Joint Standing Committee on the National Disability Insurance Scheme

Transitional Arrangements for the NDIS

February 2018

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Abbreviations

ACT	Australian Capital Territory
AHPA	Allied Health Professions Australia
AMA	Australian Medical Association
AMSANT	Aboriginal medical Services Alliance of the Northern Territory
CALD	Culturally and Linguistically Diverse
CDM	Chronic Disease Management
CEO	Chief Executive Officer
CMHA	Community Mental Health Australia
COAG	Council of Australian Governments
CRM	Customer Relationship Management system
CSSA	Catholic social Services Australia
DAA	Dietitians Association of Australia
DWIN	Disability Workforce Innovation Network Innovative Project
DoH	Department of Health
GP	General Practitioner
IAC	Independent Advisory Council to the National Disability Insurance Agency
IGA	Intergovernmental Agreement
ILC	Information Linkages and Capacity Building
IWF	Innovative Workforce Fund
LAC	Local Area Coordination
LACs	Local Area Coordinators
MBS	Medicare Benefits Schedule

MJDF	MJD Foundation
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NSW	New South Wales
NT	Northern Territory
OTA	Occupational Therapy Australia
PCIS	Personal Care in Schools
PDCN	Physical Disability Council of NSW
PEG feeding	Percutaneous endoscopic gastrostomy feeding
PHN	Primary Health Network
PLR	Provider of Last Resort
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
SA	South Australia
SDA	Specialist Disability Accommodation
SDF	Sector Development Fund
SPC	Supra-pubic catheter
TAS	Tasmania
VCOSS	Victorian Council of Social Services
VIC	Victoria
WA	Western Australia

Executive Summary

Transition to the full National Disability Insurance Scheme started in July 2016 and is expected to be completed by 2020. At full Scheme, about 475 000 people will be NDIS Participants. The arrangements, timelines and implementation of the transition to the NDIS are set out in the Bilateral Agreements between the Australian and state and territory governments and vary across jurisdictions. To date, the Australian Capital Territory is the only jurisdiction to have completed full transition to the Scheme. Elsewhere, the intake of Participants is falling behind schedule. The transition period presents significant challenges, which are explored throughout this report.

Delays in processes

The committee received evidence of delays in accessing the Scheme as well as delays in plan approvals, plan activations and access to services. As a result of the delays in the intake of Participants against bilateral estimates, there were over 34 500 people in September 2017 who should have already been Participants who were yet to access the Scheme. The committee heard that the plan review process is too lengthy and can jeopardise Participants' ability to access services.

Interface between the NDIS and mainstream services

The committee received evidence that whilst interactions between the NDIS and mainstream services are guided by the Principles agreed by COAG, they are subject to interpretation and lack clarity. This is resulting in boundary issues and funding disputes, which can lead to reduced access or no access to services for both NDIS Participants and people with disability not eligible for the NDIS. Additionally, the committee found that the current transition of Commonwealth, state and territory programs to the NDIS is contributing to emerging service gaps and the lack of clear delineation of funding responsibility between the NDIS and state and territory services. In particular, the committee received significant evidence of boundary issues in the areas of health, aged care, education, transport, housing and justice.

Impediments to deliver services

The committee heard that the administrative burdens experienced by service providers, the inadequacy of NDIS pricing caps and disability workforce shortages are significant barriers to the delivery of NDIS services across all jurisdictions.

Rollout of the Information, Linkages and Capacity Building Program (ILC)

The ILC is still in its infancy and has not yet started in all jurisdictions. However, the committee heard that insufficient funding has been allocated to the ILC program during the transition period. The committee is concerned that the current grant funding approach for ILC activities may result in service gaps for some essential services and has potential to disadvantage some cohorts because of their type of disability or geographical location.

Thin markets and Provider of Last Resort

The transition to a market based system brings new challenges for delivering services in areas of thin markets. The committee found that thin markets will persist for some Participants, including for those living in rural and remote areas, people with complex needs, people involved in the criminal justice system, people from CALD backgrounds and Aboriginal and Torres Strait Islanders. Greater clarity is required on how the NDIA intends to intervene in areas of thin markets. The committee is concerned that Provider of Last Resort arrangements remain unclear and incomplete.

Service Gaps

The committee heard that the transition to a market-based system combined with the transition of Commonwealth, state and territory programs have resulted in emerging service gaps in important areas, including advocacy, assertive outreach and support coordination.

People from culturally and linguistically diverse (CALD) backgrounds

The committee received evidence that the current NDIS participation rates for people with disability from CALD backgrounds are significantly below what had been anticipated. The committee is concerned that a comprehensive NDIS CALD Strategy is yet to be published and implemented.

Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander people are experiencing additional challenges to engage with the NDIS. The committee found that pre-rollout and pre-planning engagement activities are essential and must be prioritised by the NDIA. The committee is concerned about reports of a lack of cultural competencies among NDIA staff. The committee found that growing the disability workforce in Aboriginal and Torres Strait Islander communities needs to be prioritised to ensure supply of services.

Conclusion

The committee received a wealth of information and evidence throughout the inquiry and thanks all those who participated. As a result, the committee has made 26 recommendations, which aim to ensure that improved and appropriate arrangements can be put in place to provide necessary and reasonable supports for all NDIS Participants and fully realise the objectives of the Scheme.

Recommendations

Interface with Health

Recommendation 1

2.50 The committee recommends the Council of Australian Government (COAG) Health Council in collaboration with the COAG Disability Reform Council urgently undertake work to address current boundary and interface issues between health and NDIS services.

Recommendation 2

2.52 The committee recommends the NDIA establish an NDIA unit specialising in dealing with Participants who are hospitalised to ensure smooth transition from hospital and avoid delays in hospital discharge and to avoid discharge to nursing homes.

Recommendation 3

2.54 The committee recommends the Council of Australian Government (COAG) Disability Reform Council conduct immediately a national audit of all Australian, state and territory disability support services transitioning to the NDIS, to identify and address emerging service gaps.

Interface with Aged Care

Recommendation 4

2.63 The committee recommends the Department of Health in collaboration with the Department of Social Services undertake a review of current supports and funding available for people with disability over 65 years of age, with the view to developing a strategy to address current funding and support shortfalls.

Interface with Education

Recommendation 5

2.80 The committee recommends the Australian, state and territory governments clarify and agree on the scope and process to deliver Personal Care in Schools (PCIS) under the NDIS.

Recommendation 6

2.82 The committee recommends the NDIA develop guidance on best practices for provision of therapies in school settings, based on lessons learnt during NDIS trials and rollout to date.

Interface with Transport

Recommendation 7

2.103 The committee recommends the NDIA review its operational and funding guidelines for transport supports to ensure NDIS Participants' needs are met.

Interface with Housing

Recommendation 8

2.131 The committee recommends the Council of Australian Government (COAG) Disability Reform Council consider the provision of housing stock and infrastructure for people with disability.

Recommendation 9

2.134 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.

Planning process

Recommendation 10

3.37 The committee recommends the NDIA ensure that across all jurisdictions people with disability can access pre-planning supports.

Recommendation 11

3.38 The committee recommends the NDIA urgently finalise and start piloting the tailored pathways it has been developing for people with psychosocial disability; children; people from Aboriginal and Torres Strait Islander communities; those from culturally and linguistically diverse backgrounds and Participants with more complex needs.

Recommendation 12

3.41 The committee recommends the NDIA publish data and analysis on the following in its Quarterly Reports:

- **number of plan reviews;**
- **waiting times Participants face for reviews;**
- **outcomes of plan reviews in terms of whether the overall package has been increased or decreased;**
- **satisfaction rating of Participants following a plan review.**

Recommendation 13

3.43 The committee recommends the NDIA focus all necessary resources and efforts on reducing waiting times at all points of the Scheme, specifically for plan approval, activation and review.

Providers' registration

Recommendation 14

3.61 The committee recommends state and territory Governments put strategies in place to facilitate and support the registration of providers during the transition period.

ILC funding

Recommendation 15

3.135 The committee recommends the Australian Government increase funding for ILC to the full Scheme amount of $131 million for each year during the transition.

Recommendation 16

3.138 The committee recommends the NDIA monitor the effectiveness of the current ILC grant funding model, with the view of introducing other types of funding, including block funding if required, to ensure appropriate and quality services are delivered across all jurisdictions.

Thin markets

Recommendation 17

4.32 The committee recommends the NDIA develop and publically release a strategy to address thin markets.

Provider of Last Resort

Recommendation 18

4.35 The committee recommends the NDIA publically release its Provider of Last Resort policy as a matter of urgency.

Advocacy

Recommendation 19

4.69 The committee recommends the Council of Australian Governments (COAG) Disability Reform Council work with the Department of Social Services to address the expected funding shortfalls for advocacy services beyond transition.

Assertive outreach

Recommendation 20

4.71 The committee recommends the Department of Social Services and the NDIA develop and publically release a plan outlining how assertive outreach services will be delivered beyond transition to ensure people with disability who are hard-to reach can effectively engage with the NDIS and / or other support programs.

Support coordination

Recommendation 21

4.74 The committee recommends the NDIA ensure support coordination is adequately funded in Plans to meet Participants' needs and not limited to a fixed period.

People from CALD backgrounds

Recommendation 22

4.87 The committee recommends the NDIA ensure its Customer Relationship Management (CRM) system is modified to enable collection of data about participation rate of people from CALD backgrounds.

Recommendation 23

4.89 The committee recommends the NDIA urgently publically release its NDIS CALD Strategy.

Aboriginal and Torres Strait Islander communities

Recommendation 24

4.108 The committee recommends the NDIA ensure culturally appropriate pre-rollout and NDIS engagement activities are in place in Aboriginal and Torres Strait Islander communities at least six months before rollout date.

Recommendation 25

4.110 The committee recommends the Minister for Social Services appoint an Aboriginal and Torres Strait Islander representative on the NDIS Independent Advisory Council (IAC).

Recommendation 26

4.112 The committee recommends the NDIA develop, in collaboration with Aboriginal and Torres Strait Islander organisations and the Aboriginal community controlled health, an Aboriginal and Torres Strait Islander Workforce Strategy.

Chapter 1
Introduction

Referral of inquiry and terms of reference

1.1 The Joint Standing Committee on the National Disability Insurance Scheme (NDIS) was established on 1 September 2016. The committee is composed of five Members and five Senators.

1.2 The committee is tasked with inquiring into:

(a) the implementation, performance and governance of the NDIS;

(b) the administration and expenditure of the NDIS; and

(c) such other matters in relation to the NDIS as may be referred to it by either House of the Parliament.

1.3 After 30 June each year, the committee is required to present an annual report to the Parliament on the activities of the committee during the year, in addition to other reports on any other matters it considers relevant.

1.4 The committee is also able to inquire into specific aspects of the Scheme. On 21 June 2017, the committee decided to undertake an inquiry into the transitional arrangements for the NDIS.

1.5 The terms of reference for the inquiry are as follows:

> As part of the committee's inquiry into the implementation, performance and governance of the NDIS, the committee will inquire into and report on the transitional arrangements for the NDIS, with particular reference to:
>
> a) the boundaries and interface of NDIS service provision, and other non-NDIS service provision, with particular reference to health, education and transport services;
>
> b) the consistency of NDIS plans and delivery of NDIS and other services for people with disabilities across Australia;
>
> c) the rollout of the Information, Linkages and Capacity Building Program; and
>
> d) any other related matters.
>
> In considering these issues, the committee will have regard to:
>
> i. the Bilateral Agreements between the Commonwealth and State and Territory Governments;
>
> ii. the Operational Plans between the Commonwealth and State and Territory Governments;
>
> iii. the risks borne by the Commonwealth and State and Territory Governments in the rollout of the NDIS nationally;

iv. NDIS decision-making processes, particularly in relation to the Disability Reform Council and COAG; and

v. the impact on rural and remote areas, with particular reference to Indigenous communities.

1.6 This report is comprised of four chapters, as follows:

- This chapter (chapter 1) outlines the context and administration of the inquiry and provides some background information about the transitional arrangements to full Scheme;
- Chapter 2 examines the boundaries and interface of NDIS service provision and mainstream services;
- Chapter 3 focuses on the impediments to delivery of appropriate and timely services and the rollout of the ILC to date; and
- Chapter 4 discusses the issues of thin markets and Provider of Last Resort arrangements as well as emerging gaps in services. The chapter also explores the challenges faced by people from CALD backgrounds and Aboriginal and Torres Strait Islanders in engaging with the NDIS.

Conduct of the inquiry

1.7 The committee received 82 submissions to the inquiry from individuals and organisations. These submissions are listed in Appendix 1.

1.8 The committee also conducted eight public hearings:

- 19 September 2017 in Melbourne;
- 21 September 2017 in Darwin;
- 26 September 2017 in Brisbane;
- 27 September 2017 in Adelaide;
- 3 October 2017 in Sydney;
- 4 October 2017 in Hobart;
- 20 October 2017 in Canberra; and
- 8 November 2017 in Melbourne.

1.9 Transcripts from these hearings, together with submissions and answers to questions on notice are available on the committee's website. Witnesses who appeared at the hearings are listed in Appendix 2.

Acknowledgments

1.10 The committee would like to thank the individuals and organisations that made written submissions to the inquiry, as well as those who gave evidence at the eight public hearings. We are grateful for their time and expertise.

Note on terminology and references

1.11 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to Committee Hansard are to official transcripts.

Background information

Agreements between the Commonwealth and State and Territory governments

1.12 The Intergovernmental Agreement (IGA) for the NDIS Launch was signed by the Commonwealth and all states and territories at the Council of Australian Governments (COAG) meeting on 7 December 2012. The purpose of the IGA was to provide the foundation for governments to work together to develop and implement the first stage of an NDIS.[1]

1.13 The IGA and its six annexes were the basis of a number of provisions in the *NDIS Act 2013* and for Bilateral Agreements for Transition to a NDIS.[2]

1.14 The full Scheme Heads of Agreement for each state and territory outlines the parameters for transition to full Scheme within specific timelines, full Scheme funding arrangements, and scope of the National Injury Insurance Scheme (NIIS). Heads of Agreements for full Scheme were signed bilaterally with each jurisdiction (except WA) during 2012 and 2013 to set out a commitment and broad parameters for full Scheme.

Bilateral agreements

1.15 On 16 September 2015, the Prime Minister, the Hon Malcom Turnbull, signed bilateral agreements with the NSW and Victorian Premiers for the transition to the NDIS. Transition began July 2016, with a geographical rollout moving from region to region, covering all eligible people under 65, over two years in NSW and over three years in Victoria. These agreements formed the basis for consistent arrangements with other states and territories.[3]

1.16 On 11 December 2015, the Prime Minister, the Hon Malcom Turnbull, signed bilateral agreements with the Tasmanian and South Australian Premiers for the transition to the NDIS. Transition began in both jurisdictions in July 2016 with an implementation on an age basis over three years for Tasmania[4] and an implementation

1 *Intergovernmental Agreement for the National Disability Insurance Scheme (NDIS) Launch*, 7 December 2012, https://www.ndis.gov.au/html/sites/default/files/Intergovernmental_Agreement_for_the_National_Disability_Insurance_Scheme_Launch-signed.pdf (accessed 3 November 2017).

2 Department of Social Services, *Submission 29*, p. 9.

3 Department of Social Services, *Submission 29*, p. 9.

4 *Bilateral agreement between the Commonwealth and the Tasmanian governments on the NDIS*, 11 December 2015, schedule A, paragraph 8, p. 1.

through a mix of ages and geographic location, based on South Australian Disability regions for South Australia over two years.[5]

1.17 On 16 March the bilateral agreement was signed with Queensland with transition beginning in July 2016 on a geographical basis over three years.[6]

1.18 On 5 May 2016; the bilateral agreement with the Northern Territory (NT) was signed with transition beginning in July 2016 on a geographical basis over three years.[7]

Western Australia

1.19 Unlike other jurisdictions, Western Australia (WA) trialled two service delivery models (WA NDIS and NDIA NDIS) from July 2014 to June 2016. Following the trial, an independent evaluation of the two models was conducted by Stantons International. Subsequently, in January 2017, a more bespoke Bilateral Agreement was agreed by the Commonwealth and West Australian Governments which resolved that a nationally consistent but state-run NDIS would be implemented in WA with transition to commence from July 2017.[8]

1.20 More recently, on 12 December 2017, the Australian and Western Australian Governments reached agreement to bring Western Australia into the NDIS. The Agreement replaces the agreement signed in January 2017 by the previous Western Australian Government for a WA administered NDIS. From 1 July 2018, the National Disability Insurance Agency will assume responsibility for the delivery of the NDIS in WA. The NDIS will continue to roll out on a geographic basis and will be fully rolled out across Western Australia by 2020. The Australian and Western Australian governments will work closely with the National Disability Insurance Agency to implement the transition.[9]

Features of the bilateral agreements

1.21 The bilateral agreements set out the roles and responsibilities for the transition to full coverage of an NDIS. Schedules to the agreements include sections on: Participant Transition Arrangements; Financial Contributions; Cross billing and Budget Neutrality Arrangements; Continuity of Support Arrangements; Sector and

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5 *Bilateral agreement between the Commonwealth and the South Australia governments on the NDIS*, 11 December 2015, schedule A, paragraph 8, p. 2.

