providers; and seek assistance from the NDIA when problems occur.

Study participants mentioned problems with clear communication of the participant pathway in particular. This partly reflects the changing nature of the disability support landscape. Under the previous system, NDIS participants who had access to support programs (typically block-funded) often relied on providers to be the 'first port of call' to seek remedies or changes to services. Under the NDIS, participants now have a range of options to seek information or clarity — including approaching a LAC or the NDIA itself. A lack of fit-for-purpose information means that confusion continues to arise among participants, and that burdens are still being placed on providers.

> There needs to be much more focus on communicating clearly and simply with clients. For instance, at the moment, plans are vague and written in 'government speak'. If the government is concerned about clients overspending, the NDIS needs to give clients clear information on what their funding is for and clear conditions under which it can be spent. (Angela Blakston, brief sub. 168)

> If anything has characterised the NDIS to date it is poor communications performance. It has failed to communicate changes in the Scheme as it has been rolled out to potential participants. Its communications have frequently been heavily jargonised and pitched at a very high level. Even people whose job it is to understand NDIS developments and operations often struggle with exactly what is being communicated. In some cases the NDIA has been successful in

[39] This process is one that is still relatively underutilised, but there are some concerns that nominees may have a narrower ability and responsibility compared to what a public trustee would ordinarily be able to do in the interests of the beneficiary. The Australian Law Reform Commission and participants in this study also noted that there may be a conflict in the duties required of a nominee as defined in the *National Disability Insurance Scheme Act 2013* (Cwlth), and relevant State and Territory legislation (ALRC 2014, pp. 151–152; Financial Services Council, sub. 98, pp. 4-5), but this is yet to be tested in court.

making elements of the Scheme intelligible to consumers; for example, in a number of their plain English guidelines to supports available under the NDIS. This approach needs to be incorporated into all communications with participants, their carers and providers. (Carers Australia, sub. 195, p. 22)

The time spent by providers in assisting participants and their carers to navigate the complex system is significant, but are often 'unbillable hours' of support. Participants and their carers indicated that they are not able to obtain helpful advice from the Agency or LACs (Macarthur Disability Services, sub. 57, p. 9). The NDIA acknowledged that:

> People with disability and their families and carers have reported that there is continued difficulty in understanding the NDIS and the process of moving through the [participant] pathway. (sub. 161, p. 107)

Reflecting the complexity and variation of needs and circumstances among participants, some participants will be more ready than others. This, in turn, partly reflects the extent of help that they received under previous disability support arrangements. For example, one study participant said that:

> I don't think I will have trouble utilising my plan, because I am overdue some support and will fully appreciate the value of NDIS funding. I've done my research and I know what's available in my area; however, I appreciate that I live in a city area where there is choice of providers and my needs will not be difficult for me to articulate and negotiate around. (Name Withheld, sub. 5, p. 1)

Another study participant commented that:

> As a now plan-managed NDIS participant I find it even harder, if anything, to manage that additional layer of administrative burden and all I really want to do is to go back to the good old days when the MS [Multiple Sclerosis] Society told me what I want and needed and provided it at a reasonable cost. … there are many benefits to it, including being able to shrug off the burden of managing your costs and choices with a reasonably low level of bureaucratic rigidity. In the meantime … I am an 'under-utilisation' risk to the NDIS, with the immediate threat of having my unused funding cut back — not because I don't want and need the features these choices provide, but because I can't get organised to utilise the promised benefits and it's easier to blow my budget RIGHT OUT than navigate the NDIS' portal … (Kirsty Magarey, sub. 150, p. 4)

8.2 How can participant readiness be improved?

The balance between support coordination and other assistance

It was recognised before the implementation of the NDIS that it would be necessary to build the capacity of participants to interact with the scheme.

The NDIA recently implemented a 'participant pathway', which includes additional funding for those participants with less capacity to navigate the scheme.

> The NDIA has designed the participant pathway to include support for participants during the planning and implementation phases … In the implementation phase, the NDIA provides LACs for those with less complex needs and funding for support coordination for the intensive participant groups. … The NDIA has also identified that there is a need for work in the support coordination sector, particularly in some cohorts such as where participants have challenging behaviours, rural and remote areas and where there are gaps in mainstream services that the NDIS cannot fill. Work continues to educate support coordinators on the capacity building role expected of their function which is designed to build the skills of individuals over time to make support decisions themselves. (NDIA, sub. 161, p. 107)

Support coordination is an element of the participant pathway, which is the key means to bolster the readiness of participants with *complex* needs. However, study participants said that there is confusion about the role of support coordinators, and that it is not clear whether they are effective in helping scheme participants find providers, nor whether they are being allocated to the participants who most need such supports.

> We need a step by step guide. A clear list of who is who and who does what. What the heck is a support coordinator and what exactly can they achieve in an hour a week? … Especially at the start of a plan, [a] support coordinator needs to be much more active. (Cheryl McDonnell, sub. 79, p. 3)

> There has been a lack of clarity and guidance around the function, allocation and use of support coordination funding … Providers also report a wide variation in the quality of the support provided. (Early Childhood Intervention Australia Victoria/Tasmania Limited, sub. 129, p. 11)

While it is too early to evaluate the efficacy of support coordination, there is some evidence to suggest that it does help those who receive and use it. For example, participants who are allocated and use support coordination have higher rates of utilisation (the ratio of used to committed supports in a plan) on average than those who are allocated, but do not use, support coordination. While many factors affect a participant's readiness to navigate the NDIS and decision to use supports provided in plans, at face value, this suggests that support coordination does help build a participant's capacity.

Support coordination funding has been significant over the transition period to date. About 4 per cent of committed supports in participant plans after 30 June 2016 have been allocated to support coordination (figure 2.9). If the same proportion were applied to total scheme costs in 2020, then this suggests that support coordination could cost around $900 million each year. (This would assume, however, that support coordination is fully utilised to the same extent as other committed supports, which is not the scheme experience to date.)

Effective support coordination is important to both deliver participant outcomes and contain scheme costs. The Commission is seeking feedback on both possible improvements to support coordination, and any complementary actions that may make support coordination more efficient.

INFORMATION REQUEST 8.1

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

How can scheme complexity be reduced?

The Commission received a lot of feedback about the complexity of the NDIS. The two main areas of concern were:

- participants finding providers
- participants (and providers) understanding and using the online portal where plans and payments are managed (box 8.2).

The rapid rollout of the NDIS has led to a number of transitional issues, including the implementation of the online portal. A review of the portal found many shortcomings in its implementation, mainly stemming from the speed of the rollout (PwC 2016). The NDIA said that it accepted the recommendations of the review and is addressing the portal issues.

> Significant difficulties with the implementation of the new ICT system in July 2016 adversely impacted on both participants and providers and caused a loss of community confidence in the NDIA's administration. An assessment of the failures from July 2016 have been documented in the PricewaterhouseCoopers *NDIS MyPlace Portal Implementation Review*. The NDIA accepts the broad thrust of those findings and has now implemented, or is the process of implementing, all of the recommendations from that report. (sub. 161, p. 15)

Given the NDIA's commitment to address portal issues, the Commission has made no finding or recommendation on this matter. However, as participants (and providers) rely heavily on the portal to manage supports and payments, it may be appropriate to examine the operation of the portal in future reviews of the NDIS, as well as closely monitor any issues with the portal to improve accessibility for scheme participants.

Box 8.2 **Problems using the NDIS online portal**

Syndromes Without A Name Australia said that:

> The portal has a number of plans on it if the plan has been reviewed, causing confusions for clients. The headings are not the same as what is written in the plan, leading to interpretation errors. The portal crashes a number of times and the dates need to be entered a certain way. Some days the portal works better than others. There is no form on the MyGov tab or NDIS website to ask for a correction if you accidently upload a payment request to the wrong category. One family is still waiting 6 weeks later to hear from NDIS re: this issue, after submitting an enquiry regarding this. As there is no way to upload receipts, the portal uploads are open to exploitation. (sub. 86, p. 2)

Mental Health Community Coalition ACT said that:

> Service Providers are often placed in the unenviable position of having to help participants use the MyGov website in order to use their NDIS plans, including by entering passwords – technically this is breaking the guidelines of use, possibly the law. (sub. 135, p. 28)

Summer Foundation said that:

> The current administration of the NDIS creates a high barrier for participation by individuals with complex needs. Young people in RAC [residential aged care] typically have few informal supports and many have cognitive impairment. Most don't have ready access to a computer and/or are not able to navigate the Internet, both of which are required to activate plans and to find and negotiate supports with providers … More accessible and flexible approaches to delivering information and building the capacity of people with disabilities and their families are desperately needed (sub. 113, p. 25)

Timely and useful information can minimise transaction costs for participants

While a functioning portal is important, participants also need information about providers. As the Prader-Willi Syndrome Association of Australia said:

> NDIS participants must have access to information about the performance of providers (e.g. number of complaints against them, participant's budgets running out too early, etc.). (sub. 112, p. 6)

Information that helps participants to exercise informed choice and control can emerge naturally from private sources, such as online comparison sites, connecting services and peer support groups for disability supports. There is evidence that this is already occurring, but the extent is unclear. Some providers also indicated that they will provide more information to participants to make choices (Australian Orthotic Prosthetic Association, sub. 123, p. 8).

That said, the NDIA's role as a market steward means that it has a responsibility to provide information about providers to reduce participant search costs, to increase competition, to better monitor the market, and to reduce information asymmetry (NDIA 2016k, pp. 24–25). This role will become increasingly important as the number of participants and the disability support market increases through transition. This role also reflects a key area for action under the *Integrated Market Sector and Workforce Strategy* (DRC 2015a, p. 15) to enhance the amount of information available to consumers, and the NDIA's (2016k, p. 24)

desire for participants to have easy access to information 'about all possible service providers from which they can choose'.

This is to be achieved, in large part, by the NDIS 'eMarketPlace', which, according to the NDIA (sub. 161, p. 65), will support information discovery, encourage industry innovation, build local community capacity, and provide timely data and analytics to assist with NDIS sustainability (box 8.3). The eMarketPlace is broadly consistent with the Commission's 2011 recommendation that the NDIA should provide a centralised internet database of service providers that indicates the range of products and services, price, availability and links to measures of performance and quality (PC 2011, pp. 486–487).

Box 8.3 The eMarketPlace aims to help participants and providers

The eMarketPlace is a project of the National Disability Insurance Agency (NDIA) to 'support information discovery, encourage industry innovation, and build local community capacity' and to 'provide timely data and analytics to assist with Scheme sustainability' (NDIA, sub. 161, p. 65). This includes the introduction of 'cognitive intelligence capabilities' — a form of artificial intelligence that will allow for easier interaction between participants, providers and the NDIA. For example, participants would be able to ask general and personalised questions about the eMarketPlace and the National Disability Insurance Scheme, rather than contacting the scheme's call centre. The eMarketPlace will be co-designed by the NDIA and people with disability.

The aim of the eMarketPlace is to maximise the benefits of the scheme by making it easier and more efficient for participants to find and access the supports that they need. It will also enable providers, businesses and community organisations to market their products and services. In turn, it will improve the responsiveness of providers to participant demand, and encourage innovation.

The eMarketPlace is expected to reduce transaction costs of both participants and the NDIA. According to the NDIA:

> By introducing an eMarketPlace and eventually automating much of the payments and processing function, the NDIA will reduce the time spent on these activities and consequently the potential costs.
>
> In general contexts, eMarket platforms may be able to reduce unit costs by between 15-30%. In the NDIA context, these cost savings may flow through to participants in some scenarios. Where the NDIS is incentivising participants to shop around, the eMarketPlace will likely result in the best price for support services, in particular homogenous supports, being achieved more often. As well as open price comparison and price competition, the eMarketPlace also adds an additional commissioning channel for the participant. Cost savings realised from eMarketPlace price competition will serve to promote the effectiveness of the eMarketPlace, incentivising eMarketPlace participation, improving the scale of use and the sustainability of the NDIS. (sub. 161, p. 66)

Source: Adapted from NDIA (sub. 161, pp. 65–66).

The NDIA (2016k, pp. 29–31) plans to introduce the eMarketPlace by the end of June 2018, but it is unclear how long this will take in practice (and there are a number of market stewardship activities and projects that are to take place during this period).

The DSS also stated that:

> The NDIA will conduct a 'Request for Information' (RFI) process to gather advice from industry stakeholders about innovative solutions and commercial models to deliver the NDIS eMarket Place to assist providers to reach their participants. (sub. 146, p. 38)

The eMarketPlace, as described, would go a long way towards meeting the needs of participants when it comes to information about providers. It can overcome some existing information gaps, such as the slow updates to existing provider lists, inaccessibility of provider lists, and lack of indicators of consumer satisfaction (particularly on service quality and performance). The eMarketPlace will also supplement other work by the NDIA to develop a range of consumer guides to best practice in areas such as therapeutic supports or equipment (DRC 2015a, p. 15), which are currently being refined. Metrics are also being developed to better understand purchasing patterns and the timing in which participants make decisions (NDIA, sub. 161, p. 107).

For participants to exercise choice and control, they must have access to information about options for supports and providers that is timely, accurate, relevant, clear and accessible. As the New South Wales Government (sub. 60, p. 4) said, 'participants are particularly vulnerable to information asymmetries and/or a differential in bargaining power between themselves and providers'. This is particularly the case for people with disability where quality of service is highly valued (as there are significant negative consequences from the provision of poor service) and switching costs are high.

The Commission considers that the eMarketPlace should be introduced as a matter of priority.

DRAFT RECOMMENDATION 8.1

The National Disability Insurance Agency should implement the eMarketPlace discussed in the *Integrated Market Sector and Workforce Strategy* as a matter of priority.

A greater role for intermediaries?

Directly reducing complexity and building participant capacity can be costly. A more cost-effective (and preferable) option for participants could be outsourcing some or all of the administration of their plans to an intermediary. This can be done by using an intermediary as a plan manager, or even a third party to procure and manage particular supports.

Intermediaries can assist participants who may struggle to deal with the detail necessary to self-manage their affairs, and reduce scheme costs by aggregating participants' purchasing power for common supports. There is evidence that the administrative burden of self-managing a plan is a disincentive for some participants to take full control of their

supports. As put by the National Institute of Labour Studies' Intermediate Evaluation of the NDIS:

> At wave 1 the option of self-managed funding was not always fully understood by NDIS participants; nor was it always discussed in the planning meetings. By wave 2 it was evident that while NDIS participants had a greater understanding of what self-management was there remained very few self-managers. The main reason for this appeared to be a reluctance to take on additional administrative activities. (Mavromaras, Moskos and Mahuteau 2016, p. 72)

Intermediaries can also reduce the stress from dealing with NDIA processes. As noted by Mind Australia Limited:

> … when processes are overwhelming or negotiations are difficult, the impact on an individual's mental health can be devastating. One participant in the choice project said that when she was accepted into the NDIS, she thought that getting good support would mean fewer stays in hospital. In fact, she was admitted to hospital eight times in her first year in the scheme, which she put down [to] the stress of dealing with the NDIS and NDIS processes. Ongoing navigational support is one means to address this situation. (sub. 144, pp. 11–12)

Intermediary-managed plans can help participants with a range of tasks,[40] including to:

- help participants find providers, and take responsibility for the hiring and firing of workers
- take charge of financial administration, including invoicing and budgeting
- assist in dispute resolution with providers and/or the NDIA
- deal with the complexities of hiring particular individuals, by administering superannuation, workers' compensation, and occupational health and safety insurance[41]
- provide assistance dealing with the NDIA and LACs, including during plan reviews.

By coordinating these activities, intermediaries can act as a 'one-stop shop' for NDIS participants, which reduces the complexity faced by participants. They can also provide systemic feedback to the NDIA on any common and recurring issues, which in turn can reinforce the scheme's insurance approach.

[40] In some ways, intermediaries could fulfil the roles that the Commission recommended for Disability Support Organisations in its 2011 inquiry (PC 2011, pp. 414–422).

[41] An alternative approach that is being used by some self-managing participants is to use independent contractors to provide supports (Home Life Association, sub. 59, p. 9). As contractors must organise their own insurance, superannuation and other administrative matters, the use of contractors may reduce the administrative burden on participants.

Financial and service intermediaries can be funded as line items in approved NDIS plans (NDIA 2016n, p. 48, 2016o, p. 48).

- Financial intermediaries hold funds and manage risk on behalf of participants.
- Service intermediaries provide broader technical assistance, including:
  - assisting participants develop skills with plan management
  - negotiating and coordinating the provision of supports
  - sourcing providers
  - negotiating the method and timing of the delivery of supports
  - negotiating individual requirements as part of support management
  - recruitment, training, support and employment of staff (NDIS IAC nd).

However, the distinction between financial and service intermediaries is somewhat blurred in practice, as the service intermediary role can only be undertaken in conjunction with the financial intermediary role (NDIS IAC nd).

What is less clear, however, are the roles and responsibilities that intermediaries can more effectively and efficiently undertake given the presence of LACs and support coordinators, and whether they should be funded out of participants' plans or elsewhere.

The Commission has been unable to identify any barriers that prevent intermediaries from helping participants manage their supports. Given that it is 'early days', it may be too soon to observe such barriers. Participants may also not be aware that intermediaries are an option, as noted by Blind Citizens Australia.

> Due to the speed of the roll out, we are increasingly concerned that participants are not always being made aware of the full range of options in regards to plan management and support coordination and as such, their plans do not always include the support that will enable them to put their plan into action. (sub. 130, p. 8)

It is also unclear what safeguards or regulations should apply to intermediaries, especially as other parts of the NDIS are implemented or improved. As the Victorian Government put it:

> It is too early to say how well equipped and how well supported NDIS participants will be to exercise informed choice in this new marketplace. As the disability service market matures, it can be anticipated that intermediaries will emerge to facilitate mutually satisfactory transactions between providers and consumers, often aided by new information and communication technologies and tools.
>
> Appropriate regulatory responses for intermediaries will also need to be determined. In the interim, the readiness of participants to exercise choice is likely to rely heavily on NDIA funded initiatives and programs designed to assist participants navigate the disability support sector. Much of this support infrastructure is yet to be fully rolled out. (sub. 174, p. 19)

Intermediaries should be closely monitored over the next few years to ensure that there are no undue barriers to their operation, but also as a means to better identify areas of

complexity that participants are seeking paid assistance to overcome as part of ongoing scheme reform. The activities of intermediaries should also be monitored with an eye to developing any necessary safeguards that may be needed beyond the NDIS Quality and Safeguarding Framework (which is currently being developed by the DSS and yet to commence).

