Chapter 5

Market intervention

5.1 As the lead market steward the NDIA are able to take actions that directly influence the marketplace and its development. These include setting prices for NDIS supports, commissioning supports or establishing preferred provider arrangements.

5.2 The first part of the chapter examines pricing under the NDIS and the impacts of current price caps on the development of the market.

5.3 The second part focuses on the issues of thin markets and provider of last resort arrangements. It discusses existing and potential intervention mechanisms which could reduce the occurrence of thin markets.

Pricing of NDIS supports

5.4 Prices are currently regulated by the NDIA, which sets maximum prices ('price caps') for most of the supports provided by NDIA registered providers. The aim is to 'ensure NDIS participants obtain reasonable value from their support packages'.[1]

5.5 The NDIA says it takes into account market risks, when setting price controls to protect against supply gaps and ensure participants receive critical supports.[2] Price controls do not apply for supports purchased by self-managing participants from unregistered providers.[3]

5.6 The NDIA anticipates that prices will be eventually deregulated as the market matures in size and quality.[4]

Independent price-setter

5.7 In the *NDIS Costs Study Report*, the Productivity Commission expressed concern that while the price-setting mechanism is held within the NDIA, there is an incentive for it to be used to offset budget pressures.[5]

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1 NDIS, *NDIS Price Guide Victoria, NSW, QLD, Tasmania*, 1 July 2018, p. 6, https://www.ndis.gov.au/medias/documents/price-guide-nsw-201819-pdf/201819-Price-Guide-VIC-NSW-QLD-TAS.pdf (accessed 29 August 2018)

2 NDIS, *NDIS Price Guide Victoria, NSW, QLD, Tasmania*, 1 July 2018, p. 6, https://www.ndis.gov.au/medias/documents/price-guide-nsw-201819-pdf/201819-Price-Guide-VIC-NSW-QLD-TAS.pdf (accessed 29 August 2018)

3 NDIS, *NDIS Price Guide Victoria, NSW, QLD, Tasmania*, 1 July 2018, p. 7, https://www.ndis.gov.au/medias/documents/price-guide-nsw-201819-pdf/201819-Price-Guide-VIC-NSW-QLD-TAS.pdf (accessed 29 August 2018)

4 NDIA, *Submission 52*, p. 16.

5 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study report*, October 2017, p. 34.

5.8 Some submitters expressed similar concerns and argued that prices should be set primarily to boost market development, not to enable the NDIA to manage the NDIS budget.[6]

5.9 Many inquiry participants are of the view that there is a need for an independent body to regulate prices.[7] For example, the Victorian Government is of the view that 'the establishment of an independent price regulator will give providers and participants certainty and transparency about pricing'.[8]

5.10 Having an independent price regulator would also avoid a potential conflict of interest for the NDIA as it both sets prices and has responsibility for the financial sustainability of the Scheme.[9]

5.11 This echoes the recommendation made by the Productivity Commission, which suggested a staged approach to independent price regulation.

5.12 The Productivity Commission proposed that the Quality and Safeguards Commission (the Commission) first start with monitoring prices set by the NDIA to enhance transparency in the short term. The second stage would transfer the price-setting powers to the Commission in July 2020. In the longer term, it is envisaged that deregulation could occur, but that the Commission would retain a price monitoring role.[10]

5.13 Inquiry participants expressed support for the monitoring and reviewing of price caps by the Commission.[11]

Adequacy of pricing

5.14 The NDIA reviews and updates price caps on at least an annual basis effective 1 July each year, taking account of market trends, changes in costs and wage rates.[12]

5.15 The issue of price caps and adequacy of pricing is not new and has been raised on many occasions, including by past inquiries undertaken by this committee,

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6 See for example: National Disability Services, *Submission 26,* p. 6; Mental Illness Fellowship of Australia, *Submission 39,* p. 17.

7 See for example: Community Mental Health Australia, *Submission 14,* p. 13; The Ella Centre, *Submission 18,* p. 4; National Disability Services, *Submission 26,* p. 6; Aspect, *Submission 27,* p. 3; Maurice Blackburn Lawyers, *Submission 54,* p. 9; People With Disability Australia, *Submission 74,* p. 5; Victorian Council of Social Service, *Submission 81,* p. 15.

8 Victorian Government, *Submission 90,* p. 11.

9 Queensland Government, *Submission 101,* p. 7.

10 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study report,* October 2017, pp. 313-317.

11 See for example: Community Mental Health Australia, *Submission 14,* p. 13; Victorian Government, *Submission 90,* p. 11; People With Disability Australia, *Submission 74,* p. 10.