6 *Bilateral agreement between the Commonwealth and the Queensland governments on the NDIS*, 5 May 2016, schedule A, paragraph 7, p. 2.

7 *Bilateral agreement between the Commonwealth and the Northern Territory governments on the NDIS*, 5 May 2016, schedule A, paragraphs 6-7, pp. 1–2.

8 The Hon. Christian Porter MP, Commonwealth Minister for Social Services, the Hon. Colin Barnett MLA, WA Premier, the Hon. Donna Faragher MLC, WA Minister for Planning, Disability Services, 'Governments sign bilateral agreement on local delivery of NDIS in WA', *Media release*, 1 February 2017.

9 The Hon. Malcom Turnbull MP, Prime Minister of Australia, *Media release*, 12 December 2017.

System Readiness; Quality and Safeguards; Performance reporting; Workforce; Mainstream Interfaces; and Supports for Specialist Disability Housing.

1.22 In the case of the NT the bilateral agreement also includes schedule K on the arrangements for a provider of last resort services during transition.[10] This schedule was added because of the significant risk of service failure where there are thin or non-existent markets, including limited supply and very low demand for services. The NDIA is the responsible entity for ensuring provider of last resort services are in place for all Participants in the NT.

1.23 Under the agreements, the Commonwealth will fund 40.4 per cent of package costs for Participants aged 0-64 (0-50 years for Indigenous Australian Participants) in the Scheme, operational costs, Information Linkages and Capacity Building, and agreed overruns. States and Territories will fund 59.4 per cent of package costs for Participants aged 0-64 (0-50 for Indigenous Australian Participants).

Risks borne by the Commonwealth, State and Territory governments in the rollout of the NDIS

1.24 The Commonwealth funds 100 per cent of the risk of any increase in costs associated with higher participant numbers and / or higher average per person care and support costs, and 100 per cent of the NDIA's cash flow risk, during transition period.[1112]

Arrangements at Full Scheme

1.25 The Commonwealth will assume 100 per cent of the risk for full Scheme subject to the review of Scheme costs by the Productivity Commission in 2017.

1.26 The Heads of Agreements state the Productivity Commission would undertake a review of Scheme Costs in 2017. This review is intended to inform the final design of the Full Scheme, prior its commencement.

1.27 Early 2017, the Productivity Commission started the NDIS Costs review and released its final report on 19 October 2017.[13]

1.28 In its media release dated 19 October 2017, the Government stated:

> (…)The Government will work with the National Disability Insurance Agency (NDIA), States and Territories to consider and respond to the findings and recommendations of the Report.
>
> The Government notes the Commission's findings that Scheme costs are broadly on track compared to the NDIA's long term modelling and the

10 *Bilateral agreement between the Commonwealth and the Northern Territory governments on the NDIS*, 5 May 2016, schedule K.

11 Department of Social Services, *Submission 29*, p. 11.

12 *Bilateral agreement between the Commonwealth and Western Australia for the transition to a NDIS in Western Australia*, 12 December 2017, schedule B, p.23.

13 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, 19 October 2017.

> support offered by the Commission for the NDIAs approach to projecting Scheme costs. The Government also acknowledges there are emerging cost pressures, which are being appropriately monitored and addressed.
>
> The Government acknowledges the number of people entering the NDIS is less than originally estimated. This experience has been absolutely consistent during the NDIS trials and since commencement of transition to full Scheme on 1 July 2016.[14]

National rollout of the NDIS, participant intake and plan activation

1.29 The Australian Capital Territory was the first jurisdiction to complete transition to the Scheme, and this was largely achieved by the end of the second quarter in 2016–17.[15]

1.30 The rollout is expected to be completed progressively, with New South Wales and South Australia by July 2018; Victoria, Queensland, Northern Territory, and Tasmania to be completed by July 2019 and Western Australia by 2020.

1.31 As at 30 September 2017, 111 188 Participants had an approved plan and a further 29 315 people were eligible with no approved plan.

Table 1.1—NDIS state and territory Participants with approved plans compared to bilateral agreement estimates of Participant intake with approved plans at 30 September 2017

State/Territory	NSW	VIC	QLD	SA	TAS	NT	ACT	WA
Participants with approved plans[16]	58 367	18 826	9237	12 991	2534	547	6301	3982
Bilateral agreement estimates[17]	72 483	23 686	18463	13 969	2853	898	5126	8716

14 *Turnbull Government committed to NDIS rollout schedule*, Media release, 19 October 2017. https://christianporter.dss.gov.au/media-releases/turnbull-government-committed-to-ndis-rollout-schedule (accessed 6 November 2017).

15 ACT Government, *Submission 58*, p. 3.

16 NDIA, *NDIS Quarterly Report for the period 1 July to 30 September 2017*, Media release, https://www.ndis.gov.au/news/media-releases/quarterly-report-firstqtr-1718.html (accessed 23 January 2018).

1.32 The Productivity Commission found that the current timetable for participant intake will not be met.[18] It further explained:

> The intake of Participants with approved plans is already falling behind the expected pace. If the trend of delivering about 80 per cent of the bilateral estimates continues, it will take an additional year before all eligible Participants are in the Scheme. (And this delay could be longer if the Scheme falls further behind when the participant intake ramps up in 2017–18.).[19]

1.33 In its submission to this inquiry, the Queensland Government noted:

> Unfortunately, the NDIA has transitioned significantly fewer Queenslanders to the NDIS than the bilateral agreement's estimates.[20]

1.34 Similarly, the Victorian Government stated:

> Victoria has experienced significant delays in bringing Victorian Participants, particularly existing state clients, into the Scheme against bilateral agreement estimates.[21]

1.35 The Productivity Commission recommended that 'the Australian, State and Territory Governments should immediately start planning for a changed timetable for participant intake for the NDIS' and added:

> In doing so, the Australian, State and Territory Governments should ensure that adequate continuity of support arrangements are in place and assess whether additional resources are required to ensure the scheme meets its objectives. The issue of resourcing disability services under the changed timetable should be dealt with by the Treasurers and Ministers responsible

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17 *Bilateral agreement between the Commonwealth and the NSW governments on the NDIS,* 16 September 2015, schedule A, p. 4; *Bilateral agreement between the Commonwealth and the Victorian governments on the NDIS,* 16 September 2015, schedule A, p. 3; *Bilateral agreement between the Commonwealth and the Queensland governments on the NDIS,* 5 May 2016, schedule A, p.3; *Bilateral agreement between the Commonwealth and the South Australia governments on the NDIS,* 11 December 2015, schedule A, p. 4; *Bilateral agreement between the Commonwealth and the Tasmanian governments on the NDIS,* 11 December 2015, schedule A, p. 3; *Bilateral agreement between the Commonwealth and the Northern Territory governments on the NDIS,* 5 May 2016, schedule A, p. 3; *Head of Agreement between the Commonwealth and the Australian Capital Territory governments on the NDIS,* 19 April 2013, paragraph 13; *Bilateral agreement between the Commonwealth and Western Australia for the transition to a NDIS in Western Australia,* 12 December 2017, schedule A, p. 17.

18 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report,* October 2017, p. 2.

19 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report,* October 2017, p. 11.

20 Queensland Government, *Submission 72,* p. 4.

21 Department of Premier and Cabinet, Victoria, *Submission 54,* p. 5.

for the disability portfolio in each jurisdiction, at the next COAG Disability Reform Council meeting.[22]

1.36 The NDIA reported that 'approximately 71% of plans approved in 2016-17 have been activated within 90 days of plan approval'.[23]

1.37 The NDIA, as part of the Participant Pathway Review, is undertaking work to accelerate plan activations, with the view to reduce the length of time between plan approval and the commencement of support.[24]

Scheme costs

1.38 The Productivity Commission found that 'based on trial and transition data, NDIS costs are broadly on track with the NDIA's long-term modelling, but this is in large part because not all committed supports are used'.[25]

1.39 The Productivity Commission reported that the NDIA has identified five early cost pressures that need to be managed for the full Scheme going forward. They are:

- 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 is 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).[26]

1.40 The NDIA's two main responses to emerging cost pressures are the Early Childhood Early Intervention (ECEI) approach for children aged 0-6 years and the use

22 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 62.

23 National Disability Insurance Scheme, *COAG Disability Reform Council, Quarterly Report*, 30 September 2017, p. 26.

24 National Disability Insurance Scheme, *COAG Disability Reform Council, Quarterly Report*, 30 September 2017, p. 26.

25 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 2.

26 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 18.

of reference package data in the planning process to reduce variability in the level of support provided to Participants.[27]

1.41 The Productivity Commission concluded:

> While it is too early to conclusively assess the effectiveness of these initiatives, there are some signs from 2016-17 data that the new planning process may be helping to alleviate cost pressures related to package costs.[28]

27 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 19.

28 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 19.

Chapter 2

The interface of NDIS and mainstream services

2.1 This chapter examines the boundaries and interface of NDIS service provision and mainstream services and discusses the transitional issues reported by those who contributed to the inquiry.

2.2 In particular, it explores the interface between the NDIS and the following services: health; aged care; education; transport; housing and justice.

Principles to Determine the Responsibilities of the NDIS and Other Service Systems

2.3 The interactions between the NDIS and mainstream services are guided by the *Principles to Determine the Responsibilities of the NDIS and Other Service Systems* (the Principles) agreed by COAG in April 2013 and updated in November 2015. The Principles form part of the Bilateral Agreements for Transition to the NDIS, and Operational Plans commit jurisdictions to work with the NDIA to develop working arrangements for operationalising the Principles.[1]

2.4 However, the committee heard the Principles are subject to interpretation and lack clarity. This is resulting in boundary issues and funding disputes, which can lead to reduced or no access to services for both NDIS Participants and people with disability not eligible to the NDIS.

2.5 For example, the Queensland Government stated:

> During transition it has become evident that different interpretation of the Principles is resulting in individual plans not including supports that Queensland considers should be included. This is most evident in relation to health supports, but also transport assistance and education support.[2]

2.6 In its submission, the Tasmanian Government noted that 'the NDIA's operational documents for interpreting the COAG Principles have not yet been finalised, which contributes to the uncertainty in this area'.[3]

2.7 The ACT Government reported that 'over time the ACT has experienced a cost pressure associated with the fact that what is "in scope" for the NDIS has moved'.[4]

2.8 The NSW Government is of the view that 'extensive further work is required by the States and the Commonwealth to scope, agree and communicate service boundaries'.[5]

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1 Department of Social Services, *Submission 29*, pp. 3 and 4.

2 Queensland Government, *Submission 72*, p. 7.

3 Department of Premier and Cabinet, Tasmania, *Submission 75*, p. 7.

4 ACT Government, *Submission 58*, p. 5.

5 NSW Government , *Submission 27*, p. 1.

2.9 The need for improved clarity between the NDIS and other government services has also been identified by the NDIS Board as a priority area under the recently refreshed NDIS Corporate Plan for 2017-21.[6]

2.10 In its submission, the NDIA 'acknowledges the challenges associated with the operational application of the COAG Applied Principles'[7] and makes the following statement:

> The NDIA will continue to work with governments on operationalising the Applied Principles, and suggests consideration be given to additional clarification of these principles via a Rule, as well as the inclusion of tangible targets and outcomes to ensure accountability on all parties-potentially via the NDS.[8]

2.11 The current transition of Commonwealth, state and territory programs to the NDIS is discussed throughout the chapter as it is contributing to emerging service gaps and the lack of clear delineation of funding responsibility between the NDIS and state and territory services.

Health

2.12 Dr Adrienne McGhee, Principal Policy and Research Officer at Office of the Advocate (Queensland) described how 'health and disability are interconnected. Yet, for the purposes of determining which government agency pays for what, we're finding that they're being artificially separated out, which is adding complexity and delays transitioning of people with disability.'[9]

2.13 Many submitters found that the delineation between the services to be provided by the NDIS and those provided by mainstream health services has not been made sufficiently clear.[10]

2.14 Ms Ellen Dunne, Director at the Office for Disability with the ACT Government acknowledged the complexity of the interface between the NDIS and mainstream services:

> I think it's really important that we recognise that there is still a lot of complexity about the interface between eligible supports for the NDIS and mainstream services—in particular, with the health system.[11]

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6 NDIA, *Submission 41*, p. 2.

7 NDIA, *Submission 41*, p. 5.

8 NDIA, *Submission 41*, p. 4.

9 Dr Adrienne McGhee, Principal Policy and Research Officer, Office of the Advocate, *Committee Hansard,* 26 September 2017, p. 1.

10 See for example: Victorian Healthcare Association, *Submission 11*, p. 3; Mr Andrew Giles, National Policy Officer, Multiple Sclerosis Australia, *Committee Hansard,* 19 September 2017, p. 20; Occupational Therapy Australia, *Submission 26*, p. 8.

11 Ms Ellen Dunne, Director, Office for Disability, Community Services Directorate, Australian Capital Territory, *Committee Hansard,* 20 October 2017, p. 1.

2.15 As a result of the lack of clarity, Ms Dunne stated that 'there is still a lack of understanding about what should be paid for by the health directorate and the ACT government and what should be paid for by the Scheme.'[12]

2.16 The Victorian Healthcare Association is concerned 'that the poorly defined interface between the NDIS and health services may result in people losing access to community-based disability services and requiring more costly, acute health services leading to poorer outcomes for people with disability'.[13]

2.17 Mr Tom Symondson, CEO of Victorian Healthcare Association explained:

> There is a very, very disturbing lack of clarity of the interface between NDIS and health. As providers of both, we see that consistently and it is causing very perverse outcomes for individuals, and obviously services are having to navigate that as well. That also brings about the issue of who is responsible for what. When you are somebody who is receiving supports under the NDIS but you also have health issues, you tend to fall in this very, very large grey zone in between the two systems. It is the health provider or the NDIS provider who end up trying to work out who is going take that cost, and it is the individual who is receiving services that suffers.[14]

2.18 As a result of the poor interface between NDIS and mainstream health services, the Allied Health Professions Australia is of the view that 'there is significant scope for failures in the handover process between services and resulting in safety risks for Participants'.[15]

Discharge from hospital

2.19 Submitters reported that transition out of hospital into the community for patients with disability can be problematic.[16] Issues reported concerned people in the process of applying for a NDIS Plan as well as people with existing NDIS Plans.

2.20 Protracted hospital stays are a concern to the Victorian Government because of the timeframes associated with NDIS access, planning and plan implementation for people who require an NDIS Plan to support hospital discharge.[17]

2.21 Ms Kim Peake, Secretary at the Department of Health and Human Services, Victoria also raised this issue during a public hearing in Melbourne:

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12 Ms Ellen Dunne, Director, Office for Disability, Community Services Directorate, Australian Capital Territory, *Committee Hansard*, 20 October 2017, p. 2.

13 Victorian Healthcare Association, *Submission 11*, p. 4.

14 Mr Tom Symondson, CEO, Victorian Healthcare Association, *Committee Hansard*, 19 September 2017, p. 10.

15 Allied Health Professions Australia, *Submission 6*, p. 5.

16 See for example: Physical Disability Council of NSW, *Submission 56*, p. 3; Summer Foundation, *Submission 22*, p. 5.

17 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 12.

> […] on occasions, delays in the planning process are really impacting on discharge of people from health services, and that has a corollary in terms of the relationship with aged-care services in particular but also into access to housing in the community.[18]

2.22 Occupational Therapy Australia noted that 'hospitals cannot continue to care for people simply because their NDIS Plan has yet to be finalised and approved'.[19]

2.23 Inadequate supports in Plans are causing delays in release from hospital. For example, Mrs Carmel Curlewis, an NDIS provider and Accredited Practicing Dietitian reported:

> […] I found across the eastern seaboard that, after speaking to 200 dietitians mainly from hospitals, it wasn't uncommon to have NDIS Participants in hospital for six months, often 12 months—and, at the worst-case scenario, 18 months—waiting for enough money in their NDIS plans to get out of hospital. It's just a ridiculous situation. [20]

2.24 The Summer Foundation also found that inadequate supports in Plans and poor coordination between the health system and disability supports have also led to increased hospitalisation of people.[21]

Withdrawal of services and boundary issues

2.25 Submitters reported issues of withdrawal of services by the health system. For example, the Victorian Council of Social Services (VCOSS) reported the case of a patient who upon applying for an NDIS package saw the hospital withdrawing services on the basis that the NDIS would cover the supports he needed, including a wheelchair. This occurred before the patient received his Plan.[22]

2.26 Multiple Sclerosis Australia stated that there are now instances where health services are no longer accepting responsibility for supporting safe discharge from hospital back into the home if the person is an NDIS Participant.[23] For example, it reported the case of a hospital in Queensland refusing to provide any wound care once a Participant was discharged from hospital because the person had an NDIS Plan.[24]

2.27 At a public hearing in Canberra, Dr Ken Baker, CEO of National Disability Services, provided the example of a funding issue arising when an NDIS Participant with complex disability needs hospitalisation:

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18 Ms Kim Peake, Secretary, Department of Health and Human Services, Victoria, *Committee Hansard,* 19 September 2017, p. 5.