The Commission is seeking feedback on a range of questions relating to intermediaries and disability support organisations, including how they fit within the broader landscape of assistance for participants; whether there are barriers to entry for intermediary services; and what safeguards should apply to them. This includes any safeguards that may be appropriate to address conflict of interest when intermediaries are both plan managers and a disability support provider at the same time.

INFORMATION REQUEST 8.2

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

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

9 Governance

Key points

- The governance arrangements for the National Disability Insurance Scheme (NDIS) provide a good foundation for the scheme. Some enhancements can be made where the governance arrangements affect, or have the potential to affect, scheme costs and financial sustainability.
- There is a lack of clarity around some roles and responsibilities, including Local Area Coordinators, mainstream services and market development.
- The current arrangements for implementing NDIS Rules need to be relaxed to ensure that they can be amended quickly when there are changing circumstances that could risk the financial sustainability of the scheme.
- Internal review processes have the potential to increase scheme costs and poor planning processes can increase the number of reviews.
- External review processes will clarify the law over time, including the entitlement to reasonable and necessary supports. Outcomes from such reviews could potentially have a significant impact on scheme costs.
- The timeframe to implement the *NDIS Quality and Safeguarding Framework* is ambitious. However, it is important that it be met to ensure quality and safety for scheme participants, to provide clarity and reduce regulatory burden for providers.
- While the Western Australian NDIS is meant to mirror the national scheme in many respects, there is a risk that the governance arrangements could lead to a divergence in participant outcomes. There are also costs associated with setting up parallel schemes. The Commission's preference is for Western Australia to be part of the NDIS.
- Current NDIS performance reporting does not have a sufficient focus on plan quality. Reporting on scheme participants' outcomes and attainment of participants' goals also requires further development.
- The National Disability Insurance Agency's (NDIA) focus on participant intake has compromised the success of the scheme. The NDIA needs to find a better balance between participant intake, the quality of plans, participant outcomes, and the financial sustainability of the scheme during the transition period. Some steps are now being taken by the NDIA to better balance these aspects, but the outcomes are not yet clear.

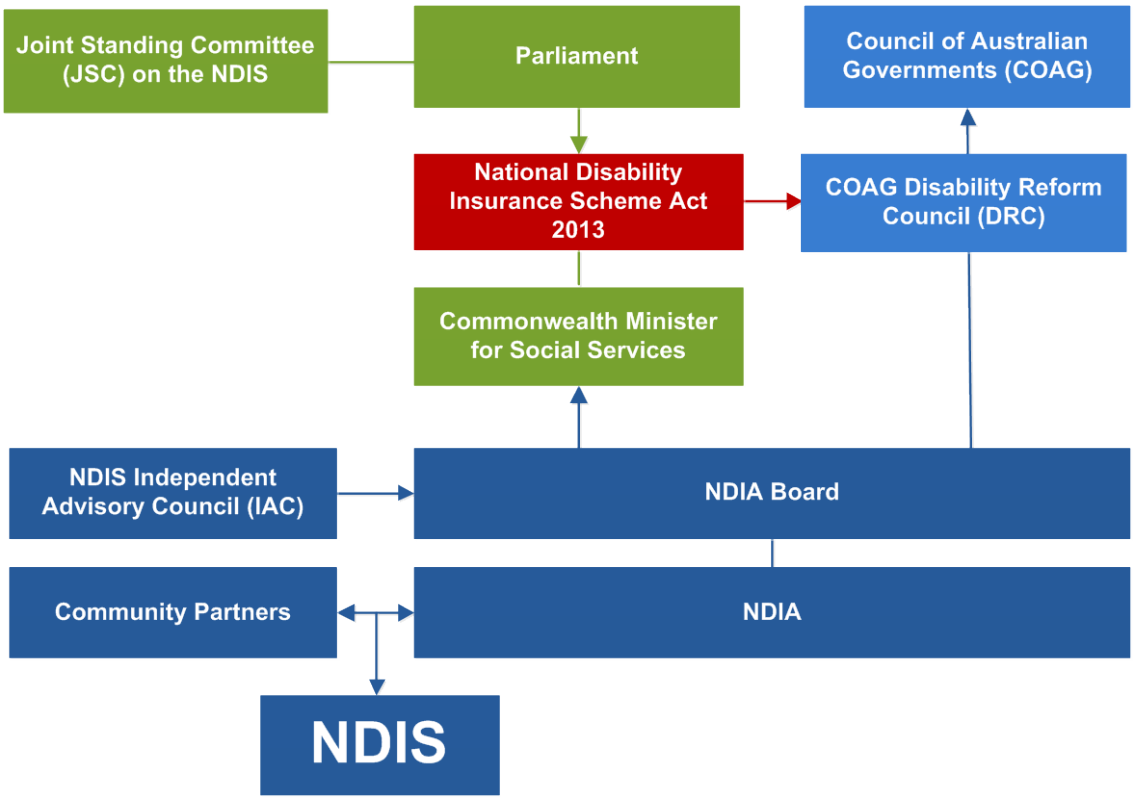
This chapter looks at the National Disability Insurance Scheme (NDIS) governance arrangements in the context of scheme costs and financial sustainability. Section 9.1 provides an overview of the governance arrangements. Sections 9.2 to 9.7 discuss issues with the current governance arrangements including: clarity and transparency around roles, responsibilities and processes; flexibility of the arrangements; the Western Australian

NDIS; review processes; regulation; and performance reporting arrangements. Section 9.8 discusses the timetable for the scheme rollout.

9.1 Overview of governance arrangements

The *National Disability Insurance Scheme Act 2013* (Cwlth) (NDIS Act) sets out the governance arrangements of the NDIS (figure 9.1). The Act is supported by the NDIS Rules, which are legislative instruments that provide more detail on the operation of the NDIS (NDIA 2017j).

Figure 9.1 **Summary of NDIS governance arrangements**



Source: Adapted from NDIA (2016g, p. 127).

The Australian, State and Territory Governments share responsibility for the governance and policy decisions of the NDIS. The Australian Government Minister for Social Services is responsible for administering the NDIS Act, and exercises statutory powers with the agreement of State and Territory Governments. The Minister can (in some cases, with the agreement of State and Territory Governments) make NDIS Rules and issue directions to the NDIA about the performance of its functions (NDIA 2016g, 2017f; NDIS Act).

The COAG Disability Reform Council (DRC) is responsible for NDIS policy and broader disability policy. Its members include the Minister responsible for disability policy and the Minister responsible for the Treasury portfolio from each Australian, State and Territory Government, and a representative from the Australian Local Government Association (DSS 2017a). The DRC:

- considers policy matters relating to the NDIS and the NDIS Act
- advises the Minister for Social Services and makes recommendations to COAG (NDIS Act s. 12)
- oversees the implementation of the NDIS and can make recommendations to COAG on the transition to full scheme
- is responsible for a range of reforms that are to be implemented through the National Disability Agreement and the National Disability Strategy to support people with disability and their families and carers (DSS 2017a).

State and Territory Governments are also responsible for regulating providers in their respective jurisdictions until the *NDIS Quality and Safeguarding Framework* is implemented (DSS 2016c, p. 17).

The NDIA is responsible for managing and delivering the NDIS. It is an Australian Government agency established under the NDIS Act and the *Public Governance, Performance and Accountability Act 2013* (Cwlth) (NDIA 2017f; NDIS Act s. 117). Its main functions include:

- delivering the NDIS to support the independence and social and economic participation of people with disability, and enable them to exercise choice and control in the pursuit of their goals
- managing, advising and reporting on the financial sustainability of the NDIS
- facilitating innovation, research and best practice in the disability sector
- building community awareness of disabilities
- collecting, analysing and exchanging data on people with disability, and the supports provided to them
- undertaking research relating to disabilities (NDIA 2017q; NDIS Act s.118).

The NDIA is governed by a Board, which is appointed by the Minister for Social Services in consultation with State and Territory Governments. The Board is responsible for managing risk and setting the strategic direction of the NDIA. It is also responsible for monitoring and reporting on the performance of the Agency (NDIA 2017n). The Board was expanded from 1 January 2017 'to ensure it has the disability service, financial management, corporate governance and insurance-based expertise needed to guide the $22 billion scheme through its critical three year expansion to 2019-20' (Porter 2016).

The Independent Advisory Council (IAC) provides independent advice to the NDIA Board on how the NDIA performs its functions. The IAC is a panel of experts including people with disability, carers of people with disability, at least one person with expertise on disability in rural or remote areas, and at least one person with expertise in the supply of equipment or provision of disability services. The IAC can provide advice either on its own initiative or at the written request of the Board. The Board must consider all advice and provide the DRC a copy of the advice and its response (NDIA 2017g).

A Parliamentary Joint Standing Committee on the National Disability Insurance Scheme was established in 2013, with the role of reviewing the implementation, administration, performance, governance and expenditure of the NDIS, and other NDIS-related matters referred to it by parliament (JSCNDIS 2017; NDIA 2016g, p. 131). It has provided two progress reports to Parliament on the implementation and administration of the NDIS and is currently undertaking inquiries into hearing services and services for people with psychosocial disabilities related to a mental health condition.

Different arrangements for Western Australia

Western Australia has different governance arrangements for the NDIS to the rest of Australia. While it is intended to provide similar supports as the national scheme, the Western Australian NDIS (WA NDIS) will:

- be administered by the Western Australian Government, not the NDIA
- be funded differently (chapter 10)
- begin rollout one year later than the national scheme (2017-18) (box 9.1).

Are the current governance arrangements effective?

The high-level governance arrangements for the NDIS mostly reflect those recommended by the Commission in its 2011 inquiry on *Disability Care and Support*, including the appointment of an independent body (the NDIA), an independent Board and an Independent Advisory Council.

The NDIS Act and its objectives are also broadly aligned with the Commission's recommendations, including the entitlement to reasonable and necessary supports, eligibility criteria and an obligation to ensure the scheme is financially sustainable (PC 2011).

The governance arrangements provide a good foundation for delivering the scheme and managing financial sustainability.

Box 9.1 The NDIS in Western Australia

In January 2017, the Western Australian and Australian Governments signed a bilateral agreement for the implementation of the WA NDIS. Under this agreement, Western Australia will have a locally administered scheme, but the scheme is to be consistent with the national NDIS. The WA NDIS is expected to begin rollout on 1 July 2017 (one year later than the national scheme).

Unlike the national scheme, the WA NDIS will be managed by the State Government under State legislation. A WA NDIS authority will be established to manage the scheme which, similar to the NDIA, will have a Board and Independent Advisory Committee.

The intention is that the WA NDIS will be consistent with the national scheme in a number of areas, including:

- eligibility requirements
- the core principles, including access to reasonable and necessary supports, choice and control and guaranteed portability
- the application of the National Quality and Safeguarding Framework
- the complaints and appeals process, which will mirror the national process including access to the Administrative Appeals Tribunal
- reporting requirements, including the requirement to report quarterly to the DRC
- other governance arrangements, including relevant Rules under the NDIS Act
- contributions to policy at the national level by the Western Australian Government.

Sources: Australian Government and Western Australian Government (2017); WADSC (2017).

One important difference is the Australian Government minister responsible for the NDIS. The Commission recommended that the Australian Government Treasurer be the responsible Minister for the NDIS because of the proposed commercial focus of the NDIA, and the need to ensure strong cost controls, insurance characteristics, long-run sustainability and appropriate management of funds (PC 2011, p. 432). The Commission also envisaged other ministers, such as the Minister for Social Services, playing a prominent role in disability policy.

However, primary responsibility for the NDIS is with the Australian Government Minister for Social Services. While the Commission has not received any evidence to suggest that the insurance and commercial focus of the scheme is compromised by these arrangements, it is important that the NDIS is managed as an insurance scheme and not as a welfare program.

The following sections discuss areas of concern about the governance arrangements.

9.2 Lack of clarity around roles and responsibilities

While the high-level governance arrangements for the scheme are clearly set out in the NDIS Act, the Heads of Agreement, the Bilateral Agreements and other policy documents, the way the governance arrangements play out in practice, including who is responsible for what, is less clear. For example, there is a lot of confusion about the role of Local Area Coordinators (LACs). For example, DARE Disability Support said:

> DARE's understanding of the role initially envisaged for the LACs, namely frontline problem solving and assistance with plan implementation, appeared to change shortly before transition to planning and the Coordination of Supports for non-complex participants, surely a foreseeable gap in NDIS planning resources. (sub. 182, p. 7)

The confusion is, in part, because the NDIA experimented during the trial with a number of options for delivering LACs' activities. The NDIA ultimately chose to outsource the LAC functions, and this arrangement was put in place for the beginning of the rollout. However, the confusion could also be because LACs have been diverted away from their intended activities towards planning-related tasks. As the NDIA said:

> The need to meet bilateral estimates has also meant that for the first period of transition the NDIA has asked LAC partners to divert their resources into information gathering to facilitate the approval of plans and implementation of plans. (sub. 161, p. 56)

There is also a lack of clarity around the responsibilities of the NDIS and mainstream services, and how governments are approaching continuity of care (chapter 5). As noted by the Department of Social Services (DSS):

> The Council of Australian Governments (COAG) agreed principles to determine the responsibilities of the NDIS and mainstream service systems, which are generally sound, but need clarifying at an operational level. (sub. 146, p. 4)

The Commission is recommending that the National Disability Strategy be strengthened to improve accountability, and a standing item be added to the agenda of the relevant COAG Councils to address mainstream and other disability services and how they interface with the NDIS (chapter 5).

Other areas in need of greater clarity include supply side arrangements, such as the responsibilities for developing the NDIS workforce, the arrangements for provider of last resort and addressing thin markets. The DSS and the NDIA are working on these issues (chapters 6 and 7).

Given the scale and complexity of the NDIS, and the focus on insurance principles — which involves ongoing monitoring and refining of the scheme — changes to roles, responsibilities and processes are expected. However, it is crucial that governments and the NDIA continue to work to ensure clarity and transparency in the governance arrangements so that they do not undermine accountability and put the success of the scheme at risk.

9.3 Flexibility of governance arrangements

The NDIA and governments need to be able to respond quickly when circumstances arise that could threaten the financial sustainability of the scheme. This requires governance arrangements that are sufficiently flexible and that allow changes to be made quickly when required. This is especially important during the transition period of the NDIS, when the compressed timeframes increase the potential for poor arrangements to lead to poorer outcomes in the longer term.

While the NDIA has some flexibility and autonomy in how it operates the scheme, governments also have significant control over its operations. For example, the Minister for Social Services, with unanimous agreement from the State and Territory Governments, is responsible for appointing NDIA Board members and can, by legislative instrument, give directions to the NDIA about the performance of its functions (NDIS Act ss. 121, 127).

Also, as the NDIA operates under legislation, including the NDIS Act and the NDIS Rules, issues that could affect scheme costs or financial sustainability may require changes to legislation. For example, an Administrative Appeals Tribunal (AAT) or Federal Court ruling that was not in line with the original intention of the scheme, and had the potential to significantly increase scheme costs, could require a legislative change.

While the Australian Government is responsible for the NDIS Act, the Australian, State and Territory Governments are jointly responsible for the NDIS Rules. There are four categories of NDIS Rules. The Minister for Social Services has overarching responsibility for making Rules, and making Rules under each Category requires a different level of involvement or agreement from State and Territory Governments (box 9.2). The Minister can also delegate the power to make Rules to the CEO of the NDIA, with the agreement of State and Territory Governments (NDIS Act s. 201).

Most of the Rules currently in force are either Category A or Category B Rules (box 9.2). Category A Rules cover most of the sections of the NDIS Act, including (but not limited to) disability and early intervention requirements, what must be included in plans, and the statement of participants' supports. They require agreement from the Australian Government and each State and Territory Government (NDIS Act s. 209).

Box 9.2 Categories of NDIS Rules

There are four main categories of NDIS Rules.

- Category A — The Australian Government and each host jurisdiction must agree to the Rule.
- Category B — The Australian Government and the specific host jurisdiction that the Rule relates to must agree to the Rule.
- Category C — The Australian Government and a majority of host jurisdictions must agree to the Rule.
- Category D — Each host jurisdiction must be consulted on the Rule (NDIS Act s. 209).

In addition, under sections 125B and 180C of the NDIS Act, the Minister responsible for the *Insurance Act 1973* (Cwlth) can make Rules related to the management of risk and the Scheme Actuary's duties.

Most of the current NDIS Rules are either Category A Rules (requiring unanimous agreement) or Category B Rules (requiring agreement between the Australian Government and the relevant host jurisdiction).

Category A rules

The current Category A Rules cover areas such as:

- rules to assist in determining who can become a participant, including extra details about age, residence and early intervention requirements (*National Disability Insurance Scheme (Becoming a Participant) Rules 2016*)
- requirements in determining representatives for children, and what that child's representative must comply with (*National Disability Insurance Scheme (Children) Rules 2013* (Cwlth))
- nominees, including their appointment, duties and cancellation and suspension (*National Disability Insurance Scheme (Nominees) Rules 2013* (Cwlth))
- how supports in a participant's plan should be specified and how to assess whether it would pose an unreasonable risk for a participant to manage their own plan (*National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth))
- criteria for approving registered providers of supports and requirements registered providers of supports must comply with (*National Disability Insurance Scheme (Registered Providers of Supports) Rules 2013* (Cwlth))
- funding of Specialist Disability Accommodation (*National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth)).

Category B Rules

Category B Rules are jurisdiction-specific Rules. They generally relate to the schedules for when areas and people will be phased into the scheme (such as the Rules regarding the preparation of participant plans), or the specific State and Territory laws that prevent a person providing certain information to the NDIA (*National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cwlth)).

Some study participants raised concerns about the governance arrangements for Rule changes. Both the NDIA and the DSS pointed to the length of time it can take to get agreement from the States and Territories on Rule changes.

> The process for amendment of the NDIS Rules requires agreement from a majority or all (depending on the rules) of the States and Territories. Recent experience of seeking amendments to rules is that the process takes considerable time. (NDIA, sub. 161, pp. 48–49)
>
> This has proved cumbersome and complicated for most rules and other actions, such as making appointments and issuing directions, requiring unanimous agreement by the Commonwealth and the States. This can delay the timely sign-off of amendments, and can potentially impact timely direction being provided to the NDIA. (DSS, sub. 146, p. 32)

Both the NDIA (sub. 161, p. 49) and the DSS (sub. 146, p. 32) raised the example of the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cwlth) (Category A Rules), which require unanimous agreement from the Australian, State and Territory Governments. According to the DSS (sub. 146, p. 32), it took about 10 months to implement these Rules. In a transition period of three years, such timeframes could pose significant operational difficulties for the NDIA.