12 NDIA, *Submission 52,* p. 12.

the NDIA FY2017-18 Price Review, and the Productivity Commission NDIS Costs Study.[13]

5.16 Key issues raised by service providers in relation to pricing included:

- the high level of administrative work that providers undertake as part of the NDIS service delivery is not factored in the NDIS pricing;[14]
- the pricing structure also does not provision of adequate supervision, mentoring and training of staff;[15]
- provider travel cost and time;[16]
- the low pricing for some supports, including some delivered by Allied Health professionals;[17]
- the low pricing to deliver supports to people with complex needs;[18]
- the low pricing to deliver supports in rural and remote areas;[19]

5.17 Overwhelmingly, submitters are of the view that NDIS pricing has been preventing the development of the market, threatening the financial viability of many organisations and leading to providers considering exiting the market.[20]

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13 See for example: McKinsey & Company, *Independent Pricing Review NDIA – Final report*, February 2018, p. 9; Joint Standing Committee on the NDIS inquiry reports: *Provision of services under the NDIS Early Childhood Early Intervention Approach*, 7 December 2017; *Transitional arrangements for the NDIS*, 15 February 2018; *The provision of hearing services under the National Disability Insurance Scheme*, 21 June 2018.

14 See for example: Mr Cris Massis, Chair, Allied Health Professions Australia, *Committee Hansard* , 14 June 2018, p. 32; Disability Council NSW & NSW Carers Advisory Council, *Submission 8*, p. 6; Occupational Therapy Australia, *Submission 46*, p. 8.

15 See for example: Mr Benjamin Keast, CEO, ARC Disability Services, *Committee Hansard*, 14 March 2018, p. 11; Thorndale Foundation, *Submission 16*, p. 3; The Ella Centre, *Submission 18*, p. 2; Queenslanders with Disability Network Ltd, *Submission 48*, p. 9.

16 See for example: MJD Foundation, *Submission 6*, p. 7; Victorian Healthcare Association, *Submission 30*, p. 2; Occupational Therapy Australia, *Submission 46*, p. 7.

17 See for example: Sunnyfield, *Submission 1*, p. 4; Exercise and Sports Science Australia, *Submission 4*, p. 6; One Door, *Submission 13*, p. 4; Australian Orthotic Prosthetic Association, *Submission 35*, p. 3; Merri Health, *Submission 44*, p. 3.

18 See for example: Cara, *Submission 9*, p. 2; National Disability Services, *Submission 26*, p. 6; Mental Health Australia, *Submission 75*, p. 5; Victorian Council of Social Service, *Submission 81*, p. 2.

19 See for example: Catholic Social Services Australia, *Submission 11*, p. 5; Community Mental Health Australia, *Submission 14*, p. 2; NACCHO, *Submission 23*, p. 10; Royal Institute for Deaf & Blind Children, *Submission 33*, p. 6; Enable Western Australia Inc., *Submission 34*, p. 3.

Independent Pricing Review (IPR)

5.18 In June 2017, as a result of the concern expressed by many service providers, the Board of the NDIA commissioned McKinsey & Company (McKinsey & Co) to undertake an Independent Pricing Review (IPR) to investigate the appropriateness of the NDIA's pricing strategy and approach, and the suitability of current price levels.[21]

5.19 In March 2018, the Board of the NDIA released the IPR Report, giving in principle support for all of the Report's 25 recommendations.[22]

5.20 From the 1 July 2018, the NDIA started to implement the first set of recommendations from the IPR. This includes:

- Recommendation 4: providers can now charge up to 45 minutes of travel time in rural areas.
- Recommendation 9: new price caps have been introduced for group supports activities and include an allowance for capital costs.
- Recommendation 10: new price limits have been introduced for short term accommodation.
- Recommendation 14: introduction of a temporary financial relief for providers as they transition their business operations of 2.5 percent loading to support standard intensity attendant care supports.
- Recommendation 15: providers can now charge 90 percent of the service booking price for short notice cancellation, up to a maximum of 12 cancellations per year for core supports and 6 hours per year for therapy.
- Recommendation 16: pricing adjustment for group care arrangements in a centre.
- Recommendation 18: the hourly rate for therapy assistants (level1) has been increased.
- Recommendation 19: the $1000 cap for therapist travel has been removed.
- Recommendation 20: amendment of the cancellation policy for therapy.
- Recommendation 21: providers can now claim time for writing reports requested by the NDIA.[23]

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20 See for example: Catholic Social Services Australia, *Submission 11*, p. 5; DARE Disability Support, *Submission 15*, p. 8; NACCHO, *Submission 23*, p. 10; National Disability Services, *Submission 26*, p. 6; Victorian Healthcare Association, *Submission 30*, p. 2; Merri Health, *Submission 44*, p. 5; Victorian Aboriginal Community Controlled Health Organisation, *Submission 66*, p. 4.