19 Occupational Therapy Australia, *Submission 26,* p. 9.

20 Mrs Carmel Curlewis, NDIS provider and Accredited Practising Dietitian, Dietitians Association of Australia, *Committee Hansard,* 20 October 2017, p. 24.

21 Summer Foundation, *Submission 22,* p. 9.

22 VCOSS, *Submission 65,* p. 26.

23 Occupational Therapy Australia, *Submission 31,* p. 4.

24 Occupational Therapy Australia, *Submission 31,* p. 5.

> […]an example from health is where a person with complex disability, who may be nonverbal, who may have a severe intellectual disability, needs hospitalisation. In practice it is traditionally the case that a support worker or a disability support worker would accompany that person into hospital and assist that person with disability to communicate with the health practitioners within the hospital. […] But under the NDIS it is a matter for dispute as to who should pay for that support worker, if that support worker is inside the hospital. I think it's not clear who should pay for that person.[25]

2.28 And, Dr Baker summarised the position of the NDIS:

> Essentially the position of the NDIS is that, once that support worker enters the hospital, the health system should be paying the support worker, or the support worker should stop at the door and hand over that person to the health practitioners.[26]

2.29 In answers to a question on notice on boundary disputes, National Disability Services provided a series of case studies illustrating the issue of responsibility and funding for support workers when a person with complex needs requires hospitalisation. In one case study, a non-verbal patient allegedly passed away due to his support worker not being present and unable to interpret the patient's non-verbal communication and explain the history of his condition.[27]

Equipment and services

2.30 In Appendix 1 of the *NDIA Operational Guidelines: Planning*, the NDIA states that the following supports may be funded by the NDIS:

> Where this is required because of the participant's functional impairment and integrally connected to the participant's support needs to live independently and to participate in education and employment (e.g. supervision of delegated care for ongoing high care needs, such as PEG feeding, catheter changes, skin integrity checks or tracheostomy tube changes).[28]

2.31 However, some submitters provided examples of NDIS Participants having reduced or no longer access to these types of services and equipment because of the NDIS arguing these supports should be met by the health system.[29]

2.32 For example, Miss Grace Poland, an NDIS Participant with cerebral palsy told the committee:

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25 Dr Ken Baker, CEO, National Disability Services, *Committee Hansard*, 20 October 2017, p. 14.

26 Dr Ken Baker, CEO, National Disability Services, *Committee Hansard*, 20 October 2017, p. 14.

27 National Disability Services, answers to question on notice, 20 October 2017 (received 14 November 2017), p. 4.

28 NDIA, *Operational Guidelines: Planning, Appendix 1, Health (excluding mental health),* https://www.ndis.gov.au/operational-guideline/planning/appendix.html#health (accessed 9 November 2017)

29 See for example: People With Disability Australia, *Submission 77,* p. 2; Carers NSW, *Submission 55,* p. 5; Multiple Sclerosis Australia, *Submission 31,* p. 4.

> So, since February 2016, my access to services and equipment has been limited. I have stopped receiving funding for orthotics, compression stockings, podiatry services and lymphatic drainage therapy, all of which I need to manage high muscle tone spasticity and chronic pain. Mercy Health, who used to provide my compression stockings, told me that the NDIS would be responsible for this funding in future, but this has not been the case.[30]

2.33 Carers NSW reported that the NDIA has refused to fund in Plans supports such as enteral and parenteral nutrition equipment and supplies; products to support the use of continence aids; and nursing support on the ground these supports are health specific. However, the health system has either disagreed with this judgment or not had the funding available to provide this support. As a result, this has left families 'in limbo, and often in crisis'.[31]

2.34 The question of whether 'equipment is disability related and funded under the NDIS' or 'medical and funded by the health system' was raised by Occupational Therapy Australia, who submitted that there is a grey area, particularly in terms of assistive technology.[32]

2.35 Multiple Sclerosis Australia reported the funding of supra-pubic catheters as an example of jurisdictional dispute between the NDIS and health services:

> Changes of supra-pubic catheters (SPC), by registered nurses, under the NDIS using 'Individual Assessment and Support by a Nurse is no longer being funded in a number of regions across NSW, Victoria and the ACT. Until earlier this year Participants in the Hunter and Barwon trial sites had received this funding across multiple plans. The message 'vaguely' being put out by some planners is that this support is to be funded by the relevant health service, however, a number of area health services are pulling out stating that they have had their HACC funding removed and are therefore no longer able to provide this service. This lack of clarity and consistency of message to Participants is creating stress and without appropriate and timely catheter changes, places Participants at a high risk of requiring hospitalisation due to complications from infections caused by retention of urine, and the triggering of an MS exacerbation due to such an infection increasing core body temperature.[33]

2.36 Similarly, in Queensland, with the transitioning of Queensland's Community Care program some people with NDIS Plans are no longer able to access wound care and catheter changing as neither the health system nor the NDIS believe it is their responsibility to fund such services.[34]

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30 Miss Grace Poland, Summer Foundation and NDIS participant, *Committee Hansard*, 19 September 2017, p. 11.

31 Carers NSW, *Submission 55*, p. 5.

32 Occupational Therapy Australia, *Submission 26*, p. 9.

33 Multiple Sclerosis Australia, *Submission 31*, p. 4.

34 Queensland Advocacy Incorporated, *Submission 21*, p. 6.

Dietetic services

2.37 The Dietitians Association of Australia (DAA) reported that planners are frequently denying the inclusion of dietetic services in Participant packages. Planners are directing Participants to seek access to dietetics services through the health system and Medicare CDM items. Allied Health Professions Australia (AHPA) believes this approach is inappropriate when the nutrition issues of Participants are grounded in their disability, and therefore access to Accredited Practicing Dietitian services is reasonable and necessary.[35]

2.38 Mrs Carmel Curlewis, an NDIS provider and Accredited Practicing Dietitian, told the committee that some NDIS Participants have to stay in hospital for extended periods of time because their Plans do not meet their needs for dietetic services:

> […] we've got Participants in the health system who cannot be discharged because they can't have enough dietitian hours and consumables funding in their NDIS packages to discharge them from hospital.[36]

2.39 Scope Australia, a not for profit organisation that supports children and adults with developmental delays and disabilities reported:

> We are aware of several instances where people with severe and multiple disabilities with dysphagia (swallowing difficulties), have had their request for funding to develop safe meal time profiles rejected by the NDIS as this is considered a health department responsibility. The health department in return, does not have the resources, capacity or expertise to provide this service and is not able to include it within their service provision.[37]

2.40 Similarly, Speech Pathology Australia (SPA) identified that 'the most problematic interface between mainstream health and NDIS services relates to the provision of speech pathology services to people with a swallowing disability and the provision of mealtime management supports'.[38] It reported:

> The National Disability Insurance Agency (NDIA) has recently informed Speech Pathology Australia that the NDIS will not fund meal time supports as part of individualise plans into the future – the rationale being that this support is primarily to prevent a health risk (pneumonia or choking) and therefore the Health sector should finance it.[39]
>
> […]
>
> [T]his ignores the important role eating, drinking and sharing a meal play in family and social life for people with disability. It also fails to acknowledge the fact that day-to-day provision of supports for mealtimes is part of the

35 Allied Health Professions Australia, *Submission 6*, p. 4.

36 Mrs Carmel Curlewis, NDIS provider and Accredited Practising Dietitian, Dietitians Association of Australia, *Committee Hansard*, 20 October 2017, p. 24.

37 Scope Australia, *Submission 16*, p. 2.

38 Speech Pathology Australia, *Submission 62*, p. 8.

39 Speech Pathology Australia, *Submission 62*, p. 8.

> responsibility of disability support workers, often as part of provision of specialist disability supports.[40]

2.41 SPA also stated that 'there are currently no alternative funding streams for meal time support services provided by a speech pathologist (or multidisciplinary team) for people with disability through the health systems. Current MBS item numbers for speech pathology services are not structured appropriately or adequately to fund this service'.[41]

2.42 Having raised this issue with relevant federal, state and territory ministers, SPA reported that the general view of all governments, (except Victoria) is mealtime support 'should remain under Disability for funding and provision of supports i.e. funding should continue to be included in NDIS participant's individual plans'.[42]

2.43 The lack of clarity and delineation of supports and funding is also affecting other services such as sexual health. Ms Ee-lin Chang, Senior Health Promotion Officer at Family Planning NSW reported:

> We are concerned about the gap between Health and the NDIS in meeting the reproductive and sexual health needs of people with disability. In particular, we are concerned that people who have sexualised behaviours of concern or who require additional support to enable them to make decisions regarding their reproductive and sexual health will fall through the gap between NDIS and Health.[43]

Mental Health

2.44 Many submitters reiterated the concerns raised during the committee's inquiry into the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*[44] about the transition of existing programs to the NDIS resulting in emerging gaps in services for people with psychosocial disability ineligible to the NDIS.[45]

2.45 For example, Mr Tom Symondson, CEO of Victorian Healthcare Association raised the issue of community-based mental health services transitioning to the NDIS in full and how this is affecting people not eligible to the NDIS and service providers:

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40 Speech Pathology Australia, *Submission 62,* p. 8.

41 Speech Pathology Australia, *Submission 62,* p. 8.

42 Speech Pathology Australia, Speech Pathology Australia briefing paper: mealtime support, additional information received 8 November 2017.

43 Ms Ee-lin Chang, Senior Health Promotion Officer, Family Planning NSW, *Committee Hansard,* 3 October 2017, p. 12.

44 Joint Standing Committee on the National Disability Insurance Scheme, *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition,* August 2017.

45 See for example, Australian Medical Association, *Submission 1*, pp. 2 and 3; Australian Psychological Society, *Submission 17*, pp. 2 and 3; Mental Health Council of Tasmania, *Submission 19,* p. 2; Catholic Social Services Australia (CSSA), *Submission 32*, p. 3.

> We have a Victorian specific issue—and we accept this—around community-based mental health. I think I'm right in saying, we're the only state that committed all of our community-based mental health funding to the NDIS. We didn't keep anything back. That means that, because of the differential eligibility for NDIS versus the existing state-based mental health system, there is the threat of a number of people—a swathe of people—who won't be eligible for NDIS funded community mental health, who currently are, and we're very concerned about what impact that will have on those individuals, and also on the rest of the service system trying to pick up that strain.[46]

2.46 Ms Elinor Heard, Sector Reform Lead at Mental Health Council of Tasmania also expressed the sector's concerns about the transition of services to the NDIS:

> Our sector remains concerned that the rolling over of Commonwealth funding to the NDIS and the resulting decrease in community-based services will lead to more episodes of crisis for individuals with a mental health condition and an increase in complex presentations to emergency departments and hospitals.[47]

2.47 Catholic Social Services Australia summarised the issue:

> As the committee has heard previously, the boundaries between NDIS and non-NDIS services are particularly unclear in the area of psychosocial disability support. There is confusion about which services are included in the NDIS and how the mental health and disability sectors interface. Clarity is needed as soon as possible on how mental health services for people who are not eligible for the NDIS will continue to be funded.[48]

Committee view

Interface between the NDIS and health services

2.48 The committee understands that people with disability may also experience a range of complex health support needs secondary to, but intertwined with, their disability. In some cases, it remains unclear where the line is, or should be, drawn between the health system and the NDIS for Participants. For example, the evidence received by the committee about issues regarding enteral and parenteral nutrition equipment and supplies; continence aids; and wound care demonstrates the lack of clarity and delineation of responsibilities between the NDIS and mainstream health systems. It appears that the quantum and types of supports to be provided for NDIS Participants by either the NDIS or health services are subject to interpretations and not consistently applied. It is impacting negatively on access, quality and delivery of services for NDIS Participants who require these supports. People are clearly missing out on necessary supports, which can lead to increased and longer costly

46 Mr Tom Symondson, CEO, Victorian Healthcare Association, *Committee Hansard*, 19 September 2017, p. 11.

47 Ms Elinor Heard, Sector Reform Lead, Mental Health Council of Tasmania, *Committee Hansard*, 4 October 2017, p. 13.

48 Catholic Social Services Australia (CSSA), *Submission 32*, p. 3.

hospitalisation. These issues are not new and must be resolved. Establishing clear and robust boundaries between the NDIS and health services is essential.

2.49 It has become apparent that the operationalisation of the COAG Applied Principles requires urgent work to clearly define roles and responsibilities of the NDIA and the state and territory health systems. The COAG Health Council in collaboration with the COAG Disability Reform Council should undertake work to address how health services interface with NDIS services. This works needs to focus on refining the COAG Applied Principles and agreeing on service boundaries.

Recommendation 1

2.50 The committee recommends the Council of Australian Government (COAG) Health Council in collaboration with the COAG Disability Reform Council urgently undertake work to address current boundary and interface issues between health and NDIS services.

NDIS operational issues

2.51 Poor planning process and delays in Plan approval and implementation are also contributing to delays in hospital discharge. This situation needs to be addressed. The committee urges the NDIA to continue its work and effort in addressing planning issues and chronic delays, and gather and publish the numbers of Participants in this situation. The committee sees merit in establishing a unit to focus specifically on this cohort of Participants.

Recommendation 2

2.52 The committee recommends the NDIA establish an NDIA unit specialising in dealing with Participants who are hospitalised to ensure a smooth transition from hospital and avoid delays in hospital discharge and to avoid discharge to nursing homes.

Transition of Commonwealth, state and territory programs to the NDIS

2.53 As the provision of services to people with disability remains a shared responsibility between all levels of government, it is imperative that governments do not systematically and prematurely withdraw services during the transition period. The committee received compelling evidence that the transition of Commonwealth, state and territory disability support services to the NDIS is resulting in emerging service gaps for both NDIS Participants and people with disability ineligible for NDIS services. The committee has identified the need for a national audit and mapping of all Australian, state and territory disability support services transitioning to the NDIS to ensure service gaps are detected and addressed accordingly.

Recommendation 3

2.54 The committee recommends the Council of Australian Government (COAG) Disability Reform Council conduct immediately a national audit of all Australian, state and territory disability support services transitioning to the NDIS, to identify and address emerging service gaps.

Mental Health

2.55 The committee remains deeply concerned about the lack of clarity on how the Australian, state and territory governments intend to provide services and funding for people with psychosocial disability beyond the supports provided through the NDIS. The committee reiterates recommendation 13 of its report on the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.*[49]

Aged Care

2.56 A number of submitters raised concerns about the ability of the aged care sector to adequately support people over 65 years of age with disabilities.[50] Many consider aged care services unsuitable and inappropriate for people with a significant disability.

2.57 One of the issues is that aged care programs funding are capped. For example, Spinal Cord Injuries Australia reported:

> The most support anyone can expect through the My Aged Care Gateway is a level four Home Care package which is currently valued at less than $50,000. There are some small supplementary programs as add-ons to this but eligibility is for such things as dementia care as an example. This level of funding is woefully inadequate for anyone with a significant disability.[51]

2.58 The Australian Blindness Forum believes the aged care sector does not meet the specialised needs of people who are blind or vision impaired and over the age of 65:

> These people do not have the same generic aged care needs as others in the sector as their needs are specialised. The boundaries between disability services and aged care services are now blurred and there is no clarity around the promised continuity of support for all people with disability who are not eligible for the NDIS and who now are part of the aged care sector.[52]

2.59 The Macular Disease Foundation argued that 'the key area of inequity between the NDIS and the aged care system is that the aged care system provides limited and inconsistent access to specialist disability support services, whereas the NDIS provides full access to these services.[53]

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49 Joint Standing Committee on the National Disability Insurance Scheme, *The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017, p. 49.

50 See for example: Vision Australia, *Submission 24*, p. 3; Spinal Cord Injuries Australia, *Submission 48*, p. 1; Australian Red Cross, *Submission 67*, Attachment 1, p. 6; VCOSS, *Submission 65*, p. 21.

51 Spinal Cord Injuries Australia, *Submission 48*, p. 1.

52 Australian Blindness Forum, *Submission 13*, p. 2.

53 Macular Disease Foundation, *Submission 28*, p. 2.

2.60 AMIDA explained that people over 65 with disability are being moved in aged care accommodation despite their needs being better met in Specialist Disability Accommodation (SDA):

> In our experience people in SDA who turn 65 are often moved into aged care despite their needs being better met in Specialist Disability Accommodation. Ratio of staff to client in SDA is at most, 1 to 5 whereas in aged persons' accommodation it can be 1 to 30, which reduces the opportunity for specialist disability needs to be met.[54]

2.61 Spinal Cord Injuries Australia also reported that people are being discharged from hospital to aged care facilities due to 'an inability to find appropriate services to support people on discharge'.[55]

Committee view

2.62 The committee is concerned that people with disability over 65 years of age are not receiving adequate supports and are potentially disadvantaged compared to NDIS Participants. The committee believes that the Department of Health in collaboration with the Department of Social Services should undertake work to map the needs and gaps in funding and services for this cohort ineligible to NDIS services, with the view of developing a strategy to address current shortfalls in supports. The committee noted that the Productivity Commission also considered that these issues need to be addressed. The Productivity Commission did put forward some of the policy options it considers worth exploring, including removing the NDIS entry cut-off age altogether and better aligning the aged care and NDIS systems.[56]

Recommendation 4

2.63 The committee recommends the Department of Health in collaboration with the Department of Social Services undertake a review of current supports and funding available for people with disability over 65 years of age, with the view to developing a strategy to address current funding and support shortfalls.