The DSS (sub. 146, p. 32) called for governance arrangements to be changed to enable more streamlined decision making, particularly by the Australian Government. The NDIA argued for a mechanism for efficient and timely amendment of NDIS Rules and suggested that it could be achieved through:

> … legislative amendment that allows some rules to be made that do not require agreement from all jurisdictions, more efficient administrative arrangements to agree changes or by the Minister making a delegation under s.201 of the NDIS Act to the CEO to make legislative instruments in limited circumstances. (sub. 161, p. 49)

State and Territory Governments did not raise this issue specifically in their submissions to this study, and they were generally supportive of the current governance arrangements. For example, the Victorian Government said:

> Victoria reaffirms its support for the governance arrangements outlined in the 2013 Heads of Agreement. This includes a standing council of state and federal ministers as the decision maker on significant NDIS policy issues, COAG as decision maker in relation to scheme costs and implications for mainstream services, and a centralised national NDIA to administer the scheme. (sub. 174, p. 5)
>
> The states must be part of any decision-making process that determines what will be funded under the NDIS. Given the critical interface between the NDIS and state-funded mainstream services, Victoria considers these arrangements as a necessary safeguard against decisions about the scheme's scope which could result in a significant transfer of costs and risks to state-funded services, and poor outcomes for people with a disability. (sub. 174, p. 22)

However, the New South Wales Government said:

> NSW has always been open to considering governance changes, if required, to provide the Commonwealth with greater capacity to effectively administer the scheme, including managing cost risks and ensuring positive outcomes for participants. (sub. 60, p. 13)

While there can be benefits from requiring agreement from all jurisdictions to implement Category A Rules (different perspectives can ensure a better overall outcome is achieved),

there are also costs and risks to delaying changes. The benefits of requiring agreement from all jurisdictions to implement many NDIS Rules, therefore, need to be balanced against the need for the NDIS to be agile and able to adapt to emerging risks within a timeframe that ensures the financial sustainability of the scheme.

The Commission's view is that the risks of delaying implementing or changing Category A Rules in response to risks to financial sustainability are greater than the benefits of requiring unanimous agreement. The requirement for unanimous agreement from the Australian Government and all host jurisdictions for changes to some Rules should be relaxed.

However, any changes to the level of responsibility of governments in making Rule changes need to be considered in light of the risk-sharing arrangements in place, so that incentives can be aligned. This, and possible options for relaxing the Rule making requirements, are discussed in chapter 10.

DRAFT RECOMMENDATION 9.1

The requirement that changes to National Disability Insurance Scheme Category A Rules have unanimous agreement from the Australian Government and all host jurisdictions should be relaxed.

9.4 Western Australian NDIS

As noted above, Western Australia has not signed up to the national NDIS. This section looks at whether the governance arrangements for the WA NDIS will affect costs and financial sustainability. The funding and risk sharing arrangements are discussed in more detail in chapter 10.

Will two schemes affect costs and sustainability?

In 2011, the Commission recommended a single national scheme, and a single national agency, to provide disability care and support across the country (PC 2011, pp. 424, 428). The Commission also recommended that, if a single national scheme could not be achieved, the scheme should still be established, but with its funding and scheme design only applying to participating jurisdictions. The proposed model in Western Australia means that the arrangements in Australia fall somewhere in between these two approaches.

There are costs involved in implementing two systems. There is the cost of two sets of legislation — the NDIS Act and the proposed Western Australian legislation. There are also additional costs associated with setting up a separate agency in Western Australia to administer the WA NDIS (in addition to setting up the NDIA), and any associated loss of economies of scale that could ensue from having a single agency. Also, it is important that

learnings from the transition, such as things that have gone well or poorly, are adopted as quickly as possible in other parts of the scheme. Having two agencies could mean that it takes longer for lessons learned from the national scheme to be adopted in Western Australia and vice versa.

There could, however, be benefits to Western Australia having its own scheme. For example, a WA NDIS could allow increased flexibility and an ability to quickly adapt to changing Western Australian conditions. While the scheme is intended to mirror the national scheme in many aspects, including most parts of the NDIS Act and the NDIS Rules, the fact that the NDIA has its own detailed operational guidelines for its functions suggests that mirroring the legislation allows for significant flexibility. This flexibility could lead to a divergence in the supports provided to scheme participants and participant outcomes between Western Australia and the rest of Australia.

There were two trials of the NDIS in Western Australia — one managed by the NDIA and the other by the Western Australian Government. There are two reviews that have compared the trials in Western Australia. One review identified key features for an effective disability support model for Western Australia, and made a number of recommendations to address gaps in processes. It found that the Western Australian-managed trial required fewer changes in policy and processes to achieve an effective model than the NDIA-managed trial (Stantons International 2016). However, the limitations of this review should be noted. It compared and contrasted the processes related to plan preparation, activation, operation and review. It did not compare actual outcomes of participants in the two trials (this was not feasible due to the timing of the review), nor did it compare the costs of the different approaches.

The WA NDIS and the NDIS scheme actuaries have also undertaken an assessment of the two Western Australian trials. The results of the evaluation are not public.

While the Goldfields Individual and Family Support Association (sub. 13, p. 3) noted it 'supports a decentralised and localised WA state governance model', the majority of study participants who commented on the Western Australian model did not support a separate scheme. A key concern was that it will create inequities in specialist disability support (box 9.3).

Under the Bilateral Agreement between the Western Australian and Australian Governments, there are to be regular reviews of the state legislation, the first occurring two years after the commencement of the WA NDIS (Australian Government and Western Australian Government 2017). While the terms of reference for these reviews are yet to be agreed, they will include the extent to which the WA NDIS is achieving consistency with the agreed provisions in the NDIS Act. If the WA NDIS is to proceed as agreed under the Bilateral Agreement, these reviews will be important for ensuring consistency between the two schemes, and that people with disability in Western Australia are not disadvantaged by not being part of the national scheme.

In April 2017, it was reported that the Western Australian Government was undertaking a review of the decision to implement the WA NDIS and that joining the national scheme was still an option (Emerson, Wearne and Carporn 2017).

It is the Commission's view that Western Australia should be in the national NDIS. There are benefits of having a national scheme (as identified in the Commission's 2011 inquiry) and there are additional costs with two schemes. Where there is evidence that different processes in the Western Australian-managed trial have resulted in better outcomes for participants than under the national scheme, these processes should be considered for the national scheme. Given the concerns about the transition timetable, Western Australia could delay joining the national scheme until the national NDIS is at full scheme. However, to minimise uncertainty for participants, providers and governments, any decision to join the national scheme should be made public as soon as possible.

Box 9.3 **Study participants' views on the WA NDIS**

Down Syndrome Australia:

> Down Syndrome Australia, as a federation of state and territory Down syndrome organisations, has advocated strongly for WA to be part of the national scheme. DSA is very concerned that people with Down syndrome in WA will not get an equitable level of support, nor the choice and control nor long-term certainty of the national scheme. (sub. 121, p. 20)

Disabled People's Organisations Australia:

> DPO Australia is very concerned about the decision by the previous Western Australian Government to establish its own NDIS. Despite a number of nationally consistent provisions in the bilateral agreement, it is concerning that the WA NDIS will have different funding arrangements and accountabilities and a greater focus on service provider control. This is highly likely to prevent market growth and innovation for people with disability in WA and create inequities in the provision of specialist disability support in WA. (sub. 165, p. 10)

Matt Burrows:

> Without WA signed up to a national Scheme, the entire Scheme is at risk. The entire Scheme is not sustainable as a *national* reform unless all States and Territories are signed up to it. (sub. 7, p. 4)

Community Mental Health Australia:

> The announcement that Western Australia (WA) would be implementing its own state-based system has immediately created a situation where there will not be a nationally consistent scheme … (sub. 11, pp. 1–2)

Queensland Advocacy Incorporated:

> [Western Australia's agreement with the Australian Government] undermines that nationally consistent approach and increases state and territory variation. (sub. 115, p. 18)

Department of Social Services:

> An additional risk to consistency and sustainability will arise if a different model is implemented in Western Australia (WA), with the Commonwealth preference for WA to be part of the national NDIS delivery model. (sub. 146, p. 33)

DRAFT RECOMMENDATION 9.2

The Western Australian Government and Australian Government should put in place arrangements for Western Australia to transition to the National Disability Insurance Scheme. Any decision to join the national scheme should be made public as soon as possible.

9.5 Review processes

There are two types of *internal review* processes that can be accessed by those dissatisfied with an NDIA decision.

- *An unexpected plan review* — a scheme participant can request that the NDIA conduct a review of their plan. The NDIA must decide within 14 days whether or not to conduct the review, begin the review within 14 days of that decision, and complete the review as soon as reasonably practicable (NDIS Act s. 48). (This is distinct from the periodic (usually annual) plan review that is discussed in chapter 4.)
- *A review of a decision* — a number of reviewable decisions relating to the NDIA are set out under s. 99 of the NDIS Act, including decisions regarding eligibility, supports provided and registration of providers. When the NDIA makes a reviewable decision, it must give written notice to each person affected by the decision informing them of the option for review. A person then has three months to request a review of the decision. The review must be completed as soon as reasonably practicable (NDIS Act, s. 100).

There are also *external review* processes. If a person is dissatisfied with the outcome from a review of an NDIA decision (not a plan review), they can apply to the AAT to undertake a merit review of the decision within 28 days of the review decision (or apply for an extension of time). And if the person is not happy with the outcome of the external review, they can appeal the AAT's decision in the Federal Court, but only if it is a question of law (NDIA 2017p).[42]

Are the review processes appropriate and effective?

Some study participants argued that the review processes are not as appropriate and effective as they could be. First, there is confusion about the two types of NDIA reviews. The NDIA said that it:

[42] A question of law can include, for example, whether the AAT denied a person procedural fairness, correctly interpreted or applied the NDIS Act, or applied or identified the correct test. This is also known as a judicial review.

> … is aware that there has been confusion around avenues for reviews of decision[s] (especially given the word 'review' is used in the legislation to refer to two different [processes] in relation to planning). (sub. 161, p. 94)

The Commonwealth Ombudsman also commented that:

> … the distinction between an 'internal review' [a review of a decision by the NDIA] and a 'plan review' often seems to be lost on participants and their representatives. This situation was demonstrated in a recent AAT decision, Bridgland and National Disability Insurance Agency, where the applicant had sought an internal review and then, remaining dissatisfied, lodged an appeal with the AAT. The Tribunal found that it did not have jurisdiction to review the matter because the NDIA reviewer had initiated a plan review, resulting in a new plan which attracted internal review rights the applicant had not yet exercised. (sub. 137, p. 12)

This confusion was also noted by Ernst & Young (2015, p. 70) in its review of the NDIS Act, which recommended that the terminology in the Act be amended to make the distinction between the two types of reviews clearer.

Second, there are concerns about the accessibility of the review processes and the adequacy of information provided to scheme participants about review options. Down Syndrome Australia (sub. 121, p. 15) said that 'it appears that people are not well enough informed about their rights to ask for an internal review within the timeframe'. Scope Australia argued that the process is not clear and that the amount of information provided is insufficient.

> … the process for resolving disputes or disagreements is not clear. The Agency rarely provides a contact name for appeals or provides a process by which participants can escalate their concerns. There is only one email address where the information and requests for review can be lodged. This is not customer friendly nor does it encourage participants to best advocate for their rights. (sub. 72, p. 19)

Similarly, Brain Injury SA commented that:

> … the information provided to participants about review is unclear and inadequate. There is minimal information about the process and no information about how or where participants can get help with a review. Brain Injury SA delivers presentations to client communities about the support it can provide to participants wanting a review of an NDIA decision and further appeal rights and support. However, NDIA should provide this sort of information to all participants and be consistent about this approach.
>
> Further, Brain Injury SA has received anecdotal evidence from parents and guardians that NDIA has not been informing participants of their right to an internal review or external merits review through the AAT. (sub. 116, p. 10)

Third, while there is no limit in the Act on how long a review can take, study participants expressed frustration about both the overall length of reviews, and the variability in timeframes. For example, Brain Injury SA (sub. 116, p. 6) said that 'reviews can take between 1 and 8 months'. Others also commented on the delays.

> If people are not satisfied with their plan, they can apply for an internal review of a decision, and if necessary escalate this to the Administrative Appeals Tribunal. However, VCOSS members report this process can be confusing and time-consuming, taking months to resolve. (VCOSS, sub 176, p. 12)
>
> The review process itself is complex and bureaucratic and we have heard of cases where it can take up to 18 months to be completed. Participants who are implementing their second plan are sometimes still waiting for the review of their first plan to be finalized. (Leadership Plus, sub. 128, p. 2)
>
> Although operational guidelines suggest NDIA has 14 days to decide to review a plan, Anglicare Tasmania have examples of cases where reviews have not been resolved for up to seven months. In all cases we have been involved with, timeframes have been very lengthy and involved a huge amount of follow up from families or workers. (Anglicare Tasmania, sub. 145, p. 33)

Governments and the NDIA are working to address concerns about review processes. COAG has agreed to implement the recommendation from Ernst and Young's review of the NDIS Act to review the terminology in the Act to make the distinction between the types of reviews clearer, and to amend the legislation to provide more guidance on the rights of scheme participants to request a review of their plan (COAG 2016a, pp. 4–5). The NDIA (sub. 161, p. 94) also said that it is working to improve its review processes, including working with the Commonwealth Ombudsman to develop service and process improvements.

It is important that the NDIA continues to improve the transparency, clarity and adequacy of the information it provides about reviews and on the timeliness of its reviews.

Are review processes affecting scheme costs?

Review processes can affect scheme costs and financial sustainability in two ways.

- Internal reviews can affect the amount of supports provided or the number of people eligible for the scheme, and thereby affect scheme costs. (But if the review reverses an incorrect decision, there will be benefits, even if it increases scheme costs.)
- Decisions resulting from external review processes will clarify the eligibility requirements and reasonable and necessary supports, which can impact scheme costs.

In addition, poor planning processes can lead to an increase in the number of reviews being requested. This can be costly for the NDIA and scheme participants, and can divert resources away from other, more valuable activities.

Some study participants said that a high number of unexpected plan reviews are being undertaken for certain types of disabilities. For example, MND Australia stated:

> From June 2016 until January 2017 100% of all Plans for people with MND in NSW and the ACT required review. (sub. 45, p. 7)

Publicly available data on the number of unexpected plan reviews being undertaken by the NDIA are limited. Between 1 July 2016 and 31 March 2017, the NDIA had conducted about 26 500 plan reviews that lasted for 30 days or more (NDIA 2017o, p. 15). However, it is not known how many of these were unexpected plan reviews. As such, there is insufficient evidence for the Commission to judge whether the number of unexpected plan reviews is higher than expected, or whether reviews are increasing scheme costs. One way to reduce the number of unnecessary unscheduled plan reviews (and the costs of such reviews), is for the NDIA to implement a process for allowing minor amendments or adjustments to plans without triggering a full plan review. Improving planning processes should also reduce the need for unscheduled plan reviews. This is discussed in more detail in chapter 4.

For internal reviews of decisions, the most recent publicly available data are included in the NDIA's June 2016 quarter report to the DRC (NDIA 2016t, p. 46). At the end of June 2016, the NDIA had conducted 772 reviews of decisions. Of these:

- 262 related to access decisions and 510 to plan decisions
- about 66 per cent of completed reviews where an outcome was recorded (430 reviews) had resulted in the original decision being overturned.

However, there is no information about whether the review decisions have increased scheme costs, for example, by allowing more participants to enter the scheme or additional supports being included in plans.

As at 31 March 2017, there had been 161 external appeals to the AAT (NDIA 2017o, p. 27). Of these, 43 related to access issues, 104 to planning issues and 14 to plan reviews. The NDIA did not report the outcomes of the AAT reviews in its March 2017 quarterly report to the DRC, but it did so in December 2016. Of the 77 (out of a total of 112) appeals that were resolved by 31 December 2016, the NDIA's decision in about half was varied or set aside (the participant was successful) (NDIA 2016v, p. 40). As with the internal reviews of decisions, while participants have successfully appealed many external reviews, it is not clear whether this has led to increased scheme costs.

Two decisions by the AAT have been appealed to the Federal Court. The first case, *Mulligan v National Disability Insurance Agency* [2015] FCA 544, was an appeal of an AAT ruling to affirm the NDIA's decision to decline access to the scheme. The Federal Court set aside the AAT's decision and remitted for another decision by the AAT (NDIA 2017d).

The second case, *McGarrigle v National Disability Insurance Agency* [2017] FCA 308, was an appeal of an AAT decision to affirm the NDIA's decision to partially fund transport to access daily activities (chapter 4). The Federal Court set aside the AAT decision and remitted for another decision by the AAT. The implications of the McGarrigle case are yet to be fully understood, and the NDIA has announced it will appeal the decision (NDIA 2017l).

There is the potential for external review processes to significantly increase costs in the future by expanding eligibility requirements and the scope of supports provided. As the NDIA said:

> Decisions by the AAT (and/or an appeal to the Federal Court) have the potential to vastly increase the scope of both access and reasonable and necessary supports and must be adhered to while in effect, even if the NDIA challenges the decision. (sub. 161, p. 49)

That said, it is important that scheme participants have access to appropriate and effective external review processes. This ensures trust in the scheme, that participants have access to the scheme where appropriate and are receiving the right level of support (even where it increases scheme costs), and that the objectives of the scheme are being fully achieved. As noted by Carers Australia Victoria:

> Internal and external reviews are a vital quality safeguard for participants and carers, enabling them to test the lawfulness and merits of NDIA decisions affecting them. Importantly, they also promote transparency in NDIA decision-making. (sub. 131, p. 14)

As discussed in section 9.3, when external reviews result in outcomes that are not in line with the objectives of the scheme and could significantly increase scheme costs, it is important that governance arrangements allow for timely responses to ensure the financial sustainability of the scheme.

To provide greater clarity and transparency around the effectiveness of the review process and their effect on financial sustainability, the NDIA should undertake more detailed performance reporting on review processes (including on the number of reviews, review timeframes, outcomes of reviews, and participant satisfaction with the review process).

DRAFT RECOMMENDATION 9.3

The National Disability Insurance Agency should publicly report on the number of unexpected plan reviews and reviews of decisions, review timeframes and the outcomes of reviews.