21 McKinsey & Company, *Independent Pricing Review NDIA – Final report*, February 2018, p. 9.

22 NDIS, *Pricing and payment*, https://www.ndis.gov.au/providers/pricing-and-payment.html (accessed 31 August 2018)

23 NDIS, *Independent Price Review Implementation 2018-19*, https://www.ndis.gov.au/news/ipr-implementation-jun18.html (accessed 31 August 2018)

Sector response to some recommendations

5.21 Following the release of the IPR Report, some recommendations were highly criticised by the sector, especially allied health professionals.[24] For example, Occupational Therapy Australia (OTA) believes that the recommendations arising from the review threaten market readiness as well as scheme viability.[25]

5.22 Goldfields Individual & Family Support Association Inc. (GIFSA) is of the view that the IPR 'lacks evidence and the language used is subjective'.[26]

5.23 OTA contended that despite five of the 25 recommendations being highly relevant to allied health providers, none of the major allied health professions were approach for input.[27]

Tiered pricing model

5.24 In particular, the IPR's recommendation proposing the introduction of a tiered pricing model attracted criticism from allied health professionals. Speech Pathology Australia reported that the initial recommendations for tiered pricing did not ease the concerns of its members.[28]

5.25 Ms Rachel Norris, CEO of OTA explained:

> The proposed tier fee structure, with participants being categorised according to the complexity of their condition, is, we contend, unworkable. Neither McKinsey nor the NDIA has so far explained who will determine a participant's complexity or how it will be measured. […] We contend that a flat rate be determined, which is simple and sustainable.[29]

5.26 OTA conducted a survey on the review's recommendations, which clearly showed that many providers would not remain NDIS registered providers if a tiered pricing structure was introduced.[30]

5.27 Therapy Focus also raised concerns about a tiered pricing structure, and further argued that the implementation of the recommendation on therapy price limits would see the viability of therapy providers severely challenged, with market failure becoming a real possibility.[31]

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24 Occupational Therapy, *Submission 46. 1*, p. 2.

25 Ms Norris, CEO, Occupational Therapy Australia, *Committee Hansard*, 14 June 2018, p. 36.

26 Goldfields Individual & Family Support Association Inc., *Submission 3.1*, p. 2.

27 Occupational Therapy, *Submission 46. 1*, p. 2. And see also: Mr Massis, Chair, Allied Health Professions Australia, *Committee Hansard*, 14 June 2018, p. 32; Mrs Andrea Douglas, Professional Adviser, NDIS, Occupational Therapy Australia, *Committee Hansard*, 14 June 2018, p. 37.

28 Ms Gail Mulcair, CEO, Speech Pathology Australia, *Committee Hansard*, 14 June 2018, p. 35.

29 Ms Norris, CEO, Occupational Therapy Australia, *Committee Hansard*, 14 June 2018, p. 36.

30 Ms Norris, CEO, Occupational Therapy Australia, *Committee Hansard*, 14 June 2018, p. 36.

31 Therapy Focus, *Submission 100*, p. 1.

Further consultations on the way

5.28 OTA explained that as a result of the backlash from allied health professions, the NDIA was ultimately obliged to defer the introduction of several key recommendations.[32]

5.29 The NDIA stated that it 'has recognised that the implementation of some recommendations required further detailed work or greater consultation with the sector' and 'work is being undertaken as a matter of priority'. In particular in relation to:

- Recommendation 6 – defining complexity,
- Recommendation 7 – price tier that accounts for complexity of supports,
- Recommendation 9 – high intensity loading for centre based activities,
- Recommendation 17 – therapy price limits,
- Recommendation 18 – therapy assistants (phase 2).[33]

Who is it working for?

5.30 The committee heard that, at present, the service providers that can do well under the NDIS pricing system are sole traders or tech-enabled providers, which serve participants via online platforms.[34]

5.31 One submitter noted that in the IPR Report the examples of successes were located in niche markets:

> I have to be honest and say that the examples that were held up of people fitting within the NDIA's efficient pricing methodology were sole traders or Uber type services connecting people through websites.[35]

5.32 At a public hearing, when asked what the sector would look like in a few years, a service provider responded 'Serco and BUPA', implying that the trend of service providers 'cherry picking' clients and no longer servicing participants with high and complex needs would continue to rise.[36]

5.33 Another provider also said that under the current approach, organisations that service people with high and complex needs will not exist in a few years' time.[37]

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32 Occupational Therapy, *Submission 46. 1*, p. 2.