Education

2.64 The allocation of roles is relatively straightforward when it comes to the education system. The NDIS funds 'supports that enable Participants to attend school education, where these supports are required by the participant to engage in a range of community activities'.[57] This includes assistance with self-care care at school, specialist transport, equipment and specialised support to transition between schools, or from school to post-school options.

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54 AMIDA, *Submission 39*, p. 4.

55 Spinal Cord Injuries Australia, *Submission 48*, p. 2.

56 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs, Study Report*, October 2017, p. 257.

57 NDIS, *Mainstream interface: School education*, January 2014, p. 1; https://www.ndis.gov.au/html/sites/default/files/documents/fact_sheet_supports_ndis_fund_education.pdf (accessed 13 November 2017).

2.65 The education system has responsibility for assisting students with their educational attainment, including through teaching and educational resources.[58]

2.66 The Department of Education and Training summarised responsibilities of the NDIS, the Commonwealth and state and territory governments:

> In summary, a student with a disability would use the NDIS for supports associated with the functional impact of the student's disability on their activities of daily living, such as personal care, transport to and from school. The NDIS will not be responsible for personalising either learning or support for students that primarily relate to their educational attainment (including teaching, learning assistance and aids, school building modifications and transport between school activities). (…) Australian Government funding informed by the NCCD is one element of the support made available for students with disability within the school setting. State and territory governments are the primary funders of students with disability in the government sector, and in the non-government sector schools and systems use resources from all sources to meet the needs of their students.[59]

2.67 However, many submitters raised concerns about the lack of clarity around the provision of supports in the school environment and how the implementation of the NDIS in educational settings is currently working.[60] For example, Allied Health Professions Australia is concerned that 'there is insufficient clarity around the split between NDIS and mainstream education services'.[61]

2.68 Prader-Willi Syndrome Australia is of the view that there are some 'grey areas' and 'a lack of clarity for who will be on the spot' to address risks for students with Prader-Willi Syndrome.[62]

2.69 Vision Australia and the Australian Blindness Forum argued that the interface between the NDIS and education 'is not always appropriate as it prevents families and communities from obtaining a holistic approach to a child's needs while they are of school age'.[63]

Personal Care in Schools (PCIS)

2.70 The Department of Premier and Cabinet, Victoria reported that COAG agreed that, under the NDIS, Personal Care in Schools (PCIS) will be funded by the NDIS

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58 NDIS, *Mainstream interface: School education*, January 2014, p. 1; https://www.ndis.gov.au/html/sites/default/files/documents/fact_sheet_supports_ndis_fund_education.pdf (accessed 13 November 2017).

59 Department of Education and Training, *Submission 64*, p. 10.

60 See for example: Allied Health Professions Australia, *Submission 6*, p. 6; Prader-Willi Syndrome Australia, *Submission 9*, p. 5; Australian Blindness Forum, *Submission 13*, p. 3; Vision Australia, *Submission 24*, p. 3.

61 Allied Health Professions Australia, *Submission 6*, p. 6.

62 Prader-Willi Syndrome Australia, *Submission 9*, p. 5.

63 Vision Australia, *Submission 24*, p. 3 and Australian Blindness Forum, *Submission 13*, p. 3.

when full scheme commences on 1 July 2019. However, some issues have yet to be resolved and include:

- reaching agreement on the 'in scope' personal care supports that will be funded by the NDIA versus 'reasonable adjustments' that schools will continue to fund; and
- identifying an agreed process for assessing, costing and delivering NDIA funded supports in schools.[64]

2.71 The ACT government listed the following key issues, which remain to be clarified around the scope of PCIS:

- how to measure and cost the provision of PCIS;
- whether it is viable for PCIS to be delivered through individualised NDIS funding packages; and
- how might NDIS funding of PCIS impact on school operations – will there be an expectation for families to exercise choice and control over who provides PCIS for their child? Will this mean external providers delivering PCIS? How does this affect a school legal responsibility for duty of care for students?[65]

2.72 In its submission, the Queensland Government pointed out that 'the section covering Personal Support in Schools remained unfinished when the Principles were approved by COAG in December 2015'.[66]

2.73 The Victorian Government Department of Education is currently leading a national project to provide a stronger evidence base around PCIS options and future operational arrangements.[67]

Access and provision of therapies in schools

2.74 Occupational Therapy Australia and other submitters[68] raised the issue of access to schools for provision of therapy services:

> Currently, the provision of therapy services is determined by a state or territory education department policy regarding access to its schools or by a given private school's willingness to allow access. It is important to note also that therapy can involve facilitating a student's work in the classroom and/or participation in extra-curricular activities.[69]

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64 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 13.

65 ACT Government, *Submission 58*, p. 14.

66 Queensland Government, *Submission 72*, p. 8.

67 See for example: Department of Premier and Cabinet, Victoria, *Submission 54*, p. 13 and ACT Government, *Submission 58*, p. 14.

68 See for example, Autism Spectrum Australia, *Submission 40*, p.2; Speech Pathology Australia, *Submission 62*, p. 8; VCOSS, *Submission 65*, p. 29; Queensland Government, *Submission 72*, p. 9.

69 Occupational Therapy Australia, *Submission 26*, p. 8.

2.75 Speech Pathology Australia stated that 'there is now widespread reports of schools across Australia restricting all access to NDIS providers to students during core learning times, school hours and in some cases on school premises'.[70]

2.76 Ms Heidi Limareff, Deputy Chief Executive at Can:Do Group explained the current lack of consistency to the committee:

> The role of school therapy is up in the air. Some schools don't allow any NDIS work. Some say it's okay, but then supply their own goals for us to work on when in the schools. Some schools have had no changes whatsoever. Some allow us in because they know us and other times they don't allow us in because they know us and want new people coming in to try new things.[71]

2.77 Occupational Therapy Australia pointed to inequities of access to therapies between jurisdictions:

> For example, children with a disability living in Queensland have vastly improved access to school based occupational therapy services compared with those living in Victoria. Such inequity needs to be addressed via a national disability scheme.[72]

2.78 As a result of reported confusion and difficulty surrounding whether or not NDIS funded supports can be accessed at school, Family Advocacy recommended that guidelines for access to therapies in school hours be produced between the NDIA and state education departments.[73]

Committee view

Personal Care in Schools (PCIS)

2.79 The committee understands that the Victorian Government is leading a national project on PCIS and future operational arrangements. The committee believes this should assist in finalising the Principles in relation to education.

Recommendation 5

2.80 The committee recommends the Australian, state and territory governments clarify and agree on the scope and process to deliver Personal Care in Schools (PCIS) under the NDIS.

Provision of therapies in schools

2.81 With the transition to individualised service provision, evidence suggests that decisions to allow NDIS service providers to deliver therapies in schools are made on a case by case basis and heavily rely on internal school policies. The committee is of the view that the NDIA should develop guidance on best practices for provision of

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70 Speech Pathology Australia, *Submission 62*, p. 8.

71 Ms Heidi Limareff, Deputy Chief Executive, Can:Do Group, *Committee Hansard*, 27 September 2017, p. 2.

72 Occupational Therapy Australia, *Submission 26*, p. 8.

73 Family Advocacy, *Submission 52*, p. 9.

therapies in school settings based on lessons learnt during NDIS trials and rollout to date.

Recommendation 6

2.82 The committee recommends the NDIA develop guidance on best practices for provision of therapies in school settings based on lessons learnt during NDIS trials and rollout to date.

Transport

2.83 The provision of transport services for NDIS Participants attracted substantial criticism from government, stakeholders and Participants.

2.84 National Disability Services stated that 'transport in the NDIS needs urgent attention'[74] and raised the following issues:

> Unresolved questions include: how much funding should be provided by the NDIS to assist Participants with transport if they cannot use public transport? What responsibility do state and territory governments have in providing accessible transport for residents with disability, including in regional areas? Should the transportation of children with disability to school be the responsibility of the NDIS? Where does the funding responsibility lie for transporting people with disability to and from medical appointments?[75]

2.85 The Department of Premier and Cabinet, Victoria reported that 'several states and territories share Victoria's concerns that NDIS Participants are not receiving adequate transport support'.[76]

2.86 The Department of Social Services reported that 'administrative differences between state and territory service systems pose a challenge to applying a consistent national approach to addressing some transport system issues, especially in developing a national approach to NDIS and mainstream funding for taxi and private transport costs for NDIS Participants not able to travel independently'.[77]

Taxi subsidy scheme

2.87 The Office of the Public advocate (Queensland) reported that the taxi subsidy scheme in Queensland ceased with the introduction of the NDIS but was reinstated in July 2017.[78]

2.88 Indeed, due to concerns raised by stakeholders about transport supports provided in NDIS Plans not meeting Participant needs, the Queensland Government

74 National Disability Services, *Submission 12*, p. 2.

75 National Disability Services, *Submission 12*, p. 2.

76 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 14.

77 Department of Social Services, *Submission 29*, p. 6.

78 Office of the Public Advocate, *Submission 37*, p. 5.

reinstated the taxi subsidy scheme for NDIS Participants until transition is completed in June 2019.[79]

2.89 Similarly, the Tasmanian and Victorian governments have decided to fund taxi subsidies to NDIS Participants to ensure people are not disadvantaged during the transition period.[80]

2.90 The Victorian Government 'holds concerns that the NDIS may not be providing adequate transport support to Participants'.[81] As a result, it is currently paying taxi subsidies to NDIS Participants as well as making its agreed contributions to the NDIS under its bilateral agreement with the Commonwealth.

2.91 Similarly, Tasmania stated that 'this gap in support effectively means that the Tasmanian Government is paying twice for this cohort of NDIS Participants'.[82]

2.92 At a public hearing in Hobart, the Tasmanian Government further explained:

> In November 2016, in response to stakeholder concerns, the Tasmanian government established a temporary taxi subsidy safety net for approximately 130 NDIS Participants who were former members of the state's taxi subsidy program and who reported that their NDIS plans do not provide adequate funding for transport supports. That's 130 individuals who signed a form in which they declared that NDIS plans do not provide adequate funding for transport supports. I think it's significant that people were willing to actually make that declaration. The gap in support effectively means that the Tasmanian government is now contributing twice for this cohort of NDIS Participants.[83]

2.93 Given the lack of consistency in access and funding for taxi subsidies across jurisdictions, Spinal Cord Injuries Australia recommended that clear policy 'be put in place across the entire country on how taxi subsidies are to be applied to Participants to ensure continued equity and access for all people with disability'.[84]

2.94 At a public hearing in Canberra, Ms Jennifer Grimwade, Executive Officer of the Australian Blindness Forum raised the issue of the uncertainty of future funding:

> We are concerned that taxi subsidy schemes will be wound down in the future and that will also have a great impact on people who are blind or vision-impaired.[85]

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79 Queensland Government, *Submission 72*, p. 8.

80 Department of Premier and Cabinet, Tasmania, *Submission 75*, p. 6; Department of Premier and Cabinet, Victoria, *Submission 54*, p. 14.

81 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 14.

82 Department of Premier and Cabinet, Tasmania, *Submission 75*, pp. 6– 7.

83 Mr Andrew Rayner, Director, Intergovernmental Relations, Department of Premier and Cabinet, Tasmania, *Committee Hansard*, 4 October 2017, p. 3.

84 Spinal Cord Injuries Australia, *Submission 48*, p. 4.

85 Ms Jennifer Grimwade, Executive Officer, Australian Blindness Forum, *Committee Hansard*, 20 October 2017, p. 20.

2.95 The Australian Medical Association (AMA) is concerned that the growth of ridesharing platforms, such as Uber, may threaten the ongoing viability of mobility taxis and further restricts the availability of transport options for people with disabilities. It provided the example of San Francisco where the introduction of private ridesharing operations resulted in a significant drop of wheelchair accessible vehicles available in the city.[86]

Student transport

2.96 The provision of transport for Participants to and from school is an ongoing issue for the Scheme. COAG agreed that transport to and from school will be funded by the NDIA at full Scheme.[87]

2.97 To address risks of inadequate design of NDIS funded school transport, the Victorian Government is working in collaboration with the Commonwealth Government, the NDIA and other jurisdictions to develop a new model for NDIS funded student transport.[88]

2.98 The Queensland Government reported that it had not been able to agree with the NDIS 'on the administrative, operational or in-kind arrangements for the delivery of specialist school transport'.[89]

2.99 Mr Andrew Rayner from the Department of Premier and Cabinet, Tasmania, explained that on a number of service areas, including school transport, clear arrangements were not in place when transition commenced:

> In Tasmania, it's the status quo until the government is convinced that there's something developed that's workable and that will continue to provide that essential service for those children. That's an open-ended commitment. For school transport, a number of service areas and policy areas were still being worked on at the point that transition commenced. That's an artefact of the speed with which the NDIS is being built. School transport is one of those. We signed on the transition agreements in full knowledge that there wasn't a model for how school transport would work under the NDIS. I know that the NDIA is working on it.[90]

Committee view

2.100 The committee agrees with submitters that transport in the NDIS needs urgent attention. Transport issues have been consistently raised throughout this inquiry and

86 Australian Medical Association, *Submission 1*, p. 4.

87 See: Principles to Determine the Responsibilities of the NDIS and Other Service Systems, Section 5 –School education.

88 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 13.

89 Queensland Government, *Submission 72*, p. 8.

90 Mr Andrew Rayner, Director, Intergovernmental Relations, Department of Premier and Cabinet, Tasmania, *Committee Hansard*, 4 October 2017, p. 10.

other inquiries conducted by the committee.[91] The committee has received substantial evidence over a long period that NDIS Participants tend not to receive adequate supports in their Plans.

Taxi subsidy scheme

2.101 The committee notes that the Queensland, Victorian and Tasmanian Governments have temporarily reinstated taxi subsidies for NDIS Participants to ensure people are not disadvantaged during the transition period. In effect, it means that these states are paying taxi subsidies to NDIS Participants as well as making their agreed contribution to the NDIS under their bilateral agreements.

2.102 The committee is concerned that the current NDIS funding levels for transport supports for adults is not meeting participants' needs, or matching funding supports accessible through state and territory taxi subsidy schemes. This is leaving Participants worse off under the Scheme. State governments have apparently recognised this disadvantage and have been forced to temporarily reinstate taxi subsidies but the future remains uncertain beyond transition. The committee recommends that the NDIA undertake a review of its current operational and funding guidelines for transport supports with the view of ensuring it meets Participants' needs.

Recommendation 7

2.103 The committee recommends the NDIA review its operational and funding guidelines for transport supports to ensure NDIS Participants' needs are met.

Student transport

2.104 The committee believes that there is still considerable work to be undertaken to achieve a suitable NDIS funded student transport model. The committee understands that the Commonwealth, state and territory governments and the NDIA have established a working group to develop a new model for NDIS funded student transport. The committee welcomes this initiative, but is of the view that ensuring choice and control for each individual student should not hamper efforts to provide a crucial service for all students to get to and from school.

Housing

2.105 AMIDA argued that there is a well-known shortage of housing options, especially for people with complex needs.[92] Accommodation was the subject of an inquiry by this committee in 2015-2016 and it remains a critical issue.[93]

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91 Joint Standing Committee on the NDIS, G*eneral issues around the implementation and performance of the NDIS,* ongoing inquiry; Joint Standing Committee on the NDIS, *Provision of services under the NDIS Early Childhood Early Intervention Approach,* December 2017.

92 AMIDA, *Submission 39,* p. 2.

93 Joint Standing Committee on the NDIS, *Accommodation for people with disabilities and the NDIS,* May 2016.

2.106 The NDIS is not responsible for the provision of housing. However, the NDIS can fund supports in relation to housing and independent living. The NDIS factsheet *Mainstream Interface-Housing* provides some information about the supports funded by the NDIS. Supports include:

- home modifications to the participant's own home or a private rental property and on a case-by-case basis in social housing;
- the NDIS may also contribute to the cost of accommodation in situations where the participant has a need for specialised housing due to their disability. The NDIS will only assist with this cost where it is higher than the standard rental cost that the participant would otherwise incur.[94]

2.107 Additionally, the NDIS can fund:

- support that builds people's capacity to live independently in the community;
- support with personal care and help around the home where the participant is unable to undertake these tasks due to their disability, such as assistance with cleaning and laundry.[95]

2.108 With the transition to the NDIS, new issues are emerging, including in relation to:

- Special Disability Accommodation;[96]
- residential aged care facilities;[97]
- short-term accommodation and respite;
- and crisis accommodation.[98]

Specialist Disability Accommodation

2.109 In July 2016, the NDIS started to include Specialist Disability Accommodation (SDA) funding in Participants' plan. SDA funding is for the dwelling

94 NDIS, *Mainstream Interface-Housing*, p. 1; https://www.ndis.gov.au/medias/documents/h0a/h10/8800552321054/Factsheet-MainstreamInterfaces-Housing.pdf (accessed 14 November 2017).