9.6 Regulation and quality assurance arrangements

Regulation and quality assurance arrangements are important for ensuring the quality of the scheme and good outcomes for scheme participants. Currently, the Australian Government and the State and Territory Governments are responsible for regulation and quality assurance in their jurisdictions, and for the programs they fund (Bilateral Agreements, sch. F; DSS 2016c, p. 17).

In December 2016, the DRC endorsed the NDIS Quality and Safeguarding Framework. Under this framework, nationally consistent regulation and quality assurance processes will be implemented from 1 January 2018 (Australian Treasury 2017a, p. 154). The focus

of the framework is on helping scheme participants to exercise choice and control, while ensuring appropriate safeguards are in place.

The Australian Government will be responsible for most of the regulatory functions under the framework, including provider registration, the complaints handling system, serious incident notification, restrictive practice oversight, and investigation and enforcement (box 9.4).

A number of entities will be established to oversee the Australian Government's regulatory functions including the:

- NDIS Complaints Commissioner, which will be responsible for handling complaints, investigating serious incident notifications and investigating potential breaches of the NDIS code of conduct. The Commissioner will refer complaints to the relevant entity where appropriate, including those about provider standards to the NDIS registrar
- NDIS Registrar, which will be responsible for:
  - registering providers
  - managing the NDIS practice standards and certification scheme
  - leading the design and broad policy settings for worker screening
  - monitoring provider compliance
  - monitoring, reviewing and reporting on the effectiveness of the market for supports
- Senior Practitioner, which will be responsible for:
  - overseeing approved behaviour support practitioners and providers
  - providing best practice advice
  - receiving, reviewing and reporting on providers using restrictive practices
  - following up on serious incidents that suggest unmet support needs (DSS 2016c, pp. 16–17).

The State and Territory Governments will be responsible for worker screening and for the authorisation of restrictive practices in their jurisdiction (box 9.4).

The Australian Government has also announced that it will establish an NDIS Quality and Safeguards Commission to implement the framework and to undertake some of the Australian Government's regulatory functions listed above, including provider registration and regulation, complaints, reportable incidents, and behaviour support practices (Australian Treasury 2017a, p. 154; DSS, sub. 146, pp. 6-7). However, there is still a lot of work to be done in terms of implementation design and roll out of the arrangements (DSS 2016c).

Box 9.4 NDIS Quality and Safeguarding Framework

The NDIS Quality and Safeguarding Framework outlines the national approach to regulation and quality assurance for the NDIS. The DRC endorsed the framework in December 2016. The aim of the framework is to 'help empower and support NDIS participants to exercise choice and control, while ensuring appropriate safeguards are in place, and establishes expectations for providers and their staff to deliver high quality supports' (DSS 2017d, p. 1).

The framework embodies a number of principles.

- Measures within the framework are designed to uphold and respect the human rights of people with disability.
- Developmental measures (measures intended to build capacity) are designed to empower and support people with disability to make informed decisions about providers and supports.
- The framework is designed to ensure that people with disability have the same protection, regardless of where they live in Australia.
- The regulatory requirements for workers and providers are tiered to ensure regulation is proportionate to the level of risk associated with the type of support offered and the needs of the participants supported.
- The framework starts from the presumption that all people with disability have the capacity to make decisions and exercise choice and control.
- The framework streamlines requirements so the system is easier for people with disability to navigate, and red tape is reduced for providers.
- The framework is designed to support the development of an efficient and effective market.

The framework includes a range of measures targeted at individuals, the workforce and providers in three domains — developmental, preventative and corrective.

The Australian, State and Territory Governments will share responsibilities under the framework. The Australian Government will be responsible for provider registration, the complaints handling system, serious incident notification, restrictive practice oversight, and investigation and enforcement. State and Territory Governments will be responsible for worker screening and for the authorisation of restrictive practices in their jurisdiction.

The framework also encompasses a range of other functions including:

- advocacy services, which are funded outside of the NDIS
- systems for detecting fraud and related issues associated with the responsibility for paying providers and verifying that supports have been delivered. These will remain the responsibility of the NDIA
- complaints about the NDIA and Local Area Coordinators, which will be addressed through existing measures
- universal complaints and redress mechanisms, including Fair Trading and professional and industry bodies, which will continue to be available to participants
- anti-discrimination and human rights legislation overseen by the Disability Discrimination and Human Rights Commissioners, which will provide additional avenues for raising a complaint.

The Australian Government has committed $209 million to establish a NDIS Quality and Safeguards Commission to implement the framework.

Sources: Australian Treasury (2017a, p. 154); DSS (2016c, 2017d).

Are arrangements for quality and safety affecting scheme costs or sustainability?

The development of the NDIS Quality and Safeguarding Framework is an acknowledgment that the current arrangements will not be satisfactory for the full scheme. Current arrangements are designed around providers being block-funded and people with disability not having the level of choice and control they have now, or will have under the new system.

Although the current arrangements will not be appropriate for full scheme, they will remain in place for the transition. Given the importance to scheme costs and sustainability of having as smooth a transition as possible, ideally the current arrangements would not impede the development of the scheme and would ensure the safety of, and good outcomes for, scheme participants.

However, submissions to this study suggested that the current arrangements pose some risks to the scheme. A concern raised by a number of study participants is the different requirements providers need to meet across jurisdictions. For example, the NDIA (sub. 161, p. 103) argued that having different requirements in each jurisdiction can act as a barrier to entry for new providers. Plan Management Partners argued that:

> The current state based approach in our view is problematic as it is inconsistent in terms of application and requirements between the states. It is important in our view that the National framework (which is being introduced) addresses the current state variability. (sub. 126, p. 13)

And the Australian Rehabilitation Providers Association said:

> Barriers to entry for allied health professionals into the NDIS is high. The variable quality and safety procedures required by each State/Territory places additional costs on businesses employing allied health professionals. (sub. 28, p. 1)

Study participants also raised concerns about the burden of the registration process. Occupational Therapy Australia (sub. 15, p. 6) said that some occupational therapists found the registration process to be quite lengthy, which could deter therapists from registering as providers. Similarly, Allied Health Professions Australia commented that:

> The registration process is slow and complex, which is resulting in costs for practitioners, primarily in the form of significant time outlays required to address the bureaucratic requirements of registration. (sub. 37, p. 5)

Queensland Advocacy Incorporated argued that the registration processes are a particular barrier for smaller providers.

> QAI submits that the requirements for registration as an NDIS service provider will have the effect of squeezing smaller or lower funded organisations out of the marketplace. This will be to the detriment of people with disability and will impact upon the choice and control they have with respect to their services. (sub. 115, p. 16)

Third party verification (TPV) was raised as a concern by some providers. For example, in New South Wales, providers wanting to register to provide specialist disability supports are required to show evidence of full TPV (NDIA, sub. 161, p. 103). The Australian Psychological Society (sub. 19, p. 2) argued that one of the reasons psychologists are choosing not to provide NDIS services is the cost associated with the TPV process. The Australian Rehabilitation Providers Association also argued that:

> … [the TPV] process has imposed an additional layer of regulation and 'red tape' on tertiary educated professionals with rigorous registration requirements already in place. (sub. 28, p. 1)

Unfortunately, the timing of the implementation of the new framework at full scheme means that many regulatory issues will not be addressed until then. It is important that governments working on the implementation design and rollout of the new arrangements take into account current arrangements that are imposing unnecessary regulatory burden on providers. Consistent requirements across jurisdictions at full scheme will reduce the compliance burden for providers who want to provide services across jurisdictions. As the NDIA said:

> The implementation of the new national quality and safeguard framework … will reduce the compliance burden for providers seeking to operate in multiple jurisdictions. The framework will drive consistent approaches to regulating provision of the NDIS funded support. (sub. 161, p. 103)

While there is still work to be done on the implementation design and rollout of the framework, some study participants commented on the framework. Topics raised included the arrangements for psychosocial disability (CMHA, sub. 11, p. 16), children and young people (Centre for Disability Research and Policy, sub. 40), the need for a cultural competence domain (Northern Territory Government, sub. 205, p. 7) and those who provide services to scheme participants who self-manage not being required to register with the NDIA (DSA, sub. 9, p. 12).

Another ambitious timeframe

The NDIS Quality and Safeguarding Framework was only endorsed by the DRC at the end of 2016 which means that the timeframe (like other NDIS timeframes) is ambitious. However, it is important that this timeframe be met to ensure quality and safety for scheme participants, and to provide clarity and reduce the regulatory burden for providers. A number of study participants supported the arrangements being clarified and implemented as soon as possible (for example, Physical Disability Australia, sub. 38, p. 14).

As many of the details of the new arrangements are yet to be worked out, the Commission is not in a position to comment on the detailed regulatory arrangements under the framework.

9.7 Monitoring the performance of the NDIS

Performance reporting requirements can influence scheme costs and financial sustainability. Effective performance monitoring can improve transparency and accountability, and provide incentives for the NDIA and governments to effectively manage the scheme and ensure that the objectives of the scheme are realised.

To be effective, performance reporting indicators should measure performance against the objectives of the scheme and cover both outputs and outcomes. They should also be transparent and ideally released publicly in a timely manner. Some features of good performance indicators are summarised in box 9.5.

Box 9.5 **Features of good performance indicators**

- *Comprehensive* — indicators in a framework should measure performance against all important objectives.
- *Meaningful and understandable* — indicators must measure what they claim to measure and provide a good indication of success.
- *Accurate* — the data should be sufficiently accurate so that the community has confidence in the conclusions drawn from the information.
- *Timely* — the data must be collected at the point in time that aligns with the achievement of the outcome or objective.
- *Comparable* — indicators should allow for comparisons, including over time and between jurisdictions and target groups.
- *Streamlined* — indicators in a framework should be concise.
- *Cost-effective* — the benefits of reporting the indicator should outweigh the costs of collecting and reporting the data.
- *Avoid perverse incentives* — the indicator should not create perverse incentives or lead to unintended consequences.

Sources: Adapted from COAG (2011a, pp. 14–15); SCRGSP (2017).

How is performance currently reported?

The performance of the NDIS is currently monitored and reported through a number of mechanisms, including the:

- Integrated National Disability Insurance Scheme Performance Reporting Framework
- Scheme Actuary's monitoring and reporting on the financial sustainability of the scheme
- NDIA's annual report and corporate plan
- key performance indicators recently agreed by the DRC to monitor NDIS market performance and identify emerging market risks (DSS, sub. 146, p. 34).

Some of these are discussed in more detail below.

The Integrated NDIS Performance Reporting Framework

The main framework used to measure the performance of the NDIS is the Integrated National Disability Insurance Scheme Performance Reporting Framework, which is set out in schedule G in the Bilateral Agreements for the transition between the State and Territory Governments and the Australian Government (schedule H for Western Australia). The Framework comprises three main components:

- *NDIS Performance* — this includes agreed outcomes, key performance indicators and measures designed to assess whether the NDIS is achieving its objectives as set out in the legislation (table 9.1). Requirements at this level are designed to meet the accountability requirements of the DRC. This information is reported annually by the NDIA Board to the DRC.
- *NDIA Operational Performance* — this reporting meets the requirements in the legislation for the NDIA Board to report on expenditure and activities related to the NDIS, and it provides information on various aspects of NDIA operations that contribute directly to the achievement of NDIS outcomes and KPIs. This information is reported quarterly by the NDIA Board to the DRC (table 9.2).
- *NDIS Activity in Jurisdictions* — this reporting provides jurisdictions with the information they need to meet their own individual accountability requirements, such as budget reporting. This information is to be provided monthly by the NDIA to each jurisdiction through the data warehouse.

The NDIA is not yet reporting against all of the performance measures or indicators in the reporting framework, as it has not yet built in to its systems the capability to measure some of the indicators. For example, the NDIA is not yet reporting detailed data on the proportion of participants who attain the goals outlined in their plans, the time between requesting access and receiving support, and the number of participants and other people with disability supported by LACs (NDIA 2016v, 2017o).

In addition, only limited baseline (not longitudinal) data are presented for some indicators, such as the proportion of participants, and their families and carers, who report improved economic and social outcomes (NDIA 2016v, 2017o).

Table 9.1 **NDIS performance outcomes, KPIs & performance measures**

Outcome	*KPIs*	*Performance measures*
1. People with disability lead lives of their choice	1.1. People with disability achieve their goals for independence, social and economic participation	1.1.1. Proportion of participants, and their families and carers, who report improved economic and social outcomes (as measured by the NDIS Outcomes Framework) 1.1.2. Proportion of participants who attain the goals outlined in their plans (as measured by the NDIA's Goal Attainment Scale) 1.1.3. Participant satisfaction
	1.2. Increased mix of support options and innovative approaches to provision of support in response to assessed need	1.2.1. Mix and number of provider services 1.2.2. Proportion of participants with capacity building supports
	1.3. People with disability are able and are supported to exercise choice	1.3.1 Proportion of participants, and their families and carers, who report being able to exercise choice (as measured by the NDIS Outcomes Framework)
2. NDIS is a financially sustainable and insurance-based	2.1. Effective estimation and management of short-term and long-term costs	2.1.1. Comparison of actual expenditure against projected expenditure 2.1.2. Changes in medium- and long-term expenditure projections 2.1.3. Projected expenditure matches projected revenue over the medium and long-term 2.1.4. NDIA operating expenses ratio 2.1.5 Reduction in long-term cost trends against population, price and wages growth 2.1.6. Estimated future lifetime costs of support for current clients (NPV), including disaggregation for new and existing clients by client group
	2.2. Benefits are realised from targeted investment strategies in enhanced disability support	2.2.1. Effectiveness of early intervention in reducing estimated lifetime costs of support measure: • In the short term through case studies which include targeted investment • In the long term through estimated returns from this investment
3. Greater community inclusion of people with disability	3.1. People with disability are able to access support from mainstream services	3.1.1. Referrals to mainstream services for participants and non-participants through Information, Linkages and Capacity Building (ILC) 3.1.2. Proportion of participants accessing mainstream services
	3.2. Community awareness of people with disability	3.2.1 Activities undertaken by the NDIA to increase community awareness of the issues that affect people with disability
	3.3. Effectiveness of Local Area Coordination and other funded community capacity building	3.3.1. Number of people supported through ILC

Sources: Bilateral Agreements, sch. G.

Table 9.2 **NDIA operational performance outcomes, measures and indicators**

Outcome	*Measures*	*Indicators*
1. People with disability lead lives of their choice	1.1. Outcomes for participants and their families	1.1.1. Proportion of participants, and their families and carers who report improved economic and social outcomes (as measured by the NDIS Outcomes Framework)
		1.1.2. Proportion of participants who attain the goals outlined in their plans (as measured by the NDIA's Goal Attainment Scale)
		1.1.3. Participant satisfaction
	1.2. Provision of support in response to assessed need	1.2.1. Number of registered service providers by characteristics and market profile
		1.2.2. Access request to receiving support within different timeframes
2. NDIS is a financially sustainable and insurance-based	2.1. Participant characteristics and their families	2.1.1. Access requests made by outcome
		2.1.2. Eligible participants against bilateral targets, including key characteristics
		2.1.3. Participants with approved plans against bilateral targets
		2.1.4. Trends in plan approvals
		2.1.5. Access request to plan approval within different timeframes
		2.1.6. Ineligible participant numbers and key characteristics
	2.2. Support packages	2.2.1. Committed support
		2.2.2. Actual payments
		2.2.3. Average and median package costs by sub-groups of the population and for all participants compared with the expected averages and medians, including trends
		2.2.4. Details of participants with second plans, including length and value of supports
		2.2.5. Distribution of package costs
	2.3. Projections	2.3.1. Cost of the NDIS in dollar terms and as a percentage of GDP (split by participants aged under 65 years and over 65 years). This measure will include NDIS operating costs
3. Greater community inclusion of people with disability	3.1. Mainstream services	3.1.1. Number of participants accessing mainstream services by service type
	3.2. Local Area Coordination (LAC)	3.2.1. Number of participants and other people with disability supported by LACs by participant characteristics
		3.2.2. Description of activities undertaken on ILC including dollars spent by regions and activities
	3.3. Information, Linkages and Capacity Building (ILC)	3.3.1. Number of participants and other people with disability supported by ILC activities by participant characteristics
		3.3.2. Description of activities undertaken on ILC including dollars spent by regions and activities.

Sources: Bilateral Agreements, sch. G.; NDIA (2016v).

Monitoring and reporting on financial sustainability

Under the NDIS Act, each time an annual report is prepared the Scheme Actuary is to:

- assess financial sustainability and identify risks to financial sustainability, and any trends in the provision of supports to people with disability

- consider the causes of those risks and trends
- estimate the future expenditure of the NDIS
- prepare a report of that assessment, consideration and estimation
- prepare a summary of that report that includes the estimates of future expenditure (NDIS sub. 161, p. 115).

The Scheme Actuary prepares an annual financial sustainability report, which includes detailed data and information on the financial sustainability of the scheme. This report is not released publicly, although a summary is included in the NDIA's annual report (NDIS Act, s. 172). It is through this reporting that cost pressures are identified.

Are performance monitoring and reporting arrangements appropriate?

As the NDIA is still developing its performance reporting against the integrated framework, it is too early to judge whether the performance reporting will be sufficient to shed light on whether the scheme is meeting its objectives. That said, the Commission has identified some gaps in the framework and the current performance reporting against that framework.

As discussed above, there are limited data reported against the outcomes indicators. In addition, there are limited indicators on mainstream services, Information, Linkages and Capacity Building and LACs, and for the indicators that do exist, the NDIA is not yet reporting against some of them (NDIA 2016v, 2017o). Given the importance of understanding the interaction between the NDIS and mainstream services, and the critical role that Information, Linkages and Capacity Building and LACs play in the scheme (chapter 5), data on these activities should be an important component of reporting on NDIS performance.

There is also not a strong enough focus on quality in the framework, including the quality of plans, and review processes (draft recommendation 9.3). Reporting on quality is especially important given that the NDIA's focus on getting people into the scheme to meet the bilateral estimates has compromised the quality of the planning process and participants' plans (chapter 4). Over time, the NDIA intends to develop its monitoring of, and reporting on, outcomes. Evidence of good outcomes will be evidence of good performance and good plans. However, it could be some time until this reporting is of a sufficient standard. Until then, reporting on quality is needed. This could include indicators such as participant satisfaction with their plans and their planning experience, the number of plans completed by phone and face-to-face, and the number and nature of plan reviews.

As discussed earlier, it is also important that performance reporting is transparent to provide incentives to manage and improve performance, and to help to identify problems early. While the quarterly report to the DRC is made available on the NDIA's website, the financial sustainability report is not.