33 NDIS, *Independent Pricing Review –Implementation update*, https://www.ndis.gov.au/news/ipr-implementation-update.html (accessed 31 August 2018)

34 See for example: Mr Graeme Mason, CEO, Accessibility, *Committee Hansard*, 18 April 2018, p. 31, McKinsey & Company, *Independent Pricing Review NDIA – Final report*, February 2018, p. 27; Australian Services Union, *Submission 69*, p. 7.

35 Mr Graeme Mason, CEO, Accessibility, *Committee Hansard*, 18 April 2018, p. 31.

36 Mr Tait, CEO, Rocky Bay, *Committee Hansard*, 17 April 2018, p. 23.

37 Mr Gordon Trewern, CEO, Nulsen Disabilities, *Committee Hansard*, 17 April 2018, p. 24.

5.34 Dr Ken Baker, CEO of the National Disability Services pointed out that even the IPR analysis of a small sample of disability providers found that 75 percent of them were not operating profitably with NDIS prices and concluded:

> We need the great majority to be operating profitably to get investment in growth. Pricing is one of the key barriers to growth.[38]

Committee view

Independent price setter

5.35 The committee agrees that, at present, price controls are needed as the market is still in its infancy. The committee is of the view that setting adequate price caps is paramount for ensuring market growth and the sustainability of the sector. Importantly, service providers must be able under NDIS pricing to deliver high quality services to participants without jeopardising their business sustainability. The committee was troubled to hear that many service providers were unable to operate even moderately profitably under NDIS pricing.

5.36 The committee agrees with the view that while price setting is held within the NDIA, there is an inherent risk for price setting to be used to offset budget pressures. In this context, an independent body is best placed to monitor and analyse market trends, and make recommendations about pricing of disability supports. The committee agrees with the Productivity Commission and inquiry participants that the Quality and Safeguards Commission (the Commission) should take on the role of price monitor and price setter until the market reaches maturity, and that this role should be supported and facilitated and funded by the Australian Government.

Recommendation 19

5.37 The committee recommends the Australian Government allocate resources to the Commission to establish a strategic unit responsible for the monitoring and review of NDIS prices with the aim of transferring the price setting powers to the Commission in July 2020.

Independent Pricing Review

5.38 The committee continues to hear that NDIS pricing is hindering market development and growth. More concerning is that, in some instances, it has led to service providers discontinuing services to NDIS participants. The committee acknowledges that the NDIA has undertaken some steps to address the issue of pricing shortfalls through the commissioning of the IPR and the subsequent implementation of some of its recommendations. It is too early to assess if these changes, which took effect on 1 July 2018, will have a positive impact on the market. The committee therefore is of the view that the changes be evaluated at the first available opportunity.

Recommendation 20

5.39 The committee recommends that an evaluation of the IPR recommendations is undertaken as part of the next annual NDIS pricing review.

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38 Dr Ken Baker, CEO, National Disability Services, *Committee Hansard*, 4 July 2018, p. 7.

Pricing of services for people with high and complex needs

5.40 The committee has heard on many occasions that the NDIS pricing framework is not working for participants with high and complex needs. The committee is of the view that unsustainable pricing caps may lead to service providers choosing not to accept clients with complex needs. Indeed, the committee has heard evidence that some service providers are 'cherry picking' clients and potentially leaving some of the most vulnerable NDIS participants with no access to adequate services.

5.41 Feedback from the sector strongly indicates that the IPR recommendations on the pricing methodology and quantum of pricing for delivering supports to participants with high and complex needs are inappropriate. In particular, providers are sceptical about the ability of the NDIA and its planners to determine the level of complexity of a participant. The sector also believes that the proposed three tier pricing structure is not workable.

5.42 The committee understands that, following vigorous protests from the sector, the NDIA is now reviewing these particular recommendations. The committee recommends the NDIA work with allied health service providers to find a way forward.

Recommendation 21

5.43 The committee recommends the NDIA work with allied health professions peak bodies and service providers to co-design a suitable methodology for pricing supports to participants with high and complex needs.

Thin markets

5.44 The issue of thin markets has been raised in previous inquiries undertaken by the committee and the Productivity Commission.[39] As the market steward, it is the role of the NDIA to put in place policies and interventions to minimise the occurrence of thin markets.