95 NDIS, *Mainstream Interface-Housing*, p. 1; https://www.ndis.gov.au/medias/documents/h0a/h10/8800552321054/Factsheet-MainstreamInterfaces-Housing.pdf (accessed 14 November 2017).

96 See for example: Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard,* 19 September 2017, pp. 15–16; National Disability Services, *Submission 12,* Attachment 1; p. 10; Summer Foundation, *Submission 22,* p. 11.

97 Ms Kym Peake, Secretary, Department of Health and Human Services, Victorian Government, *Committee Hansard,* 19 September 2017, p. 6.

98 Office of the Public Advocate, *Submission 69,* p. 14.

itself, and is not intended to cover support costs (such as Supported Independent Living), which are assessed and funded separately by the NDIS.[99]

2.110 Submitters reported a shortage of Specialist Disability Accommodation (SDA).[100] The Summer Foundation acknowledges that 'there is a real promise in the SDA or specialist accommodation framework' but reported implementation issues.[101]

2.111 At a public hearing in Melbourne, Dr George Taleporos, Policy Manager at the Summer Foundation, further explained some of the current issues which impend on housing development:

> The issue, however, is that we are not seeing people receiving SDA payments in their plan. The only people who are receiving SDA payments in their plan are people who are currently in in-kind housing funded by the state governments. Developers, investors and people who want to build housing are not seeing that there's a market for this housing, because no-one has SDA in their plans. Our sister organisation, Summer Housing, is providing housing for eight people, and not even they have SDA in their plans.[102]

2.112 Dr Taleporos stressed that until payments start appearing in people's Plans, 'there will be very few developers who will actually take the risk and build housing'.[103]

2.113 The SDA pricing framework guarantees funding for five years. The Summer Foundation believes investors need a longer period of price certainty to feel confident about developing housing options.[104]

Residential Aged Care

2.114 As described by Dr George Taleporos, the lack of housing has resulted in people 'currently trapped in residential aged-care facilities'.[105] He also pointed out that

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99 NDIS, *Specialist Disability Accommodation*, https://www.ndis.gov.au/specialist-disability-accommodation.html (accessed 22 November 2017)

100 See for example: Prader-Willi Syndrome Australia, *Submission 9*, p. 9; National Disability Services, *Submission 12*, Attachment 1; p. 10; Summer Foundation, *Submission 22*, p. 11.

101 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard*, 19 September 2017, p. 12.

102 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard*, 19 September 2017, pp. 15 and 16.

103 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard*, 19 September 2017, p. 16.

104 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard*, 19 September 2017, p. 16.

105 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard*, 19 September 2017, p. 12.

with the withdrawal of state services, people are finding themselves in 'funding limbo', which is 'particularly concerning' for young people in residential aged care.[106]

2.115 At a public hearing in Melbourne, Ms Kym Peake, Secretary of Department of Health and Human Services with the Victorian Government acknowledged the increased number of young people in residential aged care facilities and advised the committee that the Victorian Government is undertaking some work in this area.[107]

2.116 Ms Peake reported that 'approximately 1569 young people are in residential aged care in Victoria, and in 2016 there was an increase of about 100 extra young people'.[108]

2.117 Dr George Taleporos told the committee that one of the reasons for the increase in people in residential aged care under the NDIS in Victoria is that when a person is in hospital, the state government is no longer taking responsibility for finding a suitable solution and the NDIS is yet to be more responsive.[109]

2.118 Ms Natalie Siegel-Brown, the Public Guardian in Queensland noted that a contributing factor to young people remaining in aged care is that nursing homes are failing to register people for the NDIS. Through an informal survey, the Office of the Public Guardian found that 'nursing homes have no idea that the young people in their homes are eligible for NDIS'.[110]

Short-term accommodation and respite

2.119 Mr James O'Brien, President of the Prader-Willi Syndrome Association of Australia reported that the NDIS pricing guide for special disability accommodation is ambiguous in relation to respite, emergency or temporary accommodation and this is resulting in short-term facilities closing down:

> My reading is that short-term stays are not funded under SDA. There is currently insufficient funds for short-term facilities to meet the demand and existing respite providers have indicated to me that they will be closing due to a lack of funding under the new system.[111]

106 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard,* 19 September 2017, p. 11.

107 Ms Kym Peake, Secretary, Department of Health and Human Services, Victorian Government, *Committee Hansard,* 19 September 2017, p. 6.

108 Ms Kym Peake, Secretary, Department of Health and Human Services, Victorian Government, *Committee Hansard,* 19 September 2017, p. 7.

109 Dr George Taleporos, Policy Manager, Summer Foundation, *Committee Hansard,* 19 September 2017, p. 17.

110 Ms Natalie Siegel-Brown, Public Guardian, Office of the Public Guardian, Queensland, *Committee Hansard,* 26 September 2017, p. 5.

111 Mr O'Brien, President, Prader-Willi Syndrome Association of Australia, *Committee Hansard,* 19 September 2017, p. 19.

2.120 National Disability Services reported that because NDIS funds the user cost of capital for long-term housing (SDA) but not for short-term accommodation, there is a risk of respite houses being converted to long-term accommodation.[112]

2.121 At a public hearing in Canberra, Dr Ken Baker acknowledged the work currently undertaken by the NDIA to respond to 'the looming crisis in short-term accommodation and respite services by announcing its intention to introduce a new pricing structure from the end of the month'.[113]

2.122 Following consultation and feedback from Participants and providers, the NDIA increased price limits for short term accommodation and the changes took effect on 30 October 2017.[114]

2.123 The new price limits per night for short-term accommodation now include increased price limits for weekend and public holidays, as well as for high intensity care.[115]

Crisis accommodation

2.124 Submitters drew the attention of the committee on the issue of some tenants with complex needs in group homes who are being given notice to vacate and are at risk of becoming homeless due to lack of Provider of Last Resort.[116]

2.125 The Office of the Public Advocate (OPA) in Victoria reported that 'in a pre-NDIS world, the Victorian Department of Health and Human Services (DHHS) could be relied upon to ensure that especially vulnerable people with disability (and complex needs that threatened tenancy arrangements) did not become homeless'.[117]

2.126 However, the OPA is of the view that, 'since the introduction of the NDIS, DHHS can no longer be depended on to provide this safety net in regions where the NDIS has been rolled out'.[118]

2.127 The OPA pointed out that 'the transitional arrangements are largely silent on who will provide and fund crisis accommodation for people whose behaviours threaten their tenancy. Neither the Victorian Bilateral Agreement nor the Operational Plan refer specifically to crisis or temporary accommodation or its provision to people with disability'.[119]

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112 National Disability Services, *Submission 12*, Attachment 1; p. 11.

113 Dr Ken Baker, CEO, National Disability Services, *Committee Hansard*, 20 October 2017, p. 11.

114 NDIS, *Pricing and payment*, https://www.ndis.gov.au/providers/pricing-and-payment.html (accessed 20 November 2017)

115 NDIS, *NDIS Price Guide Victoria, New South Wales, Queensland, Tasmania*, version released on 30 October 2017.

116 See for example, AMIDA, *Submission 39*, pp. 2 and 3; Office of the Public Advocate, *Submission 69*, p. 14.

117 Office of the Public Advocate, *Submission 69*, p. 14.

118 Office of the Public Advocate, *Submission 69*, p. 14.

119 Office of the Public Advocate, *Submission 69*, p. 14.

2.128 The OPA noted:

> Under the NDIS there are no provisions available for alternative accommodation – no additional 'crisis' funding from the NDIA and no one responsible for providing a bed. This situation was recognised and addressed in the recently released Productivity Commission Position paper on NDIS Costs, and NDIA's response to that paper. NDIA has stated that they are currently developing a 'Market Intervention Strategy' and are prepared to ensure market supply and act as provider of last resort in cases of 'thin markets' and market failure including in crisis care and accommodation situations and service gaps for Participants with complex, specialised or high intensity needs, or very challenging behaviours.[120]

Committee view

Specialist Disability Accommodation

2.129 The committee is cognisant of the ongoing shortage of Specialist Disability Accommodation (SDA). The committee has received anecdotal evidence that Participants are not receiving SDA funding in their Plans. Because it has not been available for long, the committee believes it is too early to comment on the effectiveness of the introduction of SDA funding in Participants' Plans. The committee is aware that the Disability Reform Council has asked the NDIA to consider mechanisms through which private investment in SDA could be encouraged. The committee understands that the NDIA has engaged McKinsey & Co to progress this work and expects to publish new information on SDA by the end of March 2018.[121] The committee will undertake work in this area during the course of its new inquiry on market readiness.

2.130 The introduction of SDA payments in plans will not address the chronic lack of housing for people with disability. The committee acknowledges that housing remains the responsibility of mainstream services and believes that the Australian, state and territory governments need to develop and introduce new initiatives to address the shortage of accommodation for people with disability. This should include considering options of land release and adapting existing housing stock.

Recommendation 8

2.131 The committee recommends the Council of Australian Government (COAG) Disability Reform Council consider the provision of housing stock and infrastructure for people with disability.

Young people in residential aged care and crisis accommodation

2.132 The committee is concerned with the reported increase in young people in residential aged care facilities since the introduction of the NDIS. The committee

120 Office of the Public Advocate, *Submission 69*, p. 15.

121 NDIS, *SDA market information*, 9 February 2018, https://www.ndis.gov.au/news/sda-drc-response.html (accessed 9 February 2018).

noted that the Victorian Government is undertaking some work in this area to address the issue. The committee also noted that one of the reasons put forward for this increase is that state and territory governments are no longer responsible at time of hospital discharge to find a suitable accommodation solution. The committee is of the view that Provider of Last Resort arrangements should be put in place to ensure no Participants end up in residential aged care facilities when discharged from hospital. The issue of Provider of Last Resort is further discussed in chapter 4 of this report.

2.133 The committee is concerned with the lack of arrangements for provision of crisis accommodation. This is increasing the risk of people with complex needs becoming homeless. The committee agrees with the Productivity Commission's finding that it is unclear whether the NDIS or state and territory governments are responsible for funding emergency supports for accommodation.[122] In the committee's view this is because the responsibilities are omitted in the majority of bilateral agreements, and subsequent operational plans. The committee believes that the Australian, state and territory governments and the NDIA need to work together to clarify roles and responsibilities of the state and territory governments and the NDIA in relation to provision of crisis care and accommodation.

Recommendation 9

2.134 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.

Justice system

2.135 The lack of integration between the NDIS and the justice system was reported by inquiry Participants.[123] The committee reported on this issue in its recent inquiry into the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.*[124]

2.136 Issues raised by submitters relate to diminished access to supports under the NDIS; lack of and/or inability to find service providers and unresolved Provider of Last Resort arrangements.[125]

122 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 250.

123 See for example: Australian Red Cross, *Submission 67*, p. 4; VCOSS, *Submission 65*, p. 30; Australian Federation of Disability Organisations, *Submission 68*, p. 6; Victoria Legal Aid, *Submission 79*, p. 2.

124 Joint Standing Committee on the National Disability Insurance Scheme, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017, chapter 5, pp.51–62.

125 VCOSS, *Submission 65*, p. 30; Australian Federation of Disability Organisations, *Submission 68*, p. 6; Victoria Legal Aid, *Submission 79*, p. 2.

2.137 For example, VCOSS members reported two cases of NDIS Participants having support cut as a result of moving to the NDIS on the grounds that these supports were related to offending behaviour. VCOSS explained:

> In both cases, the individuals were receiving funding through their Victorian Individual Support Packages for psychological services to help reduce offending related behaviour and promote pro-social behaviour and broader life skills. The NDIA has ruled this support is not 'reasonable and necessary' on the grounds it relates to offending behaviour. However, the COAG principles states the NDIS will cover 'supports to address behaviours of concern (offence related causes) and reduce the risk of offending and reoffending such as social, communication and self-regulation skills…' Some service providers specialising in forensic support services to people with disability have also been informed they cannot provide this support under the NDIS. It is unclear if they will continue to receive state-based funding. Without these support these people risk becoming entrenched in the criminal justice system.[126]

2.138 Victoria Legal Aid reported cases of clients unable to be released from custody because they are not able to attract service providers.[127] Victoria Legal Aid is of the view that 'urgent and immediate solutions must be developed to address circumstances where the continued detention of our clients with complex disabilities is directly linked to the failure of the market to provide disability services under the NDIS'.[128] They called on the NDIA and the Victorian Government to 'urgently allocate clear and transparent responsibility for immediately providing services to his vulnerable cohort of clients'.[129]

2.139 In its submission, the NDIA stated it is working on a number of projects to improve interface issues at the jurisdictional level, including a project on 'improvements in criminal justice system intersection with the Victorian Government'.[130]

Committee view

2.140 The committee believes it is imperative that the interface between the NDIA and the criminal justice system works effectively. As discussed in Recommendation 23 in its report on the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health,* the committee supports the

126 VCOSS, *Submission 65,* p. 31.

127 Victoria Legal Aid, *Submission 79,* p. 4.

128 Victoria Legal Aid, *Submission 79,* p. 8.

129 Victoria Legal Aid, *Submission 79,* p. 9.

130 NDIA, *Submission 41,* p. 5.

proposal of establishing an NDIA unit specialising in the interaction of the Scheme with the criminal justice system.[131]

131 Joint Standing Committee on the National Disability Insurance Scheme, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017, pp. 61–62.

Chapter 3

Delivery of services

3.1 This chapter reviews the impediments to delivery of appropriate and timely services under the NDIS, which have been identified throughout the inquiry by NDIS Participants, peak bodies, Governments and service providers.

3.2 Firstly, it discusses issues associated with the planning process leading to poor quality of Plans and need for Plan reviews. Then, it explores the concerns raised by submitters about Plan reviews and outcomes.

3.3 The second part of the chapter focuses on the barriers experienced by service providers to operate and provide quality services in the NDIS environment. This includes issues with the registration process, NDIS pricing caps and workforce shortages.

3.4 The final part of the chapter explores the rollout of ILC and reported issues associated with the quantum of funding allocated to ILC activities during the transition period; the funding model itself; and the emerging gaps in services.

Quality of Plans

3.5 Across all jurisdictions, submitters continue to report poor planning experiences and outcomes for Participants. These include inconsistencies in Plans; and inadequate levels of support in Plans leading to Participants asking for plan reviews.

3.6 Overall, the committee received significant evidence of inconsistent packages being granted to NDIS Participants across all jurisdictions, with some Participants with similar conditions and similar support needs receiving vastly different Plans. [1]

3.7 The quality of NDIS Plans appears to be dependent on two main factors: 1) the NDIS Planner's knowledge and expertise and; 2) the level of advocacy families and NDIS Participants can undertake and their knowledge of the disability sector.[2]

Planners' expertise

3.8 Many submitters reported a general lack of knowledge, expertise and experience of Planners resulting inconsistent and inadequate plans.[3] Some plans may be over-funded, whilst others are significantly under-funded.

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1 See for example: Allied Health Professions Australia, *Submission 6,* p. 7; Prader-Willi Syndrome Australia, *Submission 9,* p. 7; Mental Illness Fellowship of Australia, *Submission 44,* Mental Health Australia, *Submission 50,* p. 7; p. 8; Speech Pathology Australia, *Submission 62,* p. 11.

2 See for example: Professions Australia, *Submission 6*, p. 7, Summer Foundation, *Submission 22*, p. 17, Department of Premier and Cabinet NSW, *Submission 27*, p. 2; Allied Health.

3 See for example: Anglicare Australia, *Submission 8,* Attachment 1, p. 8; National Disability Services, *Submission 12,* Attachment 1, p. 6; Occupational Therapy Australia, *Submission 26*, p. 3; Multiple Sclerosis Australia, *Submission 31*, p. 6.

3.9 The NSW Department of Premier and Cabinet noted that 'it appears that Planner knowledge and capability is highly varied, as is their interpretation of reasonable and necessary supports'.[4]

3.10 Allied Health Professions Australia reported that 'understanding of allied health professions is poor among Planners, leading these supports to be absent from Participant packages'.[5] For example, the committee received evidence that Assistive Technology supports are often inconsistent and expert recommendations are often ignored by Planners.[6]

3.11 MJD Foundation (MJDF) reported that 'the variable quality of Planners has meant that clients of the MJDF have experienced a range of planning outcomes'.[7]

3.12 In its submission, Speech Pathology Australia conveyed the view of its members:

> Speech pathologists report that the NDIS Planning process and the decisions made by the NDIS Planners themselves generally demonstrate a lack of understanding of the complexity of needs for individuals with disability and the complexity involved in developing an outcome based plan for supports and services.[8]

3.13 At a public hearing in Melbourne, Ms Rachel Norris, CEO of Occupational Therapy Australia (OTA), summarised the views of OTA members:

> The quality of NDIS Plans varies considerably from person to person and depends on the planner's level of experience and understanding of the breadth of services available to Participants. Planners are recruited from a variety of backgrounds, and it is clear that they frequently underestimate the hours of therapy required for a participant to achieve their goals, which subsequently affects the quality of their plan. Nor do they understand occupational therapy's key role in the prescription and review of assistive technology and home modifications.[9]

Advocacy and access to pre-planning

3.14 Mental Health Australia noted that 'strong anecdotal evidence indicates that consumers who are well supported by strong advocates (whether they happen to be carers, support workers, formal advocates or others) continue to receive Plans which better suit their needs'.[10]

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4 Department of Premier and Cabinet NSW, *Submission 27*, p. 2.