As the performance reporting on the NDIS is still being developed, the framework should be regularly reviewed and refined as needed. The Bilateral Agreements on transition state that the framework is reviewed annually (Australian Government and Queensland Government 2015, sch. G, p. 2).

DRAFT RECOMMENDATION 9.4

The performance of the National Disability Insurance Scheme (NDIS) should be monitored and reported on by the National Disability Insurance Agency (NDIA) with improved and comprehensive output and outcome performance indicators that directly measure performance against the scheme's objectives.

The NDIA should continue to develop and expand its performance reporting, particularly on outcomes, and Local Area Coordination and Information, Linkages and Capacity Building activities. The NDIA should also fill gaps in its performance reporting, including reporting on plan quality (such as participant satisfaction with their plans and their planning experience, plans completed by phone versus face-to-face, and plan reviews).

The *Integrated NDIS Performance Reporting Framework* should be regularly reviewed by the NDIA and the COAG Disability Reform Council and refined as needed.

9.8 The rollout timetable

As discussed throughout this paper, the ambitious timetable for the rollout presents a risk to the success and financial sustainability of the scheme. The speed of the rollout has:

- compromised the quality of plans (chapter 4)
- implications for the development of other parts of the scheme, especially the disability care workforce, which is unlikely to be sufficiently developed by 2020 to deliver the supports the NDIA is expected to allocate (chapter 7)
- imposed challenging timeframes on the development of important structural elements of the scheme — including details in relation to responsibilities at the coalface in services like health and transport (chapter 5); and instituting the new quality and safeguarding arrangements (section 9.6).

Some study participants argued that the rollout should be slowed down (box 9.6). For example, the Mental Health Community Coalition of the ACT (sub. 135, p. 24) argued that slowing down the implementation of the NDIS would mean that you could 'replace costly mistakes with getting it right in the first place'.

However, others argued that the rollout schedule should not be changed. For example, the Australian Federation of Disability Organisations said that slowing down the rollout is unacceptable to people who are waiting for support:

> Some in the sector have responded by arguing for a slow down [to] the roll out and to lengthen the transition period. To AFDO and its members, this would be completely unacceptable. For many people with disability, the wait has already been too long. For people who have had little or no support for many years, the NDIS cannot come quickly enough. Slowing down the roll out is therefore not an option. (sub. 180, p. 8)

Box 9.6 Some argued for a slowing down of the transition timetable

Cerebral Palsy Alliance:

> We would strongly recommend that the Commonwealth and States revise the transition timetable to support a realistic and manageable change management process for all stakeholders — as per NSW Bilateral Agreement - Management of Risk Clauses 48-51 — if the risk of market, sector and system readiness to transition emerges — changes to the participant phasing schedule may be considered by both parties. (sub. 163, attachment 2, p. 1)

David Parkin:

> The rollout to new areas needs to be slowed. Get the current system as right as it can be. There are enough participants now … who are actually using the system to understand where the effort needs to be applied. The NDIS has to listen to people and Providers. (sub. 177, p. 10)

Australian Lawyers Alliance:

> One important response to the challenges ought in our view to be a reconsideration of the rollout schedule. As at the date of this submission, the rollout is less than nine months old, yet the level of dissatisfaction with the scheme, and the clarity with which problems are being identified, are both rapidly escalating. (sub. 54, p. 6)

Australian Physiotherapy Association:

> Our members are concerned that the balance between the speed of the roll-out and its effectiveness needs to be changed, and the roll-out slowed so that the NDIS can properly train its team, manage its workload and provide consistent support to the regions in which the roll-out is occurring. (sub. 93, p. 8)

Maurice Blackburn Lawyers:

> A prudent approach would be to consider a slower roll-out schedule to help minimise the risks associated with the introduction of the scheme. … A revised rollout schedule could involve a complete cessation of the rollout on a regional basis for a specified period, to enable the remedial work to be undertaken, and a fresh analysis of readiness after that period.
>
> Aside from managing financial risks, a roll-out over an extended period would avoid significant frustration and distress for those living with disabilities and their families, and allow lessons learned from the early results to be incorporated into the scheme's final design. (sub. 58, p. 7)

The Commission acknowledges the hardship that has been imposed on some people with disability under the pre-NDIS arrangements that were 'inequitable, underfunded, fragmented and inefficient' (PC 2011, p. 5). Given the problems under the current rollout schedule, however, it may be that it will be in the interests of people with disability to slow down the rollout timetable.

A slowdown would provide the NDIA with more time to deal with planning and system issues. It would also give the market for disability care and support more time to develop, given that it could take at least a decade for a mature disability services market to develop (chapter 6). Governments at all levels would have more time to deal with interface issues at

an operational level, which is essential to ensure gaps do not emerge in a way that sees costs shifted to people with disability and their carers (chapter 5).

The rollout timetable is tied to the schedules set out in the Bilateral Agreements. Given that the numbers of scheme participants in the Bilateral Agreements are estimates and not hard targets, and that the NDIA is already behind on these estimates (chapter 2), there may be some flexibility for the NDIA to slow down the pace of the rollout should that be required.

The Bilateral Agreements for the transition also provide a potential mechanism for implementing a slowdown. For example, clause 50 of the NSW bilateral agreement on transition allows for a change in the participant phasing arrangements in the event of financial or other risks emerging. It requires the party with primary responsibility for the risk to work with other parties, including the NDIA, to develop an agreed strategy, and notes that other strategies must be pursued fully prior to considering changes in phasing agreements.

Any slowdown would have implications for scheme funding arrangements and the disability services provided by the states and territories. These matters would need careful attention should a slowdown be implemented.

The NDIA is aware of the current problems …

The NDIA acknowledges that the scale of the participant intake has affected the quality of participants' and providers' experiences (NDIA, sub. 161). The NDIA is working with participants, providers, peak disability bodies and other stakeholders to identify changes or improvements required to achieve:

- the intake of participants at the rate required by the Bilateral Agreements
- plans that maximise choice and control for participants, and contribute to improved participant outcomes
- plans that are of high quality
- plans that are financially sustainable so that the aggregate value of all plans remains within the funding envelope (sub. 161, p. 4).

While the NDIA's proposed new approach is yet to be tested with participants and providers, at this stage the Agency plans to have a greater focus on outcomes, more active involvement with communities, more face-to-face communications, and improved interaction with providers and disability organisations. The NDIA also plans to make improvements to its call centre and portal to make it easier to navigate (NDIA, pers. comm., 22 May 2017).

However, it will take time to implement the changes and for the changes to be reflected in the performance reporting data. On the information the Commission has received about the changes proposed by the Agency, the Commission is not in a position to form a judgment

about whether a greater focus on participant and provider experiences can be achieved while also meeting the bilateral estimates. A slowdown in the rollout of the scheme may be required. The Commission is seeking feedback on how a slowdown, if required, could be operationalised, and what the implications of a slowdown would be.

DRAFT RECOMMENDATION 9.5

In undertaking its role in delivering the National Disability Insurance Scheme, the National Disability Insurance Agency needs to find a better balance between participant intake, the quality of plans, participant outcomes and financial sustainability.

INFORMATION REQUEST 9.1

The Commission is seeking feedback on the most effective way to operationalise slowing down the rollout of the National Disability Insurance Scheme in the event it is required. Possible options include:

- *prioritising potential participants with more urgent and complex needs*
- *delaying the transition in some areas*
- *an across-the-board slowdown in the rate that participants are added to the scheme.*

The Commission is also seeking feedback on the implications of slowing down the rollout.

… but scheme success and financial sustainability are about more than the rollout

The rollout schedule is only one of the risks to achieving the objectives and financial sustainability of the scheme. A number of the other risks are outside the control of the NDIA (table 9.3). As the NDIA noted, levers that affect NDIS financial sustainability that it cannot control include:

- The responsiveness of the disability support market to changes in demand;
- National quality and safety regulation in the disability support market;
- Decisions by the Administrative Appeals Tribunal (AAT) or court system in interpreting the boundaries of access and reasonable and necessary supports;
- The efficiency of supports provided by mainstream support systems and community and natural supports. (sub. 161, p. 45)

Table 9.3 **Factors that influence financial risks to the scheme**

Outside the NDIA's control	The NDIA has some influence	Factors within NDIA's control
• Participant intake estimates in bilateral agreements • Adequacy of government disability and mainstream services • Continuity of support outside the NDIS • External reviews of decisions • Quality and safeguards regulation • Legislative framework and amendments	• Market development • Linking people to services outside the NDIS • Provider readiness and registration • Participant readiness • Broader disability policy and the National Disability Strategy	• Upholding eligibility criteria • Effective use of Early Intervention • Planning processes • Assessment of reasonable and necessary supports • Administration of supports • Quality of planners • Prices of supports • Information, Linkages and Capacity Building Activities • Local Area Coordination

Making the scheme work is not just the NDIA's responsibility — it is also the responsibility of governments, service providers, community organisations, employers, participants and their families and carers.

10 NDIS funding arrangements

Key points

- When the National Disability Insurance Scheme (NDIS) is fully rolled out in 2019-20, it is expected to cost about $22 billion. This is an increase of just over 150 per cent in funding from the $8.4 billion allocated to funding disability supports in 2015-16.
- The Australian, State and Territory Governments share responsibility for funding the NDIS. There are different funding arrangements for transition and full scheme.
  - During transition, the Australian, and State and Territory Governments will each contribute an agreed amount per participant based on the intake of participants in each state, which equates to around a 40-60 split respectively.
  - At full scheme (from 2019-20), State and Territory Governments will contribute $10.3 billion to the NDIS (escalated at 3.5 per cent each year). The Australian Government will fund the remainder.
- There are four main levers that affect the federal division of funding responsibilities: funding contributions by the Australian and State and Territory Governments; escalation parameters (which can affect funding contribution from the States and Territories over time); responsibility for funding cost overruns; and the approach taken to underspends.
- The Commission is seeking further input on the role of escalation parameters, as the objective is not clear. The 3.5 per cent escalation parameters currently specified in Bilateral Agreements is at the lower bound of a range that would be expected to keep real per capita contributions from the States and Territories constant over time. It is also likely to be too low to keep funding shares between the Australian Government and the States and Territories constant over time (after allowing for those over 65 who age in the scheme, who will be funded entirely by the Australian Government).
- In line with an insurance-based model, establishing a sufficient reserve fund would enable the National Disability Insurance Agency greater capacity to operate the scheme on insurance principles.
- Responsibility for cost overruns among governments should be allocated according to the proportion of risk controlled by each party. This is not the case in transition — the Australian Government bears liability for cost overruns, but important cost drivers are controlled by the State and Territory Governments. At full scheme, arrangements should apportion cost overrun risk and governance responsibility in line with control of risk.
- While in-kind contributions are necessary in the transition period, they risk jeopardising the objectives of the NDIS and should be phased out by the end of the transition period.

Funding for the National Disability Insurance Scheme (NDIS) is shared between the Australian and State and Territory Governments. The NDIS involves a significant increase in funding provided to people with disability. As discussed earlier in this report, when the NDIS is fully rolled out in 2019-20, it is expected to cost about $22 billion. This is an increase in total government spending on disability supports of:

- just over 150 per cent from the $8.4 billion in funding in 2015-16
- about a 200 per cent increase from the $7.1 billion government spending at the time of the 2011 Commission inquiry into *Disability Care and Support* (PC 2011, p. 675; SCRGSP 2017, p. 15.4).

In 2011, the Commission concluded that people with disability required more certainty about getting reasonable supports over their lifetime, and any disability insurance scheme would need a predictable revenue source:

> … revenue must not vary substantially from year to year or be subject to significant risks that future governments will cut it as part of changing budget circumstances. That implies the need for governments to make a binding commitment that makes it very difficult for them to divert the funding subsequently to other areas of spending. (PC 2011, p. 649)

The Commission's preferred funding option in 2011 was for the Australian Government to finance all the costs of the NDIS using its more efficient taxation base (compared to the State and Territory Governments' relatively limited tax options for raising additional revenue).[43] Another option was for all governments to pool funding subject to a long-run arrangement and with pre-specified funding shares (the arrangement that was put in place). As the Victorian Government said:

> The NDIS was developed against the background of a very high degree of vertical fiscal imbalance within the Australian federal system. In recognition of this, the PC originally recommended the Commonwealth take full responsibility for meeting the entire funding needs of the NDIS in part to '….*reflect the Australian Government's unique capacity to raise efficient and sustainable taxes of the magnitude required*' (PC 2011, p. 35).
>
> In the event it was agreed that the Commonwealth would fund the NDIS, with contributions from states as agreed bilaterally. (sub. 174, p. 23)

This chapter examines the current funding arrangements and the funding levers that affect the division of responsibilities between the Australian and State and Territory Governments.

The way the NDIS is funded in transition and at full scheme is examined in section 10.1. Section 10.2 looks at funding issues arising from the interface between Australian and State and Territory Governments' funding responsibilities, including funding shares, escalation parameters and cost overruns. Section 10.3 examines funding from an insurance-based approach, and section 10.4 looks at in-kind contributions.

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[43] Chapter 14 of the Commission's Disability Care and Support inquiry report (PC 2011) examined in detail various options for financing the NDIS.

10.1 How is the NDIS funded?

The complex funding arrangements for the NDIS are set out in a range of intergovernmental agreements (box 10.1). The agreements outline, among other things:

- the respective funding responsibilities of the Australian and State and Territory Governments
- how the arrangements will change over time
- the different arrangements for transition and full scheme.

Box 10.1 Funding arrangements as set out in the intergovernmental agreements

Before the *National Disability Insurance Scheme Act 2013* (Cwlth) was passed (December 2012), the Australian Government and all State and Territory Governments signed the *Intergovernmental Agreement for the National Disability Insurance Scheme (NDIS) Launch*. This agreement established high-level funding principles including how underspends and overspends would be treated. More specific Heads of Agreement between the Australian Government and each of the State and Territory Governments (except Western Australia) set out funding details such as:

- responsibility for cost overruns
- the overall funding shares at full scheme, and escalation parameters
- in-kind arrangements.

For the NDIS transition period, the Australian Government and every State and Territory Government also signed Bilateral Agreements that detail:

- the number of participants that will be funded by the State and Territory Governments (participant numbers are capped in each quarter and preference is given to existing clients of State and Territory Government disability services)
- that the Australian, State and Territory Governments will each contribute a fixed amount per participant, based on actual intake of participants — around a 40-60 split respectively.

Sources: Australian Government and Western Australian Government (2017, p. 14); COAG (2012b).

As discussed in chapter 9, Western Australia has opted for a locally administered scheme and has different funding arrangements to the other states and territories (box 10.2).

Box 10.2 Funding arrangements in Western Australia are different

Western Australia has opted not to join the national scheme, but rather to have a separate WA NDIS (chapter 9).

WA NDIS during transition

During the transition period, as in other jurisdictions, the Western Australian Government will contribute 59.4 per cent of care and support package costs for an agreed number of eligible participants each year.

The Western Australian Government will cover a larger proportion of cost overruns than other State and Territory Governments.

- The Australian Government will bear a maximum of 25 per cent of any cost overruns for the WA NDIS when those overruns are due to a higher than expected number of participants or higher package costs.
- Cost overruns due to any other reasons will be funded by the Western Australian Government.
- If there are lower than expected package costs or participant numbers, the remaining funds will be split according to the contributions of each government.

The Western Australian Government and the Australian Government will share equally in the cost of Information, Linkages and Capacity Building grants and Local Areas Coordinators in that state. The Western Australian Government will fund the administrative costs of the WA NDIS. And as in the other states and territories, the Australian Government will fund supports for participants over 65 years old who choose to remain in the scheme, and Indigenous participants over 50 years old.

WA NDIS at full scheme

Limited details about the WA NDIS at full scheme are available, but at full rollout the Australian Government will make a fixed per person contribution towards the cost of the scheme in Western Australia and this amount will escalate at 3.5 per cent per annum.

Source: Australian Government and Western Australian Government (2017, p. 14).

Transition funding arrangements (2016-17 to 2018-19)

During the transition, the Australian Government will cover 40.6 per cent of the costs for participants under 65 years, and 100 per cent for non-Indigenous participants 65 years and over and Indigenous participants over 50 years who decide to remain in the scheme. The State and Territory Governments will fund the remainder (59.4 per cent of an agreed contribution).

The Australian Government will also fund Information, Linkages and Capacity Building (ILC) activities and the National Disability Insurance Agency's (NDIA's) operating expenses.

All cost overruns in the transition period are to be funded by the Australian Government.

Funding arrangements at full scheme

At full scheme, the State and Territory Governments, excluding Western Australia, will contribute about $9 billion[44] (table 10.1). The Australian Government will contribute the remainder. The fixed funding contributions of each State and Territory are based on the New South Wales fixed contribution of $3133 million in 2018-19 pro-rated, based on census population shares (DSS sub. 146, p. 21).

The Heads of Agreement stipulate that the state and territory contributions will increase at a rate of 3.5 per cent per year, subject to the responses to the recommendations of this study.

Table 10.1 **State and Territory funding commitments in 2019-20**

State or Territory	*Contribution ($ millions)*
New South Wales[a]	3 243
Victoria	2 510
Queensland	2 030
South Australia[a]	748
Tasmania	232
Australian Capital Territory	167
Northern Territory	99
Total[b]	9 029

[a] Not stated directly in Bilateral Agreement, instead a figure of $3133 million is given for 2018-19 which was escalated at 3.5 per cent for the 2019-20 figure. The same calculation was performed for SA where a figure of $723 million is given for their contribution in 2018-19. [b] The total excludes WA's contribution if it joined the national scheme.

Source: Heads of Agreement with each of the State and Territory Governments (except Western Australia).

While arrangements for cost overruns at full scheme are still being finalised, the Australian Government in the Heads of Agreement committed to fund at least 75 per cent of these overruns at full rollout subject to the outcomes of this review (Australian Government and New South Wales Government 2012).

It is evident from the above that funding arrangements are highly complex. Given this complexity, it is essential that comprehensive and timely data from the NDIA be made available to relevant Finance and Treasury departments in all jurisdictions to allow for proper oversight of NDIS costs.

[44] Estimated to be $10.3 billion once agreement with Western Australia is reached.