Occurrence of thin markets

5.45 During the inquiry, the committee heard that thin markets are persisting or worsening for some groups, including:

- participants living in rural and remote areas;[40]
- participants with high and complex needs;[41]

39 See for example: Joint Standing Committee on the NDIS, *Transitional arrangements for the NDIS*, 15 February 2018, pp. 65-70 and Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, 19 October 2017, pp. 268-276.

40 See for example: Queensland Advocacy Incorporated, *Submission 61*, p. 9; Victorian Aboriginal Community Controlled Health Organisation, *Submission 66*, p. 6; The Benevolent Society, *Submission 87*, p. 11; Queensland Government, *Submission 101*, p. 8.

41 See for example: Victorian Aboriginal Community Controlled Health Organisation, *Submission 66*, p. 6; The Benevolent Society, *Submission 87*, p. 11.

- participants who are from CALD backgrounds;[42]and
- Aboriginal and Torres Strait Islander participants, including in both remote and urban areas.[43]

NDIA initiatives to address thin markets

Market intervention framework

5.46 The *NDIS Market Approach –Statement of Opportunity and Intent*, published in November 2016, commits the NDIA to market interventions.[44]

5.47 To operationalise its market approach to thin markets, the NDIA says 'it is now developing a market intervention strategy and an analytical framework to create a process for identifying and responding to thin markets'.[45]

5.48 At a hearing in Cairns on 14 March 2018, Ms Liz Neville, Branch Manager, NDIA talked about the work underway around the production of the market intervention framework:

> This work in developing a market intervention framework is effectively an operating model for helping us understand when we do need to intervene and what the seriousness of the intervention should be. It is a model that will wrap around some of the existing good practice that already occurs at regional level.[46]

5.49 At a hearing in Sydney on 4 July 2018, Dr Ken Baker, CEO of National Disability Services (NDS), reiterated the need for clarity about interventions and concluded:

> We know that a market enablement framework is being developed but we haven't had sight of it, or at least I haven't.[47]

5.50 At the time of writing, the NDIA is yet to release the market intervention framework.

Adjusting prices

5.51 The NDIA says it has used its role as price setter to address thin market issues and risk of market failure. For example:

> In the case of short-term accommodation or centre based respite, there were concerns that we would have a market failure situation for that particular

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42 See for example: Federation of Ethnic Communities Councils of Australia, *Submission 49*, p. 7; The Benevolent Society, *Submission 87*, p. 11; Queensland Government, *Submission 101*, p. 8.

43 See for example: NACCHO, *Submission 23*, p. 7; The Benevolent Society, *Submission 87*, p. 11; Queensland Government, *Submission 101*, p. 8; Mr Geoff Rowe, CEO, Aged and Disability Advocacy Australia, *Committee Hansard*, 14 March 2018, p. 22.

44 NDIA, *Submission 52*, p. 19.

45 NDIA, *Submission 52*, p. 19.

46 Ms Liz Neville, Branch Manager, NDIA, *Committee Hansard*, 14 March 2018, p. 3.

47 Dr Ken Baker, CE), National Disability Services, *Committee Hansard*, 4 July 2018, p. 28.

> class of support, and we adjusted the price. We felt the price was relevant in that case, so we have adjusted the price.[48]

5.52 The IPR Recommendations 3 and 4 attempt to address the issue of pricing for delivering services in rural and remote areas where thin markets are an ongoing issue. Ms Liz Neville from the NDIA commented:

> Recommendation 3 allows us to explore the opportunity for quotation for support in remote and very remote areas, as compared to our current model which involves reliance on an individualised funding model with a 25 per cent rural and remote loading. That's a significant departure.[49]

Potential solutions and initiatives identified by the sector

5.53 Throughout the inquiry, the committee heard that alternative funding models, including block funding, direct commissioning, seed funding and grants to encourage and support diversity of providers in thin market areas should be considered by the NDIA.[50]

5.54 For example, Mr Peter Mewett, CEO of Cootharinga North Queensland, put forward the proposal of bulk-purchasing arrangements for a limited time to develop markets:

> We spoke to McKinsey and suggested that […] you should potentially look at bulk purchasing arrangements for a couple of years […]. The market doesn't exist. If a provider is prepared to put in the investment to develop a market, you should potentially look at having a bulk purchase arrangement in that market for, say, two years, but after that it's all bets off.[51]

5.55 Ms Gail Mulcair, CEO of Speech Pathology Australia, put forward that to develop the market and address some of the service issues in rural and remote areas, the NDIA should consider 'providing system-wide funding and structural supports for services to be delivered via tele-practice'.[52]

5.56 NACCHO submitted that some of the issues could be addressed if Aboriginal Community Controlled Health Services became providers of NDIS services beyond providing allied health services. However, some barriers exist, including the pricing of

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48 Ms Liz Neville, Branch Manager, NDIA, *Committee Hansard*, 14 March 2018, p. 3.