5 Allied Health Professions Australia, *Submission 6*, p. 7.

6 See for example: Can: Do Group, *Submission 25*, p. 10; Vision Australia, *Submission 24*, pp.5–6; Occupational Therapy Australia, *Submission 26*, p. 3.

7 MJD Foundation, *Submission 7*, p. 5.

8 Speech Pathology Australia, *Submission 62*, p. 12.

9 Ms Rachel Norris, Chief Executive Officer, Occupational Therapy Australia, *Committee Hansard*, 8 November 2017, p. 4.

10 Mental Health Australia, *Submission 50*, p. 8.

3.15 Ms Rachel Norris, CEO of Occupational Therapy Australia, also pointed out that 'too often the quality of a plan comes down to how effective the participant or advocate is at stating their needs during plan development conversations'.[11]

3.16 Ms Natalie Siegel-Brown, the Public Guardian (Queensland), explained how having an advocate during the planning process can make a real difference in outcomes:

> […]sometimes just having an advocate sitting beside a person in the NDIS-planning process with a planner will reap a different quantum of funds compared to a very similarly profiled person who doesn't have an advocate sitting there and who is in front of the same planner.[12]

3.17 Cohealth related the following example, which illustrates the critical role of advocacy during the planning process:

> For example, two consumers of cohealth mental health community support services, with very similar conditions and circumstances received very different Plans. The main difference appeared to be that one had an advocate/support accompany them to the planning meeting.[13]

Importance of pre-planning

3.18 According to submitters, pre-planning also plays a fundamental role and can make a significant difference in quality of outcomes for Participants.[14]

3.19 For example, Neurological Alliance Australia reported that the 'lack of pre-planning can result in ineffective Plans which require an NDIS review and / or result in negative health impacts for people with a progressive neurodegenerative disease'.[15]

3.20 The Summer Foundation also reported the importance of supporting people during the pre-planning and planning process and identified funding gaps:

> A lack of preparation support for planning means significant gaps have emerged because individuals are unable to articulate their complete needs and goals as is required for a good outcome from planning. The important work of supporting people with NDIS pre-planning and through the planning process is not being funded in the national rollout, and services such as case management that could have assisted are being de-funded prematurely as the NDIS rolls out.[16]

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11 Ms Rachel Norris, Chief Executive Officer, Occupational Therapy Australia, *Committee Hansard*, 8 November 2017, p. 4.

12 Ms Natalie Siegel-Brown, Public Guardian, Public Guardian Office of Queensland, *Committee Hansard*, 26 September 2017, p. 11.

13 Cohealth, *Submission 34*, p. 5.

14 See for example: Community Mental Health Australia, *Submission 3*, p. 8; Victorian Healthcare Association, *Submission 11*, p. 5; VCOSS, *Submission 65*, p. 8.

15 Neurological Alliance Australia, *Submission 31*, Attachment 2, p. 3.

16 Summer Foundation, *Submission 22*, p. 17.

3.21 Other submitters[17] identified a lack of funding available for pre-planning, which is why organisations such as VCOSS[18] and Neurological Alliance Australia[19] are calling for funding comprehensive pre-planning support.

3.22 However, some organisations receive funding from state governments to provide pre-planning support. For example, Mr Kevin Stone, CEO of VALID, told the committee that VALID is receiving funding from the Victorian Government's Transition Support Package to provide information and support to people during pre-planning:

> That fund allows us to do a number of different things. Our main strategy is to provide information sessions to people with disability and to families about the NDIS and its operation. That's what we basically call a NDIS 101 session. […] That equips parents or family members in the skills of person centred planning, goal setting, supporting their sons and daughters to self-advocate et cetera. Basically, it supports them to negotiate the system. The evidence that we have is that families who go through that process are much better equipped to enter into the NDIS process.[20]

3.23 The NSW Government is also funding a few organisations to deliver pre-planning support and information. Ms Serena Ovens, Executive Officer at Physical Disability Council of NSW, explained:

> Currently, we're funded by the New South Wales department of disability, ageing and home care, and that's just approximately five to six organisations in New South Wales, to assist in pre-planning. So we do have limited capacity to assist some people to work with us one on one for a far greater period of time than they will do in their own planning meeting. We have the ability to go back and forth and show a pre-plan to them, talk about it, look at what might be missing and redo and readjust more than once for those people before they even get to their NDIA or LAC planning meeting.[21]

Plan reviews

3.24 According to submitters, poor planning has led to an increase in the number of reviews being requested.[22]

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17 See for example: Ms Sarah Pastro, Placement Coordinator, Baptist Care, *Committee Hansard*, 27 September 2017, p. 6; Victorian Healthcare Association, *Submission 11*, p. 5; Mental Health Australia, *Submission 50*, p. 7.

18 Ms Emma King, Chief Executive Officer, Victorian Council of Social Service, *Committee Hansard*, 8 November 2017, p. 1.

19 Neurological Alliance Australia, *Submission 31*, Attachment 2, p. 3.

20 Mr Kevin Stone, CEO, VALID, *Committee Hansard*, 19 September 2017, p. 24.

21 Ms Serena Ovens, Executive Officer, Physical Disability Council of NSW, *Committee Hansard*, 3 October 2017, p. 9.

22 See for example: Family Advocacy, *Submission 52*, p. 18; Ms Serena Ovens, Executive Officer, Physical Disability Council of NSW, *Committee Hansard*, 3 October 2017, p. 6; Anglicare Australia, *Submission 8*, Attachment 1, p. 10.

A slow and frustrating process

3.25 Feedback received by Family Advocacy through a survey of 100 families reveals that 'the review process is slow, frustrating and stressful'.[23] For example, one family related the following experience:

> Too long to tell. Three Plans in eight months - none of which were instigated by us but because planner had stuffed up. Had to appeal but appeal was dismissed as having 'no grounds'. Received a phone call this week by NDIS saying there had been a 'programming error' and they would like the opportunity to have a face to face meeting with them.[24]

3.26 Occupational Therapy Australia noted that plan reviews are lengthy and this can jeopardise Participants' ability to progress toward achieving their goals:

> These reviews can take months to complete, resulting in added frustration for families and potentially affecting the relationship between participant and provider. In addition, the long wait associated with plan reviews frequently results in any progress that the participant has made towards their goals being lost due to lack of continuity. This ultimately results in increased supports being required to re-establish progress.[25]

3.27 At a public hearing in Melbourne, Miss Grace Poland, an NDIS Participant, told the committee that she requested a review of her NDIS Plan and 'it took 11 weeks to get a response'.[26]

3.28 Allied Health Professions Australia also reported that 'reviews are currently taking weeks and even months to complete, resulting in added frustration for families and potential service gaps'.[27]

3.29 Anglicare Australia raised the issue of people not having access to services because of reviews taking too long:

> With reviews often taking months rather than the stipulated two weeks the result is people in limbo without access to services critical to their health and wellbeing.[28]

3.30 The Office of the Public Advocate (Victoria) identified a need for the NDIA to address the long wait time for plan review.[29]

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23 Family Advocacy, *Submission 52*, p. 10.

24 Family Advocacy, *Submission 52*, p. 19.

25 Occupational Therapy Australia, *Submission 26*, pp. 3 and 4.

26 Miss Grace Poland, Summer Foundation, *Committee Hansard*, 19 September 2017, p. 11.

27 Allied Health Professions Australia, *Submission 6*, p. 8.

28 Anglicare Australia, *Submission 8*, Attachment 1, p. 10.

29 Office of the Public Advocate, *Submission 69*, p. 24.

Plan reviews leading to reduced funding

3.31 Submitters told the committee that there are instances where Participants have sought a Plan review which has resulted in a reduction in funding.[30]

3.32 The ACT Government was approached by a number of Participants whose Plans are being cut after a plan review and reported:

> In some occasions Plans are being cut by up to 80%. The ACT has also been informed that Participants are unwilling to ask for a plan review as they are concerned their Plans will be cut.[31]

3.33 In its submission, Carers NSW said 'there have been widespread reports in NSW of funding being significantly reduced following a Plan review' and provided the following examples:

> Ariana cares for her daughter Jocelyn and was forced to participate in a phone based plan review. […] When the plan came back, the funding allocation had been reduced by three quarters, placing Ariana's employment at risk.
>
> Fatimah's son Mohamed is nonverbal and exhibits behaviours of concern. When his plan was reviewed, the funding allocated to Mohamed was drastically reduced, leaving only around $700 for the year to cover respite, and no funding at all for vacation care. This loss of funding greatly distressed Fatimah, who will not be able to work until the matter is resolved.[32]

Committee view

Planning process

3.34 The committee acknowledges the work undertaken by the NDIA to improve the planning process and Participants' experiences and outcomes. The new Participant Pathway,[33] which is currently being piloted, is a step in the right direction to improve the pre-planning and planning processes. The pilot is expected to be completed by the end of April 2018 and then rolled out nationally. The committee recommends the NDIA ensure that ability for Participants to see, discuss and potentially amend their draft Plan before it is finalised is rolled out nationally as soon as possible.

3.35 The committee noted the importance and benefits of pre-planning supports, and is aware that, currently, some state Governments are funding such activities. The

30 See for example: Queensland Advocacy Inc, *Submission 21*, p. 4; Carers NSW, *Submission 55*, p. 12; Queensland Government, *Submission 72*, p. 10.

31 ACT Government, *Submission 58*, p. 19.

32 Carers NSW, *Submission 55*, p. 12.

33 NDIS, *The NDIS pathway experience*, https://www.ndis.gov.au/pathways-experience (accessed 20 December 2017).

committee recommends the NDIA ensure that across all jurisdictions people with disability can access pre-planning supports.

3.36 The committee understands that the NDIA is continuing to develop tailored pathways for people with psychosocial disability; children; people from Aboriginal and Torres Strait Islander communities; those from culturally and linguistically diverse backgrounds and Participants with more complex needs.[34] Whilst the committee is pleased to see such work under way, it is concerned with the long time it is taking for the NDIA to respond and address the planning issues experienced by these cohorts. The committee urges the NDIA to ensure these new pathways are piloted as soon as possible and then promptly rolled out nationally.

Recommendation 10

3.37 The committee recommends the NDIA ensure that across all jurisdictions people with disability can access pre-planning supports.

Recommendation 11

3.38 The committee recommends the NDIA urgently finalise and start piloting the tailored pathways it has been developing for people with psychosocial disability; children; people from Aboriginal and Torres Strait Islander communities; those from culturally and linguistically diverse backgrounds and Participants with more complex needs.

Plan review

3.39 The committee believes the number of requests for plan reviews due to inadequate Plans should drop once the practice of allowing Participants to see and comment on their draft Plan before it is finalised is implemented. The committee notes that the NDIA is currently not reporting in a consistent manner on the number of unscheduled plan reviews. The committee agrees with the recommendation made by the Productivity Commission that the NDIA publicly report on the number of unscheduled plan reviews, on reviews of decision, review timeframes, outcomes of reviews and stakeholder satisfaction with the review process.[35]

3.40 The committee is concerned with widespread reports of funding in Participants' Plans being significantly reduced following a Plan review. Whilst the committee acknowledges there is no publically available data to determine the extent of the practice of cutting funding at Plan reviews, the anecdotal evidence from a number of sources suggests a trend in reduction of funding and supports in Participants' Plans after a Plan review. More clarity and transparency around review processes and outcomes are urgently required. The NDIA must publically and regularly report on the outcomes of reviews and undertake an analysis as to why funding in Plans may have been reduced in some cases.

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34 NDIS, *CEO Opening statement - Senate Estimates*, 25 October 2017, https://www.ndis.gov.au/news/ceo-senate-estimates-25oct.html (accessed 20 December 2017).

35 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, Canberra, October 2017, p. 61.

Recommendation 12

3.41 The committee recommends the NDIA publish data and analysis on the following in its Quarterly Reports:

- **number of plan reviews;**
- **waiting times Participants face for reviews;**
- **outcomes of plan reviews in terms of whether the overall package has been increased or decreased;**
- **satisfaction rating of Participants following a plan review.**

Waiting times

3.42 The committee is concerned with the lengthy waiting times experienced by Participants in getting their Plans approved, activated and reviewed. This is impeding on Participants' access to initial services and continuity of supports.

Recommendation 13

3.43 The committee recommends the NDIA focus all necessary resources and efforts on reducing waiting times at all points of the Scheme, specifically for plan approval, activation and review.

Impediments to deliver services

3.44 The following section deals with the impediments to deliver services identified by service providers during the course of this inquiry. Barriers to deliver services include the registration and administrative burdens experienced by providers; the inadequacy of NDIS pricing caps; and disability workforce shortages.

Registration processes and costs

3.45 At present, during the transition period, ensuring the quality and safeguards of disability supports remains the responsibility of the Commonwealth, state and territory Governments. As the quality and safeguards arrangements differ between jurisdictions, providers must comply with the individual requirements of each jurisdiction in which they are providing supports.[36] As a result, the registration requirements and processes to become an NDIS service provider differ across jurisdictions.

3.46 Overall, submitters expressed concerns about the inconsistent provider registration requirements across jurisdictions, arguing it is a significant barrier to entry into the NDIS marketplace.[37]

36 NDIS, *Provider Guide to Suitability V 1.07*, November 2017, p. 5.

37 See for example: Allied Health Professions Australia, *Submission 6*, p. 8; Royal Institute for Deaf and Blind Children, *Submission 35*, p. 15; Dietitians Association of Australia, *Submission 36*, p. 5.

3.47 For example, Dietitians Association of Australia described the registration process as difficult for some providers, 'with some States requiring compliance with onerous processes'.[38]

3.48 Some occupational therapists have reported that 'the registration process can be quite lengthy, which may deter some people from signing up as providers'.[39]

3.49 A provider in Victoria reported that to register as a provider for NDIS Early Childhood Supports is 'overly onerous, particularly for sole traders and small organisations'.[40]

3.50 Speech Pathology Australia explained that after receiving 'concerning feedback' from many of its members seeking to register as NDIS providers, it examined the requirements in each state and territory and formed the following view:

> […] it is the view of Speech Pathology Australia that the requirements have been designed (and are entirely appropriate) for assessment of larger disability specific organisations. When these requirements are applied to small or solo allied health businesses, they act as a significant disincentive for speech pathologists to become NDIS registered providers within some states.[41]

3.51 Speech Pathology Australia noted that 'alternative arrangements have now made for small speech pathology and occupational therapy practices within New South Wales (NSW) and in Northern Territory (NT)'.[42]

Third Party Verification

3.52 According to Allied Health Professions Australia, the requirement for third party verification in particular has been a frequent issue reported by small providers, especially in NSW and Victoria.[43] Similarly, Making Connections Together argued that 'providers have their hands tied by Third Party Verification which is excessive for small businesses'.[44]

3.53 Dietitians Association of Australia also expressed concerns about the process of verification within registration to be implemented from July 2018, arguing that 'the proposed process presents considerable burden to providers compared to the current allied health application for provider with Medicare' and that 'whereas there is no cost to register with Medicare, it is likely that the NDIS verification process and

38 Dietitians Association of Australia, *Submission 36*, p. 5.

39 Occupational Therapy Australia, *Submission 26*, p. 3.

40 Name Withheld, *Submission 4*, p. 1.

41 Speech Pathology Australia, *Submission 62*, p. 16.

42 Speech Pathology Australia, *Submission 62*, p. 16.

43 Allied Health Professions Australia, *Submission 6*, p. 8.

44 Making Connections Together, *Submission 43*, p. 1.

components such as police checks and working with vulnerable person checks will cost some hundreds of dollars'.[45]

3.54 Speech Pathology Australia reported that the average estimated cost of Third Party Verification is around $4,500 and is a reason for not registering, with one provider saying:

> I deliberately have not registered for supports that require 3rd party verification, it is not worth it for a sole trader.[46]

3.55 Occupational Therapy Australia recently conducted a survey which revealed that reasons provided by therapists for not registering included 'negative feedback from colleagues about the NDIS, and the administrative work and costs involved in registering'.[47]

Administrative burden

3.56 Submitters raised concerns about the additional administrative burden of providing services through the NDIS.[48] This is resulting in additional costs borne by service providers as well as some providers choosing not to register as NDIS providers.[49]

3.57 Speech Pathology Australia members explained the situation:

> Members reported the increased administration burden of providing services through the NDIS (in comparison to other funding streams including Better Start for Children with Disability, Medicare, Department of Veteran Affairs and private health insurance). Many practices have resorted to employing additional administrative staff to work solely on NDIS administration processes in the transition. The additional excessive administrative burden cannot continue to be absorbed into the per hour NDIS fee for speech pathology services for many private practitioners.[50]

3.58 This is resulting in speech pathologists 'delaying entering the NDIS market, reducing the share of their practice case load of NDIS clients and/or restricting service to self-managed clients to avoid the costs associated with excessive administrative burden'.[51]

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45 Dietitians Association of Australia, *Submission 36*, p. 6.