Sources of NDIS funding

Australian Government funding for the NDIS comes from a number of sources:

- funds redirected from previous Australian Government disability service programs to the NDIS
- funds previously provided to State and Territory Governments under the National Disability Agreement and the 2011 National Health Reform Agreement
- a 0.5 percentage point increase in the Medicare Levy on taxable income which provides funding via the DisabilityCare Australia Fund (DCAF) (box 10.3). Around 75 per cent of the revenue from the DCAF goes to the Australian Government — the remainder is allocated to the State and Territory Governments to partially reimburse their contributions to the NDIS
- debits from the soon-to-be-established NDIS Savings Fund (box 10.3), which will source funding from:
  - an additional 0.5 per cent increase in the Medicare Levy on taxable income (subject to legislative passage)
  - underspends and realised savings from the NDIS (through, for example, changes to budget forecasts reflecting cost saving measures by the NDIA)
  - uncommitted funds from the Building Australia Fund and Education Investment Fund.

State and Territory Government contributions are funded through:

- redirected funding previously used for legacy specialist disability services
- about 25 per cent of the funds available from the DCAF — approximately $825 million from 2014-15. This payment will increase by 3.5 per cent each year until 2023-24 (*DisabilityCare Australia Act 2013* (Cwlth), box 10.3)
- consolidated general State Government revenue.

Box 10.3 The DisabilityCare Australia Fund and the NDIS Savings Fund

The Australian Government increased the Medicare Levy by 0.5 per cent from July 2014-15 to provide funding for the NDIS. The funds from the Medicare Levy are credited to the DisabiltyCare Australia Fund (DCAF) to be invested through the Future Fund to provide payments to the Australian, State and Territory Governments to partially meet their funding obligations for the NDIS.

As set out in the *DisabilityCare Australia Fund Act 2013* (Cwlth), from 2014-15, the State and Territory Governments are entitled to credits of $825 million in funding from the DCAF. This amount will increase at 3.5 per cent each year until 2023-24. Over 10 years (ending 2023-24), State and Territory Governments will have access to a total of $9.7 billion between them, which they can use to partially fund their portion of the NDIS contributions.

State and Territory Governments can draw down from the DCAF when they meet key conditions, including agreement to full scheme and when at least 50 per cent of their eligible population is covered by the scheme. Funds not allocated to State and Territory Governments can be used by the Australian Government to fund its portion of the NDIS.

At 31 December 2016, the DCAF had just over $6 billion in assets.

The DCAF is also to be complemented by the recently announced NDIS Savings Fund. The Australian Government's 2017-18 Budget includes plans to increase the Medicare Levy by (a further) 0.5 per cent which will be credited to a new NDIS Savings Fund (separate from the DCAF) alongside other contributions from underspends on NDIS and recommitting funds from the Building Australia Fund and Education Investment Fund. The increased Medicare levy and creation of the NDIS Savings Fund are subject to legislation passing through parliament.

The NDIS Savings Fund will ring-fence — or hypothecate — revenue specifically for use for the NDIS. These funds will not be made available to the NDIA any sooner than they would if the Australian Government had continued funding their contributions from general consolidated revenue.

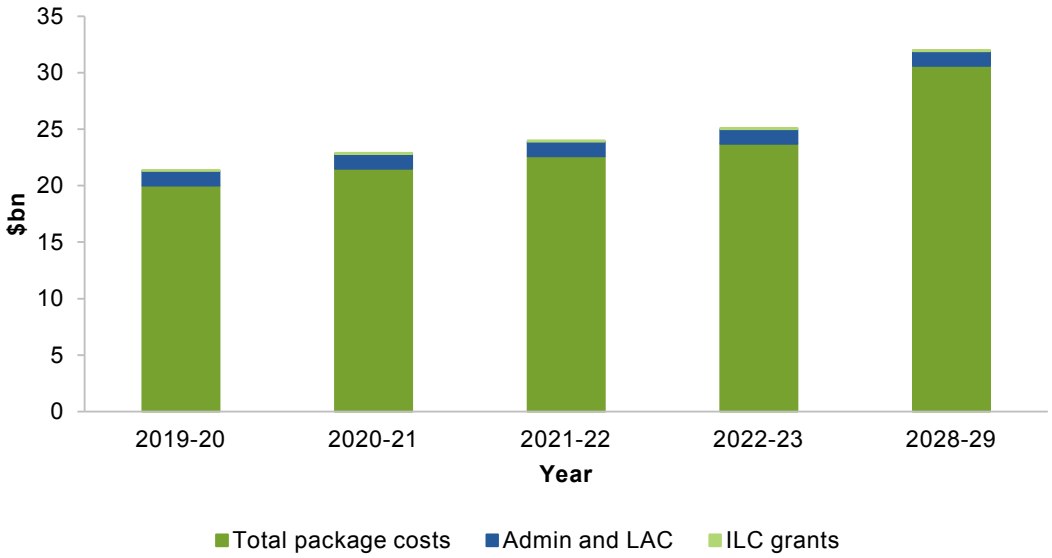
Sources: Australian Government (2012); Australian Treasury (2017c).

The majority of funds are for individualised supports

Individualised support costs make up the majority of the NDIA's funds (around 93 per cent) at full scheme (figure 10.1). The operating budget includes funding for assessment, planning and Local Area Coordination (LAC). The Information, Linkages and Capacity building (ILC) grants program is a separate pillar of the NDIS (Australian Treasury 2017b, p. 140).[45]

[45] ILC will provide information, linkages and referrals to people with disability, their families and carers, with appropriate community and mainstream supports (chapter 5).

Figure 10.1 **Full scheme funding uses over time**[a]



[a] While most chapters in this report use modelling based on NDIA models and data, this chapter uses a funding and costs model provided by the Department of Social Services (DSS). The DSS model is more fit for purpose (than an actuarial model) to examine matters about NDIS costs and funding shares by the Australian, State and Territory Governments. Accordingly, there is a small difference in total scheme costs in this chapter compared to other chapters, reflecting the different purposes of the models and the periods of data used.

Source: Estimates provided by the DSS (sub. 146, p. 17) based on MYEFO 2016-17 data.

10.2 Creating the right incentives in a federal system

As discussed above, Bilateral Agreements define the boundaries of Australian and State and Territory Government responsibility. This section discusses some issues arising out of the interface between Australian and State and Territory Government responsibilities, including:

- escalation parameters
- how any potential large changes to scheme costs might be addressed in the allocation of funding
- how cost overruns are funded and who has control over them.

Escalation parameters and funding shares

As the NDIS is designed to be a no-fault scheme that covers the entire population, the contributions of governments to the NDIS can be thought of as an insurance premium paid by individuals through their taxes. At full scheme, the Australian Government will

contribute an 'insurance premium' to the NDIA on behalf of the citizens in each state. This premium is calculated based on scheme costs and the number of participants in each state.

As discussed above, the State and Territory Governments contribute a fixed amount which escalates at an agreed rate of 3.5 per cent each year from 2019-20 (table 10.2). The escalation parameters are based on:

- the Consumer Price Index (CPI) (midpoint of the long term CPI target Reserve Bank of Australia range (2.5 per cent)) and
- a long term net population growth of one per cent each year (table 10.2).

Table 10.2 **Projections of the funding split over time**[a]

	2019-20	*2020-21*	*2021-22*	*2022-23*	*2028-29*
	$ billion	$ billion	$ billion	$ billion	$ billion
Gross scheme costs	21.5	22.8	24.0	25.1	32.1
- Participant package costs	20.0	21.5	22.0	23.7	30.6
- ILC block grants	0.1	0.1	0.1	0.1	0.1
- Admin and other	1.3	1.3	1.3	1.3	1.3
Commonwealth contributions	11.1	12.0	12.7	13.5	17.9
- % of gross scheme costs	52	52	53	54	56
State and territory contributions	10.3[b]	10.9	12.2	11.6	14.3
- % of gross scheme costs	48	48	47	46	44

[a] While most chapters in this report use modelling based on NDIA models and data, this chapter uses a funding and costs model provided by the Department of Social Services (DSS). The DSS model is more fit for purpose (than an actuarial model) to examine matters about NDIS costs and funding shares by the Australian, State and Territory Governments. Accordingly, there is a small difference in total scheme costs in this chapter compared to other chapters, reflecting the different purposes of the models and the periods of data used. [b] The $10.3 billion estimate of the contribution from the States and Territories in 2019-20 includes the agreement contributions of the State and Territory Governments (excluding Western Australia), plus the estimated contribution from the Western Australian Government once agreement is reached.

Source: DSS (sub. 146, p. 17).

The Heads of Agreement state that, in the event COAG agrees to revise the escalation parameters (based on the advice of this study), escalation parameters will be revised for the State and Territory Governments. There will also be a review every five years (similar to this review), in order to rebase funding per capita based on Census population figures. The first re-basing is expected to occur from 1 July 2023 based on 2021 Census figures.

The objectives of the escalation parameters

The terms of reference for this study ask the Commission to look at changes in the agreed escalation parameters. This was far from straightforward because there is no clearly stated objective for the escalation parameters in the Heads of Agreement. There are also different views about what escalation parameters should be designed to achieve.

Different views among participants

Some participants were of the view that escalation parameters should be used to maintain real per capita contributions to the NDIS by State and Territory Governments. However, others argued that the parameters should be used to increase contributions in line with changes in scheme costs.

The New South Wales Government, for example, argued that the contributions of State and Territory Governments should not increase in line with changes in scheme costs:

> Unlike other sectors like electricity the NDIS is administered under Commonwealth, not State legislation.
>
> In this context, NSW contributed its full disability funding to the NDIS at 2018-19, namely a fixed $3.2 billion per annum plus escalation (3.5%). This is akin to how the Commonwealth provides Specific Purpose Payments to States for health, education, housing and disability. That is, having made a contribution and defined indexation rate the Commonwealth does not vary its payments based on actual costs.
>
> Currently, States are expected to administer state service systems using Commonwealth and State funds. (sub. 60, pp. 12–13)

The Victorian Government also said:

> Current cost and risk sharing arrangements should be maintained as they reflect the reality that the ability of the states to take on any greater financial risk is severely limited. (sub. 174, p. 23)

However, the NDIA observed that scheme costs are likely to increase by more than the current 3.5 per cent escalation parameters and this will mean that funding shares will change:

> The NDIA can observe that wage inflation and the Equal Remuneration Order (ERO) are likely to result in an increase above 3.5 per cent in the short-term, which will result in a skewing of the contributions. Longer-term assumptions should be set considering wage inflation levels, population growth rates, and efficient prices. (sub. 161, p. 114)

The Department of Social Services (DSS) also said:

> The NDIS is currently estimated to cost in the order of $22 billion once fully rolled out in 2020. Over the medium term, this cost is expected to grow above long-term inflation and population growth trends due to the impact of people ageing over 65 in the Scheme. As a result, the cost of the NDIS is expected to increase to more than $32 billion by 2030, with the Commonwealth

> share roughly half of all costs in the short-term, but growing through time as existing participants turn 65 to around 56 per cent by 2030. (sub. 146, p. 17)

And, while the DSS agreed that in the long term, when the scheme has matured, an escalation rate informed by a small number of key economic parameters would be appropriate, it also argued that in the short to medium term:

> … the escalation rate is unlikely to reflect underlying cost growth in the Scheme. This is because the expansion of the market does not lend itself to long-term growth rates in the near future, and it will take some time for the number of participants aged 65 and over in the scheme to stabilise. Instead, a medium- term escalation rate should be developed that considers known transition variables. (sub. 146, pp. 20-21)

The DSS suggested that a medium-term escalation parameter should take into account scheme cost drivers such as social and community services award wages, market development issues, the impact of early intervention, projected disability prevalence rates and observed growth in similar markets or schemes.

The DSS (sub. 146, p. 21) also suggested that the state contribution escalation parameters should be adjusted to take account of the State and Territory Governments' roles and responsibilities, including the extent to which states support and fund mainstream services.

Different arrangements for funding shares between transition and full scheme

Differences in views about the role of escalation parameters reflect tensions about whether current funding shares of the State and Territory Governments should remain the same or change over time. (Noting that the Australian Government is to fund participants over 65 years, and this alone will mean an increasing share of funding will fall to the Commonwealth).

During transition, state and territory funding shares are explicitly tied to scheme costs — the State and Territory Governments make a contribution towards an agreed reasonable average package cost on a per participant basis for up to a set number of participants. But at full scheme, the State and Territory Governments' funding contributions are fixed (escalating at 3.5 per cent per year), which means if scheme costs increase by more than inflation and population then the states contribution share will decline over time.

Some stakeholders suggested to the Commission that escalation parameters should be used, in lieu of adjusting the way funding shares are calculated, to ensure that State and Territory Government contributions increase in line with scheme costs.

The objectives need to be clearer

The way initial funding contributions are calculated and how they increase over time are key determinants of the division of funding responsibilities between the Australian and

State and Territory Governments. (Responsibility for cost overruns and underspends are the other key levers, discussed below.)

The threshold issue for designing the escalation parameters is whether or not State and Territory Government contributions at full scheme and beyond should be designed to keep pace with scheme costs, or simply maintain existing real per capita contributions. The New South Wales Government noted that it did not commit to meeting scheme costs:

> NSW's disability funding was our contribution towards the NDIS, not a commitment to meet actual costs or activity levels as the scheme evolved. This is clear in paragraphs 15 and 16 of the Heads of Agreement between the Commonwealth and NSW Governments. (sub. 60, p. 13)

One argument in favour of State and Territory Governments contributions not increasing in line with scheme costs over time is that they rely on less efficient tax bases and have more limited ability to raise funds than the Australian Government.

However, the Commission also notes that the DCAF is designed to partially fund State and Territory Government contributions via the Medicare Levy, which is administered by the Australian Government. As discussed in box 10.3, the State and Territory Governments will be entitled to $825 million from the DCAF from 2014-15, but are not guaranteed access before 2023-24. This arrangement could overcome inefficiencies in relying more on state tax bases, but it is due to expire after ten years.

If it is agreed that State and Territory Government contributions should keep pace with scheme costs, there are two ways to achieve this.

The first is to rework the way State and Territory Governments' funding shares are calculated, so that they are adjusted over time to explicitly reflect scheme costs. If state and territory funding shares were calculated to explicitly reflect scheme costs over time then the escalation parameters should be calculated to maintain these shares on a constant real per capita basis over time. It is worth noting that the existing escalation parameters of 3.5 per cent per annum seems to be on the lower bound of estimates that would achieve this (box 10.4).

The alternative approach is to leave the State and Territory Governments' funding shares at full scheme as they are and use the escalation parameters to increase state and territory government contributions in line with scheme costs.

This would require the escalation parameters to be calculated using additional variables to account for cost drivers over time. As noted above, the DSS (sub. 146, p. 21) suggested a number of potential cost drivers, including social and community services award wages, market development issues, the impact of early intervention, projected disability prevalence rates and observed growth in similar markets or schemes.

Box 10.4 Different assumptions lead to different escalation parameters

Using recent history as a guide, the low inflation of recent years could imply the agreed escalation parameters of 3.5 per cent seem reasonable. However, the Reserve Bank of Australia expects inflation to return to its range of 2-3 per cent by 2019-20 and the Australian Bureau of Statistics have previously projected population growth to be higher than one per cent well into mid-century. On this basis, escalation parameters in the range of 3.3 per cent to 4.8 per cent (midpoint of about 4 per cent) seem more appropriate than the current 3.5 per cent.

Any changes to the escalation parameters applied to State and Territory Government contributions towards the National Disability Insurance Scheme (NDIS) should also be applied to other NDIS funding factors linked to the escalation parameters — that is, State and Territory Government receipts from the DisabilityCare Australia Fund and the Australian Governments' planned contribution towards WA NDIS post 2020. This would require legislative change.

	Population	*Inflation*	*Implied escalation parameter*[a]
Historical 10 year average annual growth (Sept 2007 to 2016)	1.66	2.36	4.02
Historical 3 year average annual growth (Sep 2014 to 2016)	1.43	1.70	3.13
Medium-term projections (June 2020 to 2023)[b]	1.31-1.83	2-3	3.31-4.83 (midpoint of 4.07)
Long-term projections	1.00	2.50	3.50

[a] Sum of population growth and inflation. [b] The Australian Bureau of Statistics projections have three different scenarios to project population growth. The numbers presented here are the range implied by their estimates.

Sources: ABS (*Australian Demographic Statistics, Sep 2016*, Cat. no. 3101.0; *Consumer Price Index, Australia, Mar 2017*, Cat. no. 6401.0; *Population Projections, Australia, 2012 (base) to 2101*, Cat. no. 3222.0); RBA (2017).

If escalation parameters were used to maintain the State and Territory Governments' funding shares, it would also be necessary to review them periodically. This is because it may be difficult to sufficiently capture all the variables that would maintain the underlying funding shares over an extended period.

Finally, even though funding shares are subject to a five yearly review, reassessing financial contributions every five years does not allow the funding arrangements to be agile enough to address sudden shocks to scheme costs. This could be problematic if any such shocks had significant implications for the financial sustainability of the NDIS. For example, if there was an unforeseen sudden structural shift in labour markets that caused wages and, as a result, package costs to increase, then under transitional arrangements the Australian Government would bear the entirety of this cost until the next five yearly review. Quickly adjusting Bilateral Agreements is not a feasible option in this instance.

One option (considered below) is to allow the NDIA to retain significant reserves. This would allow them to keep windfalls from underspends for later use if there are sudden overruns and so reduce the need for external funding of overruns.

The Commission seeks more information on these issues.

DRAFT FINDING 10.1

The objective of the escalation parameters is not specified in the Bilateral Agreements between the Australian Government and the State and Territory Governments at full scheme.

The existing escalation parameters are unlikely to reflect the full increase in National Disability Insurance Scheme (NDIS) costs over time, which would result in the Australian Government bearing a higher share of NDIS costs over time.

INFORMATION REQUEST 10.1

The Commission is seeking views on the role of the escalation parameters in the Bilateral Agreements between the Australian Government and the State and Territory Governments.

Should escalation parameters be set on the basis of maintaining a constant real per capita contribution to the National Disability Insurance Scheme by State and Territory Governments; or should they be more explicitly tied to scheme costs so that the proportion of funding allocated to the Australian Government and the State and Territory Governments is maintained over time?

Any changes to state and territory funding shares will affect a number of issues discussed in the remainder of this chapter (and in chapter 5), including:

- the level of participation by State and Territory Governments in the scheme's implementation and governance and the implied incentives to fund mainstream services and disability services outside the NDIS
- the incentives for the Australian Government to manage NDIS cost overruns
- how cost overruns are treated in the absence of agreed package costs and participant numbers.

These factors should also be taken into account in considering reallocation of state and territory funding shares and escalation parameters.