49 Ms Liz Neville, Branch Manager, NDIA, *Committee Hansard*, 18 April 2018, p. 16.

50 See for example: National Disability Services, *Submission 26,* p. 27; NACCHO, *Submission 23,* p. 12; Catholic Social Services Australia, *Submission 11,* p. 6; Victorian Aboriginal Community Controlled Health Organisation, *Submission 66,* p. 6; Victorian Council of Social Service, *Submission 81,* p. 23; The Benevolent Society, *Submission 87,* p. 11; Public Service Research Group, UNSW Canberra, *Submission 25,* p. 6; Federation of Ethnic Communities Councils of Australia, *Submission 49,* p. 7; Victorian Government, *Submission 90,* p. 6.

51 Mr Peter Mewett, CEO, Cootharinga North Queensland, *Committee Hansard* , 15 March 2018, p. 31.

52 Ms Gail Mulcair, CEO, Speech Pathology Australia, *Committee Hansard,* 14 June 2018, pp. 35-36.

services below cost to provider, the need for upfront investment, and lack of available disability workers.[53]

Multipurpose Service model (MPS)

5.57 Mr Tom Symondson, CEO of the Victorian Healthcare Association, is of the view that a multipurpose service model (MPS) would address the issue of thin markets and avoid the need for a provider of last resort to be appointed.[54]

5.58 The MPS model is used in the aged care sector, as a solution to market failure in rural and remote areas. The MPS model amalgamates all or most health and aged care services within a community under a single, locally governed organisation. An essential feature underpinning the MPS program is the pooling of state and Commonwealth program funds. The pooled funding budget is provided to a local community controlled MPS agency, which can allocate funding according to community needs for health and aged care services.[55]

5.59 According to the Victorian Healthcare Association the MPS model has been shown to be successful in enabling integrated health, community and aged care services in small rural communities,[56] and the Association is proposing a trial of the MPS model as an alternative model for providers of NDIS services in rural and remote areas.[57]

Committee view

5.60 The committee is concerned with the lack of progress on addressing the issue of thin markets experienced by some groups. As market steward, the NDIA should take a proactive role and put in place strategies and intervention mechanisms to address the significant risk of market failure in some areas and for some groups. The thin markets identified are not new; it is now urgent that the NDIA intervene beyond making small adjustments to pricing.

5.61 The committee is of the view that the NDIA must finalise and publicly release its market intervention framework as a matter of urgency. The framework must clearly outline the processes the NDIA will put in place to respond to thin markets and the intervention options it will use.

Recommendation 22

5.62 The committee recommends the NDIA publicly release its Market Intervention Framework as a matter of urgency.

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53 NACCHO, *Submission 23,* p. 9.

54 Mr Tom Symondson, CEO, Victorian healthcare Association, *Committee Hansard,* 14 June 2018, p. 40.

55 Answer to Question on Notice, Victorian Healthcare Association, 14 June 2018, pp. 1-2.

56 Answer to Question on Notice, Victorian Healthcare Association, 14 June 2018, p. 2.

57 Answer to Question on Notice, Victorian Healthcare Association, 14 June 2018, p. 1.

Multipurpose service model

5.63 The committee is of the view that the NDIA must work with the sector to address persisting and emerging thin markets. The NDIA should consider and trial some of the proposals put forward by submitters. For example, the committee sees potential in the MPS model used in the aged care sector in Victoria as a possible solution to market failure in rural and remote areas. The committee recommends the NDIA trial the MPS model in rural and remote Victoria as this will the NDIA to utilise the experience and expertise of the Victorian Healthcare Association and other organisations, which are familiar with the MPS model.

Recommendation 23

5.64 The committee recommends the NDIA trial the MPS model in rural and remote Victoria and publicly report on its effectiveness with an evaluation after 12 months of operations.

Provider of last resort

5.65 As market steward, the NDIA is responsible for the provider of last resort (PLR) arrangements. Under the circumstances of insufficient market supply with no provider available or in the event of provider failure, the NDIA may directly commission and procure disability supports for Scheme Participants.