46 Speech Pathology Australia, answers to questions on notice, 8 November 2017 (received 27 November 2017).

47 Occupational Therapy Australia, answers to questions on notice, 8 November 2017 (received 24 November 2017).

48 See for example: Municipal Association of Victoria, *Submission 30*, p. 2; VICSERV, *Submission 33*, p. 3; cohealth, *Submission 34*, p. 3; VCOSS, *Submission 65*, p. 3.

49 See for example: Department of Premier and Cabinet, Victoria, *Submission 54*, p. 12; Speech Pathology Australia, *Submission 62*, p. 16.

50 Speech Pathology Australia, *Submission 62*, p. 16.

51 Speech Pathology Australia, *Submission 62*, p. 16.

Committee view

3.59 The committee acknowledges that during the transition period and until the NDIS Quality and Safeguarding Framework (the Framework) is implemented, the Commonwealth, state and territory Governments remain responsible for quality and safeguarding arrangements, including registering providers. The current situation is obviously creating disparities in processes and potentially deterring some providers, especially sole traders or small organisations to become NDIS providers. The committee is concerned that some small providers may not register as NDIS providers due to current onerous processes. This may restrict choices and availability of providers for Participants.

3.60 The committee understands that, as part of the Framework, a risk responsive registration system for service providers will be established. One of the responsibilities of the Independent NDIS Quality and Safeguards Commission to be established in early 2018 will be to register NDIS providers and oversee provider quality once at full Scheme. The committee suggests that consideration be made to establish different levels of registration requirements based on size of the organisations to ensure that sole providers and small organisations have capacity and resources to go through the registration process without excessive burdens. Meanwhile, during transition, the committee encourages state and territory Governments to put strategies in place to support sole traders and small organisations through the registration process. The committee will further consider this issue in the context of its inquiry into market readiness.

Recommendation 14

3.61 The committee recommends state and territory governments put strategies in place to facilitate and support the registration of providers during the transition period.

NDIS pricing

3.62 Submitters raised concerns about the current NDIS price caps and argued they do not always reflect the real cost of service delivery.[52] It risks the sustainability and growth of the disability sector as well as reducing quality and availability of services for Participants.

3.63 For example, Catholic Social Services Australia reported that 'the inadequacy of this transitional pricing methodology has been consistently raised by the sector' and 'is threatening the viability of providers and safety of Participants, and risking market failure for particular service types'.[53]

3.64 Similarly, Ms Emma King, CEO of VCOSS explained:

> NDIS pricing policies directly affect service quality and coverage. Members report the prices are insufficient to recruit and retain experienced

52 See for example: Community Mental Health Australia, *Submission 3*, p. 13; Catholic Social Services Australia, *Submission 32*, p. 2; VCOSS, *Submission 65*, p. 3.

53 Catholic Social Services Australia, *Submission 32*, p. 5.

> and qualified workers and the prices do not cover the services of quality service provision, including professional development, adequate supervision or administration.[54]

3.65 National Disability Services pointed out that service providers are losing money on delivering one-to-one supports, noting that 'this situation is not sustainable' and that 'the NDIS maximum price is significantly lower than the comparable community aged care price'.[55]

3.66 MJD Foundation (MJDF) argued that 'the NDIS unit pricing for the supports that the MJDF expects to deliver under the NDIS are significantly lower than MJDF's unit costs'.[56]

3.67 The Australian Services Union is concerned that the 'NDIS pricing assumptions do not meet the minimum Award conditions, nor do they reflect the reality of disability support work' and 'this will only exacerbate the workforce shortages in the sector, and mean less quality and continuity in support for people with disability'.[57]

3.68 Mr Robbi Williams, CEO of JFA Purple Orange, raised concerns about fixed pricing and impacts on quality and differentiation of services:

> I'm concerned that, in the implementation of the Scheme, this focus on fixed price for services is causing enormous problems for service providers who want to differentiate on quality elements but cannot afford to do so with the fixed price.[58]

Inadequate pricing for psychosocial supports

3.69 Some submitters are concerned about the inadequate pricing for psychosocial supports, which is impeding on quality of services.[59] Mental Illness Fellowship of Australia noted:

> Since rollout commenced, mental health providers have repeatedly highlighted that the price of supports is set well below the hourly rate for psychosocial support work currently delivered by suitably qualified people. There is no hourly price for psychosocial support services in the NDIS Price Guide, and mental health providers have had no involvement in the process to set prices for different support types.[60]

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54 Ms Emma King, CEO, Victorian Council of Social Service, *Committee Hansard*, 8 November 2017, p. 1.

55 National Disability Services, *Submission 12*, p. 5.

56 MJD Foundation, *Submission 7*, p. 10.

57 Australian Services Union, *Submission 57*, p. 5.

58 Mr Robbi Williams, CEO, JFA Purple Orange, *Committee Hansard*, 27 September 2017, p. 15.

59 See for example: Community Mental Health Australia, *Submission 3*, p. 13; VICSERV, *Submission 33*, p. 3; cohealth, *Submission 34*, p. 4, VCOSS, *Submission 65*, p. 15.

60 Mental Illness Fellowship of Australia, *Submission 44*, p. 3.

3.70 At a public hearing in Hobart, Ms Elinor Heard, Sector Reform Lead at Mental Health Council of Tasmania, recommended that prices for psychosocial supports be aligned with the award rate of pay for qualified staff:

> We recommend that the NDIS pricing structure be adjusted to address the well-documented disconnect between line item unit pricing and the award rate of pay for qualified mental health workers. At the moment we have members operating at a 50 per cent loss per episode of care as a result of this discrepancy. We hope that the independent pricing review will endorse action in this area.[61]

3.71 Similarly, Anglicare Australia reported that 'there is enough evidence to show that the current unit pricing is insufficient to purchase services which can meet the needs of people with higher needs and complex psychosocial disability'.[62]

Inadequate pricing for supports for people with complex needs

3.72 Submitters stressed that NDIS pricing is particularly inadequate for delivering services to people with complex needs, who are likely to require workers with more specialised skills.[63]

3.73 ACT Minister for Disability, Children and Youth, Ms Rachel Stephen-Smith, reported that 'from the feedback we've had from providers, there are genuine issues with the appropriate pricing of support for people with high and complex needs'.[64]

Impacts on the disability sector workforce

3.74 A risk identified by submitters is that the inadequacy of prices may drive skilled workers to stop engaging with the NDIS. For example, the Victorian Government pointed out that 'current pricing may incentivise existing skilled workers to seek roles in other sectors (for example the aged care sector)'.[65]

3.75 At a public hearing in Melbourne, Ms Kym Peake, Secretary of the Department of Health and Human Services, Victorian Government reinforced the view that adequate pricing is needed to grow the workforce:

> […] Certainly, our stakeholders raise with us that current price setting do not take into account the real cost of service delivery. Pricing will also be fundamental to growing a skilled workforce, and it must be addressed head-

61 Ms Elinor Heard, Sector Reform Lead, Mental Health Council of Tasmania, *Committee Hansard*, 4 October 2017, p. 18.

62 Anglicare Australia, *Submission 8*, Attachment 1, p. 6.

63 See for example: Ms Emma King, CEO, Victorian Council of Social Service, *Committee Hansard*, 8 November 2017, p. 1; Anglicare Australia, *Submission 8*, Attachment 1, p. 6; Department of Premier and Cabinet, Victoria, *Submission 54*, p. 18.

64 Ms Rachel Stephen-Smith, Minister for Disability, Children and Youth, ACT Parliament, *Committee Hansard*, 20 October 2017, p. 9.

65 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 18.

> on during transition so that there is an appropriate provider market with a workforce with the right skills and competencies.[66]

3.76 National Disability Services warned that 'without resolution of pricing issues, the market will not grow to meet the increase in demand under the NDIS.'[67]

3.77 Similarly, in its submission, the Department of Premier and Cabinet NSW said:

> The market for the provision of supports is developing, but this will likely be slow if there is uncertainty regarding the ability of service providers to recover their reasonable costs.[68]

3.78 In its *NDIS Costs Study Report*, the Productivity Commission noted that the NDIA's approach to setting price caps 'has hindered market development' and 'it has led to poor participant outcomes, especially for those with complex needs'.[69]

An independent body for price-setting

3.79 Overall, submitters suggested that pricing decisions should be the responsibility of an independent price regulator, not the NDIA.[70] In its report, the Productivity Commission recommended that an independent body be responsible for regulating the price of supports under the NDIS.[71]

3.80 At a hearing in Canberra, the NDIA explained its position in relation to the Productivity Commission findings and recommendation on an independent price regulator:

> I would like to add is that the board and management did also make a statement about the Productivity Commission report. In that statement they also drew attention to their view that they didn't agree with one of the recommendations in the report. That was for the independent pricing regulator to be established. I think that the board and management would probably want it stated that their reasons for that is that they believe that at this moment, while we do want to get to a point of deregulation of the market altogether, while the market is developing it's in the interests, of Participants particularly, to have an active oversight of price caps so that Participants aren't taken advantage of. I'm not suggesting that providers would do this; simply that there is a risk that that may happen where the

66 Ms Kym Peake, Secretary, Department of Health and Human Services, Victorian Government, *Committee Hansard*, 19 September 2017, p. 3.

67 National Disability Services, *Submission 12*, p. 6.

68 Department of Premier and Cabinet NSW, *Submission 27*, p. 4.

69 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, Canberra, October 2017, p. 55.

70 See for example: Anglicare Australia, *Submission 8*, Attachment 2, p. 6; Vision Australia, *Submission 24*, p. 7; Multiple Sclerosis Australia, *Submission 31*, Attachment 1, p. 8; Department of Premier and Cabinet, Victoria, *Submission 54*,p. 4.

71 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs, Study Report*, Canberra, October 2017, p. 55.

> market is thin. It's happened in other markets. There are a range of other reasons. We want to make sure we can price accordingly to get the outcomes for Participants that we need and that's the focus that we want to bring to pricing. We want to be transparent in the way that we do that, but I think they believe that in terms of their stewardship role of the agency they need to maintain some oversight of that, particularly in relation to the impact of that on sustainability of the Scheme. They believe that it's best left at the moment with the NDIA.[72]

Independent Pricing Review

3.81 In June 2017, following the outcome of the FY2017-18 pricing review, the NDIA announced an Independent Pricing Review to be undertaken by McKinsey & Company and completed by the end of 2017.[73]

3.82 The Review was tasked to:

- Provide recommendations in relations to improved pricing effectiveness, including but not limited to:
- National versus regional pricing;
- Pricing of services with different levels of complexity;
- Pricing of short stay support, and for emergency and crisis supports;
- Thin and undersupplied markets, particularly in regional and remote areas;
- Relative provider efficiencies (including overheads);
- Adequacy of provider returns; and
- Effectiveness of the Hourly Return approach used to set prices.
- Provide recommendations in relation to the potential early de-regulation of price in more mature sub-markets and the glide path for the eventual de-regulation of price more generally.[74]

Committee view

NDIS Pricing

3.83 The committee noted that many service providers are of the view that the current NDIS pricing caps have potential to negatively impact on the capacity for providers to deliver quality services. The committee is particularly concerned that the

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72 Ms Vicki Rundle PSM, Acting Deputy Chief Executive Officer, Market and Supports, NDIA, *Committee Hansard*, 20 October 2017, p. 28.

73 NDIS, *Letter to Registered NDIS Providers from CEO David Bowen*, 12 June 2017, https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html (accessed 20 December 2017)

74 NDIS, *Letter to Registered NDIS Providers from CEO David Bowen*, 12 June 2017, https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html (accessed 20 December 2017)

pricing for supports for psychosocial supports and for people with complex needs appear to be well below industry standards.

3.84 The committee is aware that the NDIA Board is currently considering the Final Report of the Independent Pricing Review undertaken by McKinsey & Company with the intent being that the Report and the NDIA's response be published by mid-March 2018.[75] The committee will consider the Report, issues of pricing and the establishment of an independent price regulator in the context of its inquiry into market readiness.

Workforce shortages

3.85 Submitters raised the issue of workforce shortages.[76] As described by the Productivity Commission in its recent *NDIS Costs Study Report*, the disability sector workforce will need to double and in some regions triple or more over the transition period to meet demand.[77]

3.86 Allied Health Professions Australia is of the view that it will not be possible to increase the NDIS workforce without changes that address 'workforce planning, education and training issues'.[78]

3.87 In its submission, the Queensland Government considered that the workforce constitutes 'one of the biggest risks of the rollout of the NDIS'.[79]

3.88 The Australian Services Union identified the need for developing a workforce plan:

> There is presently no comprehensive plan that deals with careers or training for disability support workers under the NDIS. This, along with pricing that supports decent pay and conditions, is essential to attracting and retaining a stable and skilled disability support workforce.[80]

3.89 Community Mental Health Australia identified a 'need to develop a National Mental Health Workforce Strategy and conduct regional Communities of Practice to support NDIS transition'.[81]

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75 NDIS, *Media Statement: NDIA Board receives NDIS Independent Pricing Review Report*, 30 December 2017, https://www.ndis.gov.au/news/ndis-pricing-review-30dec.html (accessed 30 January 2018)

76 See for example: Allied Health Professions Australia, *Submission 6*, p. 10; Multiple Sclerosis Australia, *Submission 31*, Attachment 1, p. 9; Australian Services Union, *Submission 57*, pp. 4–5; Office of the Public Guardian NT, *Submission 63*, p. 5.

77 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 36.

78 Allied Health Professions Australia, *Submission 6*, p. 10.

79 Queensland Government, *Submission 72*, p. 6.

80 Australian Services Union, *Submission 57*, p. 8.

81 Community Mental Health Australia, *Submission 3*, p. 14.

3.90 National Disability Services stated that 'a clear and coherent national industry plan is required to support the sector's development and transition to the NDIS market'.[82]

3.91 In its submission, the ANAO reiterated the findings it made in its performance audit report No. 24 of 2016–17, National Disability Insurance Scheme–Management of Transition of the Disability Services Market:

> The magnitude of the growth and change required to the disability services market cannot be underestimated, and the transition to full Scheme elevates an already high risk environment. This requires ongoing monitoring and active management. Within this context, both DSS and the NDIA need to invest in their capability to identify and resolve emerging market concerns for many years to come.[83]

Initiatives to build the NDIS workforce

3.92 In April 2015, the Disability Reform Council agreed the NDIS Integrated Market, Sector and Workforce Strategy in preparation for the full roll out of the NDIS. The strategy was developed by the Commonwealth, state and territory governments and the NDIA to provide a clear plan to align market, sector and workforce development activities.[84]

3.93 In its submission, the Department of Social Services explained 'it has been working with state governments, the NDIA, and the sector, to support disability workforce development' and that 'the Boosting the Local Care Workforce 2017–18 budget measures will invest $33 million over three years, to boost local job opportunities in care work, particularly in rural, regional and outer suburban areas'.[85]

3.94 Allied Health Professions Australia noted that 'initiatives such as the Sector Development Fund (SDF) and Innovative Workforce Fund (IWF), which allow individuals and organisations to apply for grants to support the development of the disability workforce, are valuable ways to ensure a ready and appropriately skilled workforce'.[86]

3.95 The Victorian Government has developed a plan to build the disability workforce, recognising that the NDIS is bringing major changes and that the Victorian disability workforce will need to grow by approximately 76 per cent over the next three years. As part of the plan, $26 million will be invested in workforce development, training and skills initiative.[87]

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82 National Disability Services, *Submission 12*, Attachment 1, p. 14.

83 ANAO, *Submission 10*, p. 2.

84 Department of Social Services, *NDIS Integrated Market, Sector and Workforce Strategy*, https://www.dss.gov.au/disability-and-carers/programmes-services/for-people-with-disability/ndis-integrated-market-sector-and-workforce-strategy (accessed 20 December 2017)

85 Department of Social Services, *Submission 29*, p. 12.

86 Allied Health Professions Australia, *Submission 6*, p. 10.

87 Department of Premier and Cabinet, Victoria, *Submission 54*, Attachment 1, pp. 5–6.

3.96 Queensland has invested $2.8 million to establish WorkAbility to drive the expansion and diversification of the Queensland workforce over the transition period, by engaging, attracting and connecting people to jobs in the sector.[88]

3.97 In its submission, the Australian Government Department of Education and Training listed its recent initiatives to address workforce shortages. This included providing funding for the Disability Workforce Innovation Network Innovative Project (DWIN). Through the DWIN, Workforce Advisers worked to develop workforce action plans in each state and territory; identify workforce planning needs and collect workforce data to identify gaps and inconsistencies. A workforce planning and profiling tool was developed to assist provider identify workforce needs and is now available on the National Disability Services website.[89]

3.98 The Productivity Commission made the following recommendation in regard to roles and responsibilities of different parties to develop the disability workforce:

> The roles and responsibilities of different parties to develop the National Disability Insurance Scheme (NDIS) workforce should be clarified and made public by the beginning of 2018.
>
> - State and Territory Governments should rely on 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 and aged care policy interact and affect the development of the workforce.
> - The National Disability Insurance Agency should provide State and Territory Governments with data and analyses 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 the National Disability Insurance Agency, the NDIS Quality and Safeguards Commission, and the Australian, State and Territory Governments about emerging and persistent workforce gaps.[90]

Committee view

3.99 Growing the disability care workforce to meet the needs of NDIS Participants is a significant challenge, which has been identified by all stakeholders. In its Study Report, the Productivity Commission found that 'the disability care workforce will not be sufficient to deliver the supports expected to be allocated by NDIA by 2020'.[91]

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88 Queensland Government, *Submission 72*, p. 7.