Cost overruns: Aligning risk and responsibility

Good risk management requires those who are best placed to manage the risk have responsibility for it. This implies that arrangements for funding cost overruns should be aligned with the ability to control them. This is not the case in the transition period, because the Australian Government bears full responsibility for cost overruns while not having complete control over the factors that contribute to these cost overruns. Two important factors affecting costs that the Australian Government does not have control over are:

- the impact of governance arrangements over NDIS scheme costs such as those contained in the NDIS Rules (box 9.2) or the processes for appointing NDIA Board members
- provision of mainstream services and their interface with the NDIS (chapter 5).

Mainstream services are within the control of the State and Territory Governments. NDIA governance arrangements — such as changing certain NDIS Rules and changing the NDIA Board — require unanimous support from the State and Territory Governments, limiting the ability of the Australian Government to control costs.

There are two options to redress this misalignment — changing the governance arrangements of the NDIS to give the Australian Government more control over cost overruns, or giving the State and Territory Governments some responsibility for cost overruns to reduce their potential incentives to cost shift from mainstream and other disability services outside the NDIS. These options may not be mutually exclusive, given they address different cost control levers.

DRAFT FINDING 10.2

Responsibility for funding National Disability Insurance Scheme (NDIS) cost overruns should be apportioned according to the parties best able to manage the risk. This is not the case in the transition period, as the Australian Government bears all the risk of any cost overruns, but not all the control.

The governance arrangements for the NDIS do not allow the National Disability Insurance Agency to respond swiftly when factors outside its control threaten to impose cost overruns.

Governance and funding arrangements are critical in defining federal-state responsibilities. And incentive issues will exist as long as multiple levels of government have the responsibility for delivering disability and mainstream services.

Giving the states more responsibility for cost overruns

One option is to give the State and Territory Governments more responsibility for NDIS cost overruns. This could reduce incentives to cost-shift from mainstream services to the

NDIS. Incentives to cost-shift under current arrangements were raised as a concern by some study participants. Physical Disabilities Australia, for example, said:

> PDA does not believe the current funding arrangements between the Commonwealth and the State and Territory Governments secure the NDIS' future. Instead, we believe they will threaten the Scheme's viability. Whilst the funding commitments are shared in this way, politicians at all levels will continue to threaten the Scheme's future by claiming the other entities 'aren't paying their fair share' or are 'exploiting [their jurisdiction's] better run economy'. (sub. 38, p. 17)

If cost overruns were to be reallocated, ideally they would be apportioned by calculating the proportion of control over cost overruns held by State and Territory Governments, and the proportion that the Australian Government controls, and allocating responsibility for cost overruns accordingly. As the NT Government said:

> NDIS governance and administrative arrangements post full Scheme should acknowledge the long term shared responsibility and investment of the Commonwealth, states, territories and the NDIA in achieving outcomes, in terms of both service delivery and financial risk. (sub. 205, p. 3)

While it is difficult to calculate such shares accurately, given the State and Territory Governments' responsibility for providing mainstream services (and some disability services), they should bear a share of cost overruns that is significant enough to mitigate any incentives to cost shift onto the NDIS.

Suggestions from participants were that between 25 and 50 per cent of the cost overruns should be borne by the states. Richard Madden, for example, said:

> A minimum of 25% State and Territory share of cost overruns would seem appropriate having regard to the impact of mainstream service provision. (sub. 101, p. 5)

The DSS suggested that the State and Territory Governments need to bear around half of cost overruns:

> Full Scheme risk sharing arrangements need to be equal until the Scheme matures, and this will require State governments to bear 50 per cent of the risk. To manage Scheme risks, agile and streamlined governance is needed, with more control going to those governments that bear the most risk — currently the Commonwealth Government bears full risk. (sub. 146, p. 33)

Decisions about the allocation of cost overruns should also take into account incentives or levers that the Australian Government might have to cost shift to the states. There are currently safeguards against such behaviour (including the requirement for unanimous agreement to make substantive changes to the scheme through the NDIS Rules, adjusting the NDIA Board membership or giving the NDIA specific directives, chapter 9). However, any increase in the cost overruns assigned to the State and Territory Governments should be considered in combination with their governance role.

Giving the Australian Government more control over governance arrangements

There are two changes to governance arrangements that could be made.

One option is to relax the governance arrangements of the NDIS that require unanimous agreement of the Australian, State and Territory Governments to change the NDIS Rules (chapter 9) on the basis that the Australian Government is responsible for cost overruns. As discussed in chapter 9, there could also be operational benefits for the NDIA from taking a more flexible approach to rule changes — including reducing the time taken to make operational decisions, or responding to emerging pressures.

However, the NDIS is not a scheme that operates in isolation — the State and Territory Governments have responsibility for funding mainstream services. The scope of the NDIS (determined by the eligibility requirements set out in the Rules) can also affect the costs borne by the State and Territory Governments. It is therefore important that the State and Territory Governments have some control over changes to the Rules.

Another option is to allow the Australian Government to have a greater influence over the composition of the Board of the NDIA. But again, for incentives to be aligned, the State and Territory Governments should play a role in Board member appointments to the extent that the Board's management of the Agency affects mainstream and non-NDIS disability services. Some stakeholders echoed these concerns. For example, the Victorian Government argued that:

> The states must be part of any decision-making process that determines what will be funded under the NDIS. Given the critical interface between the NDIS and state-funded mainstream services, Victoria considers these arrangements as a necessary safeguard against decisions about the scheme's scope which could result in a significant transfer of costs and risks to state-funded services, and poor outcomes for people with a disability. (sub. 174, p. 22)

A number of options could potentially strike a balance between giving the Australian Government more control over governance while still allowing the State and Territory Governments to have a significant say in the operation of the NDIS. For changes to the Rules, these options could include: a requirement for majority rather than unanimous agreement (including the Commonwealth); relaxing the formalities required to reach agreement to speed up the process; or having a mechanism that lets the majority (including the Commonwealth) be the deciding vote if agreement is delayed past a certain time limit. The Commission is seeking feedback on possible options for reforming governance that achieve this objective.

INFORMATION REQUEST 10.2

The Commission is seeking information on the best way to align the ability to control cost overruns with the liability to fund cost overruns. Possible options include:

- *estimating the proportion of cost overruns that the Australian and State and Territory Governments are responsible for and allocating funding responsibility accordingly*
- *altering the governance arrangements of the National Disability Insurance Scheme to give the Australian Government greater authority to manage the risk of cost overruns, to better reflect their funding liability.*

However, there are no easy answers to reforming funding and governance arrangements, as changes to governance also affect the operation of the NDIA itself. This is discussed further in the next section.

Arrangements in Western Australia

As discussed above, the Western Australian Government has agreed to bear the majority of the cost overruns in the transition to the WA NDIS, with the Australian Government agreeing to contribute no more than 25 per cent over the transition.

Given the role the Western Australian Government has in managing and implementing the WA scheme, it is reasonable for the State Government to bear greater risk.[46] However, Western Australia's separate management of the scheme also poses risks to national consistency of the NDIS (chapter 9).

Should the Western Australian Government choose to join the national scheme, the Commission considers the risk-sharing arrangements between the Australian and Western Australian Governments should be aligned in accordance with the principles applied for the rest of the NDIS.

10.3 Funding an insurance scheme

While the NDIS is an insurance-based scheme, the way the funding and governance arrangements are designed means that it departs from the principles applying to an insurance scheme in a number of areas. As discussed above, the NDIA does not determine its own funding envelope, and as discussed in chapter 9, COAG controls the NDIS scheme's Rules.

46 The WA NDIS Authority, although a Western Australian Government agency, will be governed by an independent Board of seven, with four of the members (including the chair) appointed by the Western Australian Government and the Australian Government appointing the remainder (Australian Government and Western Australian Government 2017).

The NDIA's capped operating costs

At full scheme, the NDIA's operating costs will be capped at 7 per cent of package costs each year. While operating costs made up 33 per cent of scheme costs in 2016, over the transition to full scheme (in 2019-20), this will decrease to a capped 7 per cent target (NDIA 2016g, p. 109).

The 7 per cent operating cost target is similar to that recommended by the Commission in 2011 (PC 2011, p. 776). However, the Commission did not recommend a hard cap. Also, while it was expected that the NDIA would require a workforce of about 10 000 people to deliver the NDIS at full scheme, the NDIA has a full scheme cap of 3000 directly employed staff. The other 7000 people will be outsourced to partner organisations (DSS, sub. 146, p. 24).

The rationale for capping the operating expenses of the NDIA appears to be to encourage administrative efficiencies, and the rationale for the staff cap to encourage the NDIA to enter into community partnerships. The DSS (sub. 146, p. 24) commented that that the 7 per cent cap was 'an aspirational approach designed to encourage best practice and efficient operations'.

However, capping operating expenses could have perverse outcomes in practice.

First, as noted in the NDIA's Annual Sustainability Report, the risks to the scheme's sustainability from the setting of operating expense budgets are clearly asymmetric:

> It is worth noting that a 10% increase in the operating budget may result in additional expenditure of approximately $150 million at full scheme, however an increase in package costs of 10% could result in an additional $2 billion at full scheme (NDIA 2016b, p. 56).

If the NDIA's operating budget is set too tightly, this could hinder its ability to contain package costs (through upfront investments in ICT, LACs, assessors and planners) which could in turn have a significant effect on package costs and scheme sustainability.

A number of study participants argued that the 7 per cent cap is too low (for example, ABF, sub. 48; PDCN, sub. 29; Sotica, sub. 67) and that it is below typical insurance scheme benchmarks.

The Commission notes that achieving a 7 per cent target by full scheme requires the NDIA to cut operating expenditure by 18 per cent ($250 million) between 2018-19 and 2019-20. This seems highly ambitious (box 10.5) without jeopardising the quality of individualised supports (chapter 4).

However, the NDIA (sub. 161, p. 110) said that it expects it can meet the 7 per cent operating cost target at full scheme and effectively manage the NDIS. But, it argued for greater flexibility in its operating costs budget to account for year-to-year fluctuations in operating expenses.

The Commission notes that comparable, more mature schemes operate close to a 7 per cent average, but have significant fluctuations in their annual operating expenses as a proportion of their overall expenses (box 10.5).

Box 10.5 Operating expenses of the NDIA and comparable schemes

NDIS expenses by category

	2015-16 (actual)	*2016-17 (actual)*	*2017-18 (projections)*	*2018-19 (projections)*	*2019-20 (projections)*	*2020-21 (projections)*
Package costs ($m)	859.9	2 973.0	8 045.1	14 267.1	17 855.8	19 165.5
ILC ($m)	10.7	33.3	68.9	105.3	119.3	118.6
Operating expenses ($m)	301.2	704.9	1 033.0	1 393.9	1 143.9	1 096.2
Total scheme costs ($m) [a]	1 171.7	3 711.2	9 147.0	15 766.2	19 119.1	20 380.3
Operating expense ratio (%)[b]	35	24	13	10	6	6

[a] The total cost of the scheme in the budget papers used in this table is less than the $22 billion figure quoted elsewhere because it does not include WA. Elsewhere in this report, estimates are made on the basis of WA being part of the national scheme. [b] The expense ratios differ from NDIA targets and estimates because the NDIA and the Department of Social Services use slightly different projections of scheme costs.

Operating expense ratios[c] of comparable schemes (per cent)

	2010-11	*2011-12*	*2012-13*	*2013-14*	*2014-15*	*2015-16*	*Average*
NZ Accident Compensation Corporation	11.9	6.0	22.9	11.1	7.4	4.9	8.1
NSW Lifetime Care and Support[d]	2.0	3.6	3.6	3.6	4.0	8.4	3.3
VIC Transport Accident Commission	8.5	4.6	11.7	7.4	6.0	4.8	6.4
Disability Care and Support Nationwide	7.6	7.4	6.6	6.5	6.2	6.4	6.8

[c] The ratio of average operating expenses between 2010-11 to 2015-16 to the average total expenses over the same period. [d] The figure for 2015-16 comes from very different reporting standards so may not be comparable with previous years. Further, the number was given in the annual reports without any information about how it was calculated. For this reason it was excluded from the average.

Sources: Accident Compensation Corporation (2011, 2012, 2013, 2014, 2015, 2016); Australian Treasury (2016a, 2017b); Lifetime Care and Support Authority (2011, 2012, 2013, 2014, 2015, 2016); SCRGSP (2016, 2017); and Transport Accident Commission (2011, 2012, 2013, 2014, 2015, 2016).

While the Commission understands the need to create incentives for administrative efficiencies, a hard cap for operating expenses enforced year in, year out does not align with the way an insurance scheme operates. Greater flexibility (including setting an operating budget that sits within a funding target) would allow investments to be made that reduce lifetime costs (for instance, investing in LACs early on to increase participant capacity and readiness which could lower costs in the long-term).

One way to balance flexibility with accountability would be to allow a target range for operating expenses, with the expectation that the Agency would sit at the bottom of this target on average. This would allow the NDIA some flexibility to smooth out year-to-year fluctuations in spending while also placing some limits on administrative spending.

Based on comparable schemes (box 10.5), a target of 7 to 10 per cent appears to be reasonable. Should the NDIA exceed this in a particular year, they should be required to publicly report the reasons why.

DRAFT RECOMMENDATION 10.1

At full scheme, the annual operating budget for the National Disability Insurance Agency should be set within a funding target of 7-10 per cent of package costs with the expectation that, on average, it would sit at the lower end of the band.

The National Disability Insurance Agency should be required, in its annual report, to state reasons why it has not met this target in any given year.

A similar rationale applies to allowing more flexibility around the current staff cap of 3000 people. Because of the cap, the NDIA needs to outsource much of its work. This presents a particular risk when the agency is so new, and therefore needs to build institutional expertise and knowledge.

However, the Commission understands there may be practical limitations to implementing any changes to the staff cap, given the Australian Government's Smaller Government agenda.

DRAFT RECOMMENDATION 10.2

The Australian Government should reconsider the staffing cap on the National Disability Insurance Agency, given the importance of developing internal capability and expertise.

Lack of flexibility in how funds are used

As discussed above, the funds received by the NDIA are allocated to three streams:

- participant supports
- Information, Linkage and Capacity Building grants (chapter 5)
- operating costs (which includes LACs, and 20 per cent of LAC funding is allocated to ILC activities) (NDIA, sub. 161, p. 13).[47]

[47] At full scheme, the Heads of Agreement state that: State and Territory Government funding will pay for participant supports, defined as: individualised support packages for scheme participants, and Local Area Coordinators and other general supports as defined by section 13(2) of the *National Disability Insurance*

Australian Government entities receive their budget in two allocations: one allocation for operating expenses, and a separate allocation for program delivery, divided into different streams (Department of Finance, nd).

Some participants to this study argued that the NDIA should be given more flexibility in how it allocates its funds. For instance, the NDIA commented:

> The funding model of the NDIS quarantines funds that have been provided to the NDIA for reasonable and necessary supports so that they cannot be used for any other purpose. The effect of this in relation to ILC is that, irrespective of the insurance approach and any potential savings to package costs from ILC, funding is strictly limited to what has been made available for operating costs.
>
> This strict split of funding constrains the NDIA's ability to manage Scheme costs by investing in community based activities that may lower the demand for individual packages. (sub. 161, p. 55)

The DSS also expressed a desire for flexibility to be considered as an option to enhance the Agency's insurance approach:

> The initial PC report recommended a small, fixed amount for ILC, but options could be explored, such as giving the NDIA greater flexibility to invest in ILC if linked to reducing overall Scheme costs via its insurance approach. (sub. 146, p. 31)

Private insurance firms have more flexibility in how they allocate their funding, but they are subject to different transparency and accountability requirements than the NDIA (for instance, more stringent reporting requirements).

The Commission recognises the benefits from having the flexibility to make investments,[48] but a better way to achieve this could be by giving the NDIS access to a pool of reserves (discussed below).

To ensure that ILC grants do not encroach on State and Territory Governments' responsibilities, it is important for State and Territory Governments to be involved in decision making about the scope of these grants.

Limited access to a pool of reserves

The NDIS is currently funded on a mostly pay as you go (PAYG) basis, which means that current taxpayers meet the current obligations of the scheme. In transition, underspends of up to three months' worth of support costs can be retained by the NDIA, with amounts

Scheme Act 2013 (Cwlth). Australian Government funding will pay for all additional participant supports, defined as: individualised support packages for scheme participants, and local area coordinators and other general supports. The Australian Government will also pay all administrative costs for the NDIA.

48 For example, New Zealand's Accident Compensation Corporation invests in programs designed to limit the number of catastrophic accidents in a variety of contexts. Their Board has discretion to undertake such activities within their funding envelope.

over this returned to the particular governments in proportion to their contribution. It is not yet certain what the arrangements will be at full scheme.

Retaining three months of reserves appears suitable for the transition period, where reserve amounts may reflect participants who were expected to transition to the NDIS but have not yet done so (and still remain on pre-NDIS services). Longer term arrangements, once funding has moved to a more stable and certain footing, would ideally allow for greater application of, an insurance approach by making sufficient funds available to allow for upfront investments to reduce outlays in future.

In 2011, the Commission (PC 2011, p. 672) recommended the NDIS be established with a large enough reserve fund to smooth out fluctuations and reduce uncertainty. The Commission continues to endorse this approach of having access to a pool of reserves in the longer term.

Providing a substantial pool of reserves has the advantage of providing greater certainty to participants and providers that the scheme will be enduring, enabling them to make long-term decisions (for example, cost pressures will be reduced if people feel they are able to leave the NDIS, knowing that it will be there in the future should they need to return). Absent a pool of reserves, the PAYG arrangement alone more closely resembles a welfare system, as funds are lacking for future looking investments.

In the longer term, the level of reserves should reflect the level of risk that the NDIA is able to manage. In 2011, the Commission suggested that the level of reserves should be determined by:

- partially funding new entrants for the scheme while also collecting enough revenue on a PAYG basis to fund the reasonable and necessary supports for existing participants or
- making an actuarial and economic determination of optimal reserves (PC 2011, pp. 672-673).

Importantly, reserve money should only be used for investments that allow future benefits to accrue, rather than allowing cross-subsidisation between activities such as increasing the operational costs budget.

The Commission is seeking further feedback on the level of reserves needed to enable the NDIS to operate like an insurance scheme, and the method by which this should be achieved.

The Commission is aware of the potential practical difficulties of establishing a reserve fund in the short term, but is also mindful of the potential long-term benefits of doing so — including enabling the NDIS to operate like an insurance scheme not a welfare scheme, and providing certainty in funding that insulates it against the vagaries of year to year budget funding.