5.66 However, as stated in the *NDIS Market Approach Statement of Opportunity and Intent*, during transition, states and territories continue to lead as PLR and will continue to do so for providers that they fund during transition.[58]

5.67 The NDIA says it will, over time, lead an integrated response jointly with states and territories as transition leads to full Scheme.[59]

Provider of Last Resort policy (PLR policy)

5.68 In the *Transitional Arrangements for the NDIS* report, the committee expressed its concerns that PLR arrangements remained unclear and incomplete. It recommended the NDIA accelerate its work with state and territory governments to progress future PLR arrangements, and called for the NDIA to publically release its PLR policy as a matter of urgency.[60]

5.69 The NDIA provided an update on its work at a public hearing held in Cairns in March 2018:

> We are at the moment working on a project, and we will be reporting to the Disability Reform Council at its next meeting on clarifying exactly what the agency's role is with respect to the so-called provider of last resort.

58 NDIA, *NDIS Market Approach Statement of Opportunity and Intent*, November 2016, p. 29.

59 NDIA, *NDIS Market Approach Statement of Opportunity and Intent*, November 2016, p. 29.

60 Joint Standing Committee on the NDIS, *Transitional arrangements for the NDIS*, 15 February 2018, p. 70.

> You will find that we are moving away from that language somewhat. We refer to this project as being concerned with how we maintain critical supports for people, so where they might be at risk of relinquishment for various reasons.
>
> That work will help us clarify precisely what the agency's role is, bearing in mind that our role is somewhat different to the states and territories, many of whom have been in the business of delivering disability supports and taking on a natural provider of last resort arrangement. The agency is not in that position, and nor do we intend to be in the business of service delivery, so the model is necessarily different.[61]

5.70 One submitter expressed concerns about the change of language to 'maintaining critical supports', worrying that 'any substitute mechanism for a PLR framework should not lead to the need for a person to justify that a support is "critical" in order to access the mechanism'.[62]

5.71 During the inquiry, submitters continued to call for the publication of the PLR policy as a matter of priority.[63]

5.72 Mr Tom Symondson, CEO of the Victorian Healthcare Association, noted the lack of progress:

> We haven't seen anywhere near as much work as we would like to have seen on issues such as provider of last resort or thin markets. Our recommendation is that work be accelerated, and we're very happy to support that.[64]

Crisis accommodation

5.73 As discussed in the *Transitional arrangements for the NDIS* report, there are concerns that existing state and territory government processes for emergencies will cease, despite new emergency arrangements having yet to be formalised.[65]

5.74 Several submitters argued that the need for clarity is a matter of some urgency.[66] Queenslanders with Disability Network argued that a clear pathway is

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61 Ms Liz Neville, Branch Manager, NDIA, *Committee Hansard*, 14 March 2018, p. 3.

62 Victoria Legal Aid, *Submission 91*, p. 22.

63 See for example: MJD Foundation, *Submission 6*, p. 9; People With Disability Australia, *Submission 74*, p. 13; Victorian Government, *Submission 90*, p. 7; Victoria Legal Aid, *Submission 91*, p. 22.

64 Mr Tom Symondson, CEO, Victorian healthcare Association, *Committee Hansard*, 14 June 2018, p. 33.

65 For example: National Disability Services, *Submission 26*, pp. 10–11; Scope Australia, *Submission 40*, p. 9; Mental Health Coalition of SA, *Submission 43*, p. 15; Queenslanders with Disability Network, *Submission 48*, p. 15; Office of the Public Advocate SA, *Submission 57*, p. 3; Queensland Advocacy Incorporated, *Submission 60*, p. 13; Northcott, *Submission 68*, p. 8.

66 For example: Mental Health Coalition of SA, *Submission 43*, p. 15; Scope Australia, *Submission 40*, p. 9; Office of the Public Advocate SA, *Submission 57*, p. 3.

essential to ensure that people have access to essential services and do not get 'stuck' in other service systems.[67]

5.75 The Office of the Public Advocate (OPA) SA drew attention to the situation in South Australia, where it is unclear how crisis service provision will operate after the state government's role ceased on 30 June 2018.[68] The OPA drew attention to the lack of arrangements in place for participants to be provided with a disability focused response in the event of an after-hours emergency. It warned that, without appropriate arrangements in place, it is likely that clients will be inappropriately admitted to hospitals or the correctional system. It suggested that sufficient funds for clients at risk of emergency should be built into plans, as guardianship services are not resourced to undertake service coordination, and as a result, a gap in service provision can arise if a participant requires an emergency response.[69]