One way of building up reserves could be to, each year, redirect a set proportion of the unspent money to a reserve fund, instead of returning it to the Australian and State and Territory Governments (effectively removing the NDIA's cash ceiling). The Commission is seeking feedback on the best way to implement an increased reserve requirement.

INFORMATION REQUEST 10.3

The Commission seeks feedback on the level of a future contingency reserve that would enable the National Disability Insurance Agency to operate like an insurance scheme, and how this would best be implemented, including any transitional arrangements.

10.4 In-kind support

A necessary part of the transition period …

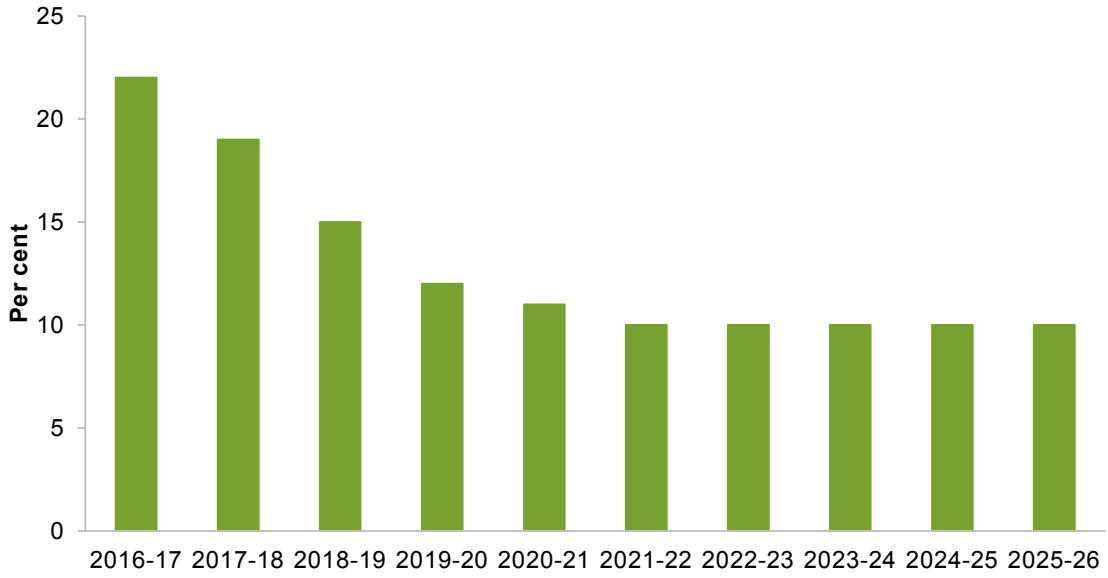
Prior to the NDIS, Australian, State and Territory Governments paid providers to deliver supports to people with disability. This meant that in July 2016 when the transition to full scheme began, governments had in place contracts with existing providers, or had previously made capital investments (like large residential centres or group homes: DSS, sub. 146, p. 22).

Because of these prior arrangements, State and Territory Governments are able to provide 'in kind' services (that is, they can transfer already funded disability supports used by NDIS participants) to the NDIA in lieu of cash contributions towards their funding commitments.

In practice, what this means for scheme participants is that supports in their plans are described specifically as having to be provided by a particular provider (that is, the provider engaged through in-kind arrangements).

In transition, in-kind contributions will account for about 19 per cent of total package costs, and about 10 per cent at the commencement of full scheme (figure 10.2). Over time, and as the assets age, the expectation, as stated in the intergovernmental agreements, is that in-kind contributions will be phased out. According to the DSS (sub. 146, p. 22), all governments are reviewing their in-kind contributions with a view to *minimising* them at full scheme, but 'this is uncertain'.

Figure 10.2 **In-kind supports as a percentage of total package costs**



Source: DSS (sub. 146, p. 23).

… but they reduce choice, increase scheme costs and delay market responses

In-kind contributions reduce choice for participants and, if they are provided at prices above market prices, they can increase scheme costs. A number of study participants pointed out that in-kind contributions undermine the core objectives of the NDIS. The DSS, for example, said:

> The provision of government in-kind contributions as part of NDIS support packages not only reduces participant choice, as in-kind supports must be used to enable the NDIS to be delivered within budget, but adds financial pressure as in-kind contributions are based on current costs to government as opposed to a market-driven efficient price. If maintained, there is a risk inefficient costs from legacy systems will be transferred to the NDIS (sub. 146, p. 21).

Lifestyle in Supported Accommodation commented:

> So much for participant 'choice and control' and 'self managing'. This [in-kind supports] is little different from block-funding. (sub. 3b, p. 2)

Bruce Bonyhady also said that in-kind arrangements:

> … are not consistent with a contestable or competitive market, because they limit control and choice and also lock-in old-style standards and prices above the efficient price (sub. 100, p. 9).

As noted above, in-kind contributions have to be used by participants (*National Disability Insurance Scheme (Plan Management) Rules 2013* (Cwlth) rr. 6.8-6.9) — there is no

ability to opt-out and choose another provider. To the extent that participants would choose another provider if they could, this limits choice.

In-kind contributions may also be of a lower quality than other supports that are more competitively provided. Because providers of in-kind supports do not need to compete for customers there is less incentive to improve the quality and reduce the cost of their services than under more competitive conditions. The NDIA (sub. 161, p. 47) said that one of the challenges to scheme sustainability caused by in-kind supports is they do not encourage innovation.

In-kind supports can also delay market transformation, and the move from a block funded model to a fee-for-service model is a major factor in provider readiness (chapter 6).

And they can result in two-tier pricing, with some participants receiving a higher priced support that is subject to less competition than other participants.

In-kind contributions should be phased out

The Commission recommends that in-kind supports be phased out by the end of the transition period. The NDIS is about developing a functioning disability care and support market that is responsive to the needs of participants and dynamically improves efficiency. The continuation of in-kind arrangements delays the development of such a market.

If in-kind supports are continued into full scheme this would effectively be cost shifting from the State and Territory Governments (who make up the largest share of in-kind contributions) to the Australian Government as well as cost shifting from State and Territory Governments with a large portion of funding provided in-kind to those that do not. As the NDIA put it:

> In-kind is higher than the notional prices, and at present the States and Territories do not carry the financial risk associated with resulting higher package costs. (sub. 161, p. 113)

If in-kind contributions continue beyond transition, jurisdictions should face a financial penalty for doing so.

DRAFT RECOMMENDATION 10.3

In-kind funding arrangements should be phased out by the end of transition and should not form part of the intergovernmental agreements for full scheme funding. Should in-kind funding persist beyond transition, jurisdictions should face a financial penalty for doing so.

A Conduct of the study

The Commission received the terms of reference for this study on 20 January 2017. It subsequently released an issues paper on 22 February 2017 inviting public submissions and highlighting particular matters on which it sought information.

In total, the study received 206 submissions (table A.1). The study also received brief submissions online, including those collected by the organisation Every Australian Counts. All public submissions have been placed on the study's website.

During the study, the Commission held consultations with people with disability, advocacy groups, peak bodies, service providers, disability care and support workers, and government departments and agencies (table A.2).

The Commission thanks all those who contributed to this study.

Data and information

The Commission acknowledges the assistance of the:

- National Disability Insurance Agency in providing unpublished data and information to the study, and allocating a staff member to spend several days in the Commission's Canberra office to provide feedback on analysis conducted by the study. Any errors in the analysis of these data and information in this paper are attributable to the Commission.
- Department of Social Services in providing unpublished data and information to the study.

This paper uses the National Centre for Vocational Education Research's data on vocational education outcomes (VOCSTATS). These data are collected by registered training organisations and state training authorities around Australia. The National Centre for Vocational Education Research is not responsible for errors in the extraction, analysis or interpretation of the data presented herein.

Table A.1 **Public Submissions**[a]

Participant	*Submission number(s)*	
Ability First Australia	62	#
The Able Movement	109	
ACT Council of Social Service	138	
ACT Disability, Aged and Carer Advocacy Service (ADACAS)	87	
ACT Government	156	#
AEIOU Foundation	32	#
Allianz Australia Insurance	42	
Allied Health Professions Australia (AHPA)	37	
Alzheimer's Australia	10	
Amaze	160	
Anglicare Australia	157	#
Anglicare Tasmania	145	#
Annecto	34	
Assistive Technology Suppliers Australasia (ATSA)	33	
Attendant Care Industry Association (ACIA)	141	
Australasian Podiatry Council	52	
Australian Association of Social Workers (AASW)	124	
Australian Blindness Forum (ABF)	48	
The Australian Centre for Social Innovation (TACSI)	65	#
Australian Federation of Disability Organisations (AFDO)	180	
Australian Lawyers Alliance (ALA)	54	
Australian Medical Association (AMA)	120	
Australian Orthotic Prosthetic Association (AOPA)	123	
Australian Physiotherapy Association (APA)	93	
Australian Psychological Society (APS)	19	
Australian Rehabilitation Providers Association (ARPA)	28	
Australian Services Union (ASU)	154	
Australian Services Union (ASU) and Disabled People's Organisations (DPO) Australia	198	
Australian Unity	173	
Autism Aspergers Advocacy Australia	178	
Barnardos Australia	85	
Belconnen Community Service Board	39	
Better Caring	184	
Blind Citizens Australia	130	
Bonyhady, Bruce	100	
Boyle, Michael	27	
Brain Injury SA	116	
Bravo Ability Service	96	#
Broken Rites	204	
Brotherhood of St Laurence	189	*
Burrows, Matt	7	
Bus Association Victoria (BusVic)	1	

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Table A.1 (continued)

Participants	*Submission number(s)*	
Business Council of Co-operatives and Mutuals	91	
Butterfly Foundation	78	#
Calvary Health Care Bethlehem	64	
Capricorn Community Development Association (CCDA)	142	
Carers Australia	195	
Carers Australia Victoria	131	
Catholic Social Services Australia	166	
Centacare Brisbane	44	
Centre for Disability Research and Policy	40, 55	
Centre for Disability Studies (CDS)	43, 49	#
Centre of Research Excellence in Disability and Health	69	
Cerebral Palsy Alliance	163	#
Children and Young People with Disability Australia (CYDA)	188	
Cohealth	50	
Commonwealth Ombudsman	137	#*
Communication Rights Australia, Disability Discrimination Legal Service and Villamanta Disability Rights Legal Service	88	#
Community and Public Sector Union (CPSU)	76	
Community Mental Health Australia (CMHA)	11	
Community Services Industry Alliance (CSIA)	77	
Companion House	84	
Condren, James	66	
Curley, Tricia	140	
DARE Disability Support	182	
Deaf Australia	183	
Deafness Forum of Australia	127	
Department of Health (DoH)	175	
Department of Social Services (DSS)	146	
Dietitians Association of Australia (DAA)	119	
Disability Services Australia (DSA)	9	#*
Disability Services Commissioner	35	
Disabled People's Organisations (DPO) Australia	165	
Down Syndrome Australia	121	
Dowse, Leanne; Paterson, Melinda; and Sprange, Mike	114	
DUO Services Australia	196	
Early Childhood Intervention Australia NSW/ACT	190	
Early Childhood Intervention Australia Victoria/Tasmania	129	
Endeavour Foundation	202	
Epic Employment Service	70	
Ethnic Communities' Council of Victoria (ECCV)	31	
Every Australian Counts	92	
Everyday Independence	133	
Fanning, Vanessa	21	#

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Table A.1 (continued)

Participants	*Submission number(s)*	
Fear, Ross	103	
Financial Services Council (FSC)	98	#*
Flourish Australia	74	
Freedom Key	125	#
Goldfields Individual and Family Support Association (GIFSA)	13	
Health Services Union	132	
Homelife Association	59	
The Hopkins Centre	105	
House with No Steps	104	
Inclusion Australia	185	
Independent Schools Council of Australia (ISCA)	83	
Integra	99	#
Jacqueline Pierce and Associates	147	
Jane, Belinda	80	
Jesuit Social Services	117	
JFA Purple Orange	186	
Jobsupport	191	
Kennedy, Richard	2	
Leadership Plus	128	
Legacy Australia	168	
Lifestart Co-operative	97	
Lifestyle in Supported Accommodation (LISA)	3	#
LINK Community Transport	194	
Lutheran Community Care Queensland	197	
Macarthur Disability Services	57	
Macular Disease Foundation Australia	75	
Madden, Richard	101	
Magarey, Kristy	150	
Mallee Track Health and Community Service (MTHCS)	6	
Maloney, Liza	68	
Mamre Association	47	
Manning, Penny	36	
Martin, Sarah	41	*
Maurice Blackburn Lawyers	58	
McDonnell, Cheryl	79	
Mental Health and NDIS Facebook Support Group	8	
Mental Health Australia	155	#
Mental Health Carers Australia	181	
Mental Health Community Coalition of the ACT	135	
Mental Health Complaints Commissioner	164	
Mental Illness Fellowship of Australia	122	
Milner & Clyde	94	
Mind Australia	144	

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Table A.1 (continued)

Participants	*Submission number(s)*	
MND Australia	45	
Municipal Association of Victoria (MAV)	152	
Name withheld	4	*
Name withheld	5	*
Name withheld	199	*
National Disability Insurance Agency (NDIA)	161	
National Disability Services (NDS)	51	
National Mental Health Commission (NMHC)	153	
NDIS Independent Advisory Council	149	
Neami National	63	
Nelson, Fergus	17	
Neurological Alliance Australia (NAA)	30	
New South Wales Government	60	
Noah's Ark	108	
Northern Territory Government	205	
NSW Council for Intellectual Disability (NSW CID)	193	
NSW Disability Network Forum	18	
NSW Disability Support Organisations	90	#*
Occupational Therapy Australia (OTA)	15	
Office of the Public Advocate (OPA)	46	
Office of the Public Guardian (OPG)	143	
One Door Mental Health	179	
O'Rourke MP, The Hon. Coralee	106	
Parkin, David	177	
Peterson, Frank Lawrence	148	
Physical Disability Australia (PDA)	38	
Physical Disability Council of NSW (PDCN)	29	
Plan Management Partners	126	
Potapczyk, Hannah	26	
Power Housing Australia	139	
Prader-Willi Syndrome Association of Australia (PWSAA)	112	
Psychiatric Disability Services of Victoria (VICSERV)	169	
Public Health Association of Australia	134	
Public Service Research Group	56	
Queensland Advocacy Incorporated	115	
Read, Suzanne	24	
Regional Development Australia Murraylands and Riverland (RDAMR)	12	
Rehab Co	23	
Roundsquared	170	
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	158	
Royal Australian College of General Practitioners (RACGP)	200	
Royal Institute for Deaf and Blind Children (RIDBC)	95	
Royal Society for the Blind (RSB)	82	#

(continued next page)

Table A.1 (continued)

Participants	*Submission number(s)*	
Morton, James	110	
Scope Australia	72	
SDN Children's Services	73	
Sharing Places	53	
The Shepherd Centre	107	
Sisters Inside	16	
Social Support & Precarious Workforce Research Discussion Group	71	
Sotica	67	#
South Australian Government	203	
Speech Pathology Australia	136	
Spinal Cord Injuries Australia (SCIA)	61	
Summer Foundation	113	
Sylvanvale	192	#*
Syndromes Without A Name (SWAN) Australia	86	
Taggart, Michael	89	
Top End Association for Mental Health (TEAMhealth)	102	
Travellers Aid Australia (TAA)	20	
United Voice	118	
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)	162	
Victorian Council of Social Service (VCOSS)	176	
Victorian Government	174	#
Victorian, Queensland, South Australian and ACT Governments	201	
Victorian Healthcare Association (VHA)	172	
Victorian Mental Illness Awareness Council (VMIAC)	167	
Western Australian Local Government Association (WALGA)	151	
Westhaven Association	81	
Wilson, Tony	14	
Windsor & Associates	171	
Woden Community Service	159	
Women with Disabilities Victoria	111	
Yanga, Anna	22	
YFS Ltd	25	*
Young People In Nursing Homes National Alliance	187	
Zemanek, Elizabeth	206	

a An asterisk (*) indicates that the submission contains confidential material NOT available to the public. A hash (#) indicates that the submission includes attachments.

Table A.2 **Stakeholder consultations**

Participants
ACL Disability Services & Gig Buddies Sydney
APM
Australian Council of Social Service
Australian National Audit Office
Australian Services Union and United Voice workers and organisers
Bonyhady, Bruce
CatholicCare Social Services
Catholic Social Services Australia
Centre for Disability Studies
Cerebral Palsy Alliance
Cohen, Dr Martin
Department of Social Services
Disability Discrimination Commissioner (Alastair McEwin)
Disabled People's Organisations Australia
Fenton, Dr Marc
Firstchance
First Peoples Disability Network
House With No Steps
Integra
Karingal
Kevin Stone from Victorian Advocacy League for Individuals with Disability and five parents of participants
LeapFrog Ability
Lifestart
Marymead
Mental Health Australia
Mental Health Coordinating Council of NSW
National Disability Insurance Agency
National Disability Insurance Agency Board members (Helen Nugent and John Walsh)
National Disability Services
Health and Community Services Union workers and organisers
National Disability Insurance Scheme — Scheme Actuary
People with Disability Australia
Physical Disability Council of NSW
SalvoConnect
Victorian Council of Social Service

(continued next page)

Table A.2 (continued)

Teleconference
Australian Capital Territory Community Services Directorate
Australian Capital Territory Chief Minister, Treasury and Economic Development Directorate
Australian Federation of Disability Organisations
Australian Government Actuary
Australian Services Union
Carers Australia
Children and Young People with Disability Australia
Cross, Rebecca
Hogan, Catherine
Department of Finance
Department of Health
Department of Prime Minister and Cabinet
Department of Social Services
Dyson, Dr Maree
Gilchrist, Prof. David (University of Western Australia)
Health and Community Services Union
Mental Health Australia
National Disability Insurance Agency
National Disability Services
National Institute of Labour Studies, Flinders University
National Mental Health Commission
Northern Territory Department of the Chief Minister
Northern Territory Department of Treasury and Finance
Northern Territory Department of Health
New South Wales Department of Family and Community Services
Knight, Dr Penny (Curtin University)
Queensland Department of Communities, Child Safety and Disability Services
South Australian Department for Communities and Social Inclusion
Tasmanian Department of Education
Tasmanian Department of Health and Human Services
Tasmanian Department of Premier and Cabinet
Tasmanian Department of Treasury and Finance
Victorian Department of Health and Human Services
Victorian Department of Premier and Cabinet
Victorian Treasury
United Voice
Western Australia Disability Services Commission
Young People in Nursing Homes

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