5.76 Despite being halfway through NDIS rollout in Tasmania, the Mental Health Council of Tasmania highlighted that the state remains without a clear framework for a provider of last resort.[70]

5.77 The Queensland Government told the committee that the state government continues to deliver a service for accommodation support and for respite service, and, where the market generally might not be able to provide the support to a person, the provider of last resort could be put in place. However, for full scheme, the state does not have a policy position.[71] Ms Helen Ferguson, Senior Executive Director, Department of Communities, Disability Services and Seniors, also addressed some of the interface issues:

> …the Queensland government does continue to pay where there are interface rubs. Where the NDIA is yet to resolve the application of the interface principle in favour of the person with disability and their situation and the person is left in dire straits, the Queensland government will pay for that. In terms of the health interface, that is an area of ongoing negotiation nationally, in terms of transport interface, particularly transport interface. In terms of child protection, as you've noted in your question there, those areas are areas where, at a national level, we are having ongoing, deep negotiations about the application of the applied principles around roles and responsibilities between the NDIA and state and territory governments for those matters. Some of those lines are grey and need to be worked through, and some of those lines, in a number of respects, seem to be more clear and yet are still being worked through.[72]

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67 Queenslanders with Disability Network, *Submission 48,* p. 15.

68 Office of the Public Advocate SA, *Submission 57,* p. 3.

69 Office of the Public Advocate SA, *Submission 57,* p. 3.

70 Mental Health Council of Tasmania, *Submission 61,* p. 6.

71 Ms Helen Ferguson, Senior Executive Director, Department of Communities, Disability Services and Seniors, *Proof Committee Hansard,* 15 March 2018, p. 39.

72 Ms Helen Ferguson, Senior Executive Director, Department of Communities, Disability Services and Seniors, *Proof Committee Hansard,* 15 March 2018, p. 39.

5.78 Similarly, the Office of the Public Advocate NT argued that the process for enacting the Provider of Last Resort in the Territory is unclear and that delays are currently being experienced in addressing crisis situations as a result of a critical supports market failure. It argued that a lead agency is required to review who is responsible for responding to crisis requests.[73]

5.79 The Office of the Public Advocate VIC argued that the NDIA, as market steward, should commission crisis and respite accommodation for participants. It encouraged the NDIA to develop a streamlined plan review process to respond to participants with an acute and immediate need for crisis care and accommodation.[74]

5.80 In response to questions from the committee, DSS advised that the NDIA is progressing work on maintaining critical supports for those requiring critical disability supports. However, this work does not replace the ongoing responsibility of mainstream services, including emergency accommodation, to ensure that a person with disability has access to universal services.[75]

Committee view

5.81 With regard to the change terminology from 'Provider of Last Resort' to 'Maintaining Critical Supports', the committee is concerned that the effect of the change may be to limit the types of services that meet the criteria. The committee seeks assurance that the policy will seek to provide services where there are none available, and that the types of services are not limited by restrictive terminology, but instead are determined according to participant needs.

5.82 The Australian Government supported Recommendation 18 made by the committee in the *Transitional Arrangements for the NDIS* report, which says 'the committee recommends the NDIA publicly release its Provider of Last Resort policy as a matter of urgency'.[76] In its supporting comments, the Australian Government advised that the NDIA would publish the outcomes of its Maintaining Critical Supports project, following the DRC endorsement of the proposed policies and processes in the first half of 2018.

5.83 The Australian Government supported in-principle Recommendation 9 made by the committee in the *Transitional Arrangements for the NDIS* report, which says 'the committee recommends that the Australian, state and territory governments and the NDIA work together urgently to include crisis accommodation and Provider of Last Resort arrangements for housing in their respective bilateral agreements and operational plans'.[77] In its supporting comments, the Australian Government said the

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73 Office of the Public Advocate NT, *Submission 76*, p. 5.

74 Office of the Public Advocate VIC, *Submission 82*, p. 3.

75 DSS, answers to questions on notice, received 20 August 2018.

76 Australian Government, *Government response to the JSC Transitional Arrangements for the NDIS report*, 19 June 2018, p. 11.

77 Australian Government, *Government response to the JSC Transitional Arrangements for the NDIS report*, 19 June 2018, p. 7.

Maintaining Critical Supports project and its operational framework will include consideration of the future arrangements and roles of all parties, including those relating to crisis accommodation. The committee is concerned that the NDIA is yet to release a policy on future PLR arrangements.

Recommendation 24

5.84 The committee recommends the NDIA publicly release the outcomes of the Maintaining Critical Supports project and its policy on Provider of Last Resort arrangements as a matter of urgency.