89 Department of Education and Training, Australian Government, *Submission 64*, p. 13.

90 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs, Study Report*, October 2017, p. 57.

91 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 336.

3.100 The committee notes the different initiatives undertaken by the Australian and state governments to address workforce development issues. However, it appears that, at present, the roles and responsibilities of the Australian, state and territory governments and the NDIA are not clearly defined. The committee agrees with the Productivity Commission's recommendation that the roles and responsibilities of different parties to develop the NDIS workforce should be clarified and made public by the beginning of 2018.[92]

3.101 The committee received evidence that workforce remuneration, training and professional development issues contribute to current challenges. The committee believes these important issues warrant further work and analysis, and will be considered within the context of the committee's inquiry into market readiness.

Rollout of the ILC

3.102 As described by the NDIA in its submission, the Information, Linkages and Capacity Building (ILC) Program is designed to provide people with disability — both inside and outside of the NDIS — with access to appropriate services.

3.103 The NDIA further explained the focus of ILC:

> The focus of ILC is community inclusion - that is, making sure that people with disability are connected to their communities and to appropriate disability, community and mainstream supports. This makes ILC a critical feature of the insurance approach, given its potential to have a significant impact on managing and reducing NDIS costs over time.[93]

3.104 In November 2016, after extensive consultation with people with disability, families and carers, as well as organisations working in the sector, the NDIA released the ILC Commissioning Framework, which identifies the priority focus areas for ILC investments.[94] The ILC Policy Framework identified five activity streams for ILC:

- Information, Linkages and Referrals
- Capacity Building for Mainstream Services
- Community awareness and capacity building
- Individual capacity building; and
- Local Area Coordination (which will also deliver the other streams).[95]

3.105 At present, the NDIA is assuming responsibility for funding ILC in each jurisdiction. The ACT was the first jurisdiction to commence ILC in 2017-18, with

92 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 57.

93 NDIA, *Submission 41*, p. 6.

94 NDIA, *Submission 41*, p. 7.

95 NDIS, *ILC Commissioning Framework co-design*, https://www.ndis.gov.au/communities/key-ilc-documents.html (accessed 20 December 2017)

NSW and SA commencing in 2018-19; and Victoria, Queensland, Tasmania and NT commencing in 2019-20.

3.106 To ensure an orderly transition of ILC-type activities funded by state and territory governments to those funded by the NDIA through ILC, Transition Plans have been agreed with each jurisdiction. The Transition Plans outline agreed actions to mitigate risks and to prepare organisations for ILC commissioning.[96]

3.107 The Transition Plans also include funding for jurisdictions to enhance or expand successful ILC type programs into other areas and to support current organisations to get ready for outcomes-based funding and ILC grant-based funding.[97]

3.108 In its submission, the NDIA pointed out that 'the effectiveness of ILC funding as an innovative means to increase inclusion of people with disability in the community is constrained. This is because during the transition years ILC funding is being provided to jurisdictions to fund legacy programs to ensure continuity of delivery. As a result, the full innovative benefits of having a nationally consistent approach to investing in ILC activities are likely to be delayed'.[98]

3.109 Given that the ILC is still in infancy, Carers NSW felt it did not have enough information to fully comment on the rollout of the ILC.[99] However, some submitters raised concerns about current level of funding; the funding approach of ILC activities; the capacity of LACs to perform their role; scope of ILC activities and capacity of ILC to deliver services to people ineligible to the NDIS.

Insufficient funding

3.110 Many submitters are concerned that insufficient funding has been allocated to the ILC Program during the transition period.[100] For example, Catholic Social Services Australia stated:

> The Information, Linkages and Capacity building (ILC) program is a fundamental component of the Scheme, however there is inadequate funding for this program, particularly in the transitional years. Funding for ILC should be increased, recognising these services provide crucial support and connections especially for Participants not eligible for NDIS individualised packages, and so promote the overall sustainability of the Scheme.[101]

96 NDIA, *Submission 41*, p. 7.

97 Department of Social Services, *Submission 29*, p. 8.

98 NDIA, *Submission 41*, p. 8.

99 Carers NSW, *Submission 55*, p. 13.

100 See for example: National Disability Services, *Submission 12*, p. 4; cohealth, *Submission 34*, p. 6; Mental Illness Fellowship of Australia, *Submission 44*, p. 9; Mental Health Australia, *Submission 50*, p. 11; Australian Red Cross, *Submission 67*, p. 6.

101 Catholic Social Services Australia, *Submission 32*, p. 1.

3.111 Submitters supported the recommendation of the Productivity Commission to increase funding for ILC to the full Scheme amount of $131 million for each year during the transition. [102] [103]

3.112 VCOSS pointed out that the former chair of the NDIA board had stated 'currently only $132 million (excluding LAC support) has been 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.'[104]

3.113 In its response to the Productivity Commission Cost Review Position Paper, the NDIA welcomed the draft recommendation that the ILC budget be increased to its full Scheme (2019–20) allocation immediately. However, the NDIA pointed out that there is no capacity for this to come from its operating budget.[105]

Funding approach

3.114 At present, ILC activities are being funded through grants to organisations. Some inquiry Participants raised concerns about the current competitive grant model used for ILC commissioning.[106] For example, the Victorian Government said:

> The Victorian Government has concerns regarding the proposed grants model for commissioning and seeks clarity from the NDIA on the length of time grants will be allocated. To effectively build capacity in the community and mainstream services the NDIA will require a longer term view, with coordinated planning to ensure long term outcomes are realised. Careful consideration should be given to the efficacy of one-off grants or small amounts of funding for local information, peer support and capacity building programs.[107]

3.115 The ACT Government reported that 'many providers expressed concerns regarding the bureaucratic impost of the ILC grant program, including the onerous administrative burden, the process delays and allocation of only one year agreements to successful providers'.[108]

3.116 Mental Illness Fellowship of Australia argued that 'the short funding period and small amounts available disincentive tendering'.[109]

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102 See for example: Multiple Sclerosis Australia, *Submission 31*, Attachment 1, p. 7; VCOSS, *Submission 65*, p. 23.

103 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 52.

104 VCOSS, *Submission 65*, p. 23.

105 NDIA, *Submission 41*, p. 8.

106 See for example: National Disability Services, *Submission 12*, p. 4; Municipal Association of Victoria, *Submission 30*, p. 3; Ms Emma King, CEO, Victorian Council of Social Service, *Committee Hansard*, 8 November 2017, p. 2.

107 Department of Premier and Cabinet, Victoria, *Submission 54*, p. 15.

108 ACT Government, *Submission 58*, p. 22.

109 Mental Illness Fellowship of Australia, *Submission 44*, p. 10.

3.117 VCOSS is of the view that year-to-year funding is not suitable for many existing ILC-types services and recommended that funding for ILC projects be greater than twelve months in duration.[110] Autism Spectrum Australia made a similar recommendation.[111]

3.118 VCOSS is also concerned that 'grant-based projects may have limited geographic coverage, introducing uncertainty about equitable coverage within and between states and territories'.[112] It also pointed out that 'it is unclear whether ILC funding will be equitable for people with different disability types and from different population groups'.[113]

Direct investment outside grant process

3.119 National Disability Services (NDS) argued that 'there is no need to have a competitive grants round for activities that are essential and are being provided by organisations that are performing well, have strong track-records and have the confidence of funding departments'. NDS believes 'this type of organisation should receive funding outside the competitive grants process'.[114]

3.120 Similarly, JFA Purple Orange recommended that ILC activities are not solely funded through competitive grants but also 'include direct investment in existing community agencies delivering effective ILC services'.[115]

3.121 Some submitters argued that ILC should provide block funding for certain services and activities, including outreach.[116] For example, Mental Health Australia recommended that ILC provide block funding for specialist assertive outreach for people with psychosocial disability.[117]

Local Area Coordinators

3.122 Through the Partners in the Community Program, Local Area Coordinators (LACs) perform three key roles:

- Link people to the NDIS;
- Link people to information and support in the community; and
- Work with local community to make sure it is more welcoming and inclusive for people with disability.

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110 VCOSS, *Submission 65*, p. 24.

111 Autism Spectrum Australia, *Submission 40*, p. 4.

112 VCOSS, *Submission 65*, p. 24.

113 VCOSS, *Submission 65*, p. 24.

114 National Disability Services, *Submission 12*, p. 4.

115 JFA Purple Orange, *Submission 60*, p. 4.

116 See for example: Australian Blindness Forum, *Submission 13*, p.4; Vision Australia, *Submission 24*, p. 6; Municipal Association of Victoria, *Submission 30*, p. 3; Mental Health Australia, *Submission 50*, p. 13.

117 Mental Health Australia, *Submission 50*, p. 13.

3.123 In relation to linking people to the NDIS, LACs are tasked with helping people from understanding and requesting access, to developing and implementing their first NDIS Plan. LACs can also help with preparing for a plan review. However, LACs do not provide case management, act as an advocate for the person with disability, and they cannot approve an NDIS plan.[118]

3.124 The Royal Institute for Deaf and Blind Children observed that 'the majority of LAC time is spent on planning and that they do not have the capacity to support plan implementation and connection to community and/or mainstream supports'.[119]

3.125 Similarly, the Victorian Government reported that 'there are widely acknowledged concerns that LACs do not have sufficient time and capabilities to perform their role' and that 'a disproportionate focus by LACs on planning will come at the expense of building community infrastructure and mainstream capacity'.[120]

3.126 Ms Carly Nowell, Policy Adviser at VCOSS pointed out that LACs currently do not have capacity to undertake outreach work:

> […] the local area coordinators, as we know, are currently under the pump trying to work through the planning process. Whilst in theory they have some capacity to do some of that outreach and to engage and do the pre-engagement support, at the moment we're hearing that they're not.[121]

3.127 Mental Health Australia highlighted the importance of assertive outreach for people with psychosocial disability and is of the view that 'this is an area where generalist LACs currently simply do not have the right skills and connections'.[122]

3.128 The Physical Disability Council of NSW shared similar concerns and stressed that if LACs do not have the resources and capabilities for proactive outreach, some people will miss out on vital services.[123]

3.129 In its submission, the Queensland Government reported that, despite the terms of Queensland's bilateral agreement requiring NDIS LACs to commence in locations six months prior to transition, this has not occurred in the transition areas in Queensland. It noted that, 'as a result, Participants have not been well prepared during their pre-planning, and a significant lag in new Participants entering the Scheme has been experienced'.[124]

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118 NDIS, *Local Area Coordination*, https://www.ndis.gov.au/communities/local-area-coordination#do (accessed 20 December 2017).

119 Royal Institute for Deaf and Blind Children, *Submission 35*, p. 14.

120 Department of Premier and Cabinet, Victoria, *Submission 54*, pp. 15–16.

121 Ms Carly Nowell, Policy Adviser, VCOSS, *Committee Hansard*, 8 November 2017, p. 13.

122 Mental Health Australia, *Submission 50*, p. 12.

123 Physical Disability Council of NSW, *Submission 56*, p. 6.

124 Queensland Government, *Submission 72*, p. 4.

Gaps in services

3.130 Many inquiry participants expressed the view that ILC is not ensuring support for individuals not eligible for the NDIS or people at risk of falling through the disability gaps.[125] For example, the Australian Blindness Forum stated:

> The ILC program as it currently stands is not going to provide any useful ongoing services and it will not help ensure individuals do not fall through the cracks.[126]

3.131 At a public hearing in Canberra, Ms Jennifer Grimwade, Executive Officer at the Australian Blindness Forum, further explained:

> The original proposal was that the ILC would reflect programs such as the block funding and early intervention programs, and the goal of this was to continue to provide disability services to those who were not eligible for the NDIS. But this is not how it has turned out. We don't think it is going to provide any useful ongoing services for people who are blind or vision impaired, and we think those people who are not eligible will fall through the cracks.[127]

3.132 Mental Health Council of Tasmania is of the view that 'it is unclear how the ILC will cover gaps, which are emerging as the NDIS is implemented'.[128]

3.133 Can:Do Group observed that the ILC is not covering services, which were previously funded:

> Services such as our community Auslan interpreting services, provide vital community wide support but the current ILC framework does not support the successful tendering for the delivery of such services, nor does it acknowledge their importance to the community.[129]

Committee view

ILC Funding

3.134 The committee agrees with submitters and the Productivity Commission that, given the broad scope of the ILC Program and its important role during the transition period in ensuring that people with disability are adequately connected with appropriate services, funding for ILC should immediately be increased to the full Scheme amount of $131 million for each year during the transition.

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125 See for example: Macular Disease Foundation Australia, *Submission 28*, p. 5; Carers Australia, *Submission 51*, p. 6; Refugee Council of Australia, *Submission 59*, pp.5–6.

126 Australian Blindness Forum, *Submission 13*, p. 4.

127 Ms Jennifer Grimwade, Executive Officer, Australian Blindness Forum, *Committee Hansard*, 20 October 2017, p. 21.

128 Mental Health Council of Tasmania, *Submission 19*, p. 6.

129 Can:Do Group, *Submission 25*, p. 9.

Recommendation 15

3.135 The committee recommends the Australian Government increase funding for ILC to the full Scheme amount of $131 million for each year during the transition.

Funding approach

3.136 The committee is concerned that the current grant funding approach for ILC activities may result in service gaps for some essential services and has potential to disadvantage some cohorts because of their type of disability or their geographical location. Grants are currently awarded for up to two years. The committee acknowledges this may restrict the capacity of some organisations to deliver ongoing services and could lead to some individuals missing out on services because of potential changes of programs and service providers every couple of years.

3.137 The committee believes that an evidence base needs to be built and used to inform future decisions on appropriate funding models for ILC activities. The committee understands that, as part of the ILC program, the NDIA and the organisations that receive grants are required to collect data on ILC activities. The committee recommends that the NDIA uses this data to monitor the effectiveness of the current ILC grant funding model, with the view of introducing other types of funding, including block funding if required, to ensure appropriate and quality services are delivered across all jurisdictions.

Recommendation 16

3.138 The committee recommends the NDIA monitor the effectiveness of the current ILC grant funding model, with the view of introducing other types of funding, including block funding if required, to ensure appropriate and quality services are delivered across all jurisdictions.

Local Area Coordinators

3.139 The committee is of the view that, because of the need to meet bilateral estimates, LACs have been focusing too much on planning-related activities. As a result, LACs have not been able to perform their other key roles. It is also resulting in emerging gaps in service delivery. The committee believes that increasing funding for ILC to the full Scheme amount for each year during the transition will assist in addressing some of the gaps and enable LACs to perform their other functions.

Chapter 4

Thin markets and emerging service gaps

4.1 This chapter discusses the issues of thin markets and Provider of Last Resort (PLR) arrangements as well as emerging gaps in services. Service gaps identified are resulting in lack of provision of advocacy supports, outreach services and support coordination for Participants.

4.2 The chapter also explores the challenges faced by people from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islanders in engaging with the NDIS and accessing culturally appropriate services.

Thin markets

4.3 The move to individualised funding under the NDIS requires providers to have sufficient economies of scale in order to operate sustainably, which can be difficult to achieve in rural and remote communities and in areas of thin markets.

4.4 Many submitters contended that thin markets will persist for the following groups of Participants:

- People living in rural and remote areas;
- People with complex needs or with very challenging behaviours;
- People experiencing homelessness;
- People involved with the criminal justice system;
- People from CALD background; and
- Aboriginal and Torres Strait Islanders.[1]

Rural and remote areas

4.5 The Municipal Association of Victoria is of the view that 'the situation for rural councils and their communities is particularly concerning as there are not necessarily viable options in existence for service provision for citizens, other than local government, in many cases'.[2]

4.6 In rural and regional areas, and some outer urban areas, VCOSS members reported that there are not enough local services to provide people with the funded supports, let alone a choice of providers.[3]

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1 See for example: cohealth, *Submission 34,* p. 8; Victorian Government, *Submission 54;* pp. 4 and 17; Tasmanian Government, *Submission 75,* p. 7.

2 Municipal Association of Victoria, *Submission 30,* p. 3.

3 VCOSS, *Submission 65,* p. 16.

Costs of delivering services

4.7 The high costs of delivering services in rural and remote areas are contributing to the lack of availability of service providers. For example, submitters stressed that the cost of travel in rural and remote areas is such that it is becoming unviable to provide services in those areas under the current NDIS pricing.[4]

4.8 Northern Territory PHN noted that transport and accommodation expenses associated with service delivery in remote areas remain exceptionally high, and continue to need to be factored in as a key cost.[5]

4.9 National Disability Services believes that the methods for funding supports in rural and remote areas need to be revised to reflect the full impact of local conditions.[6]

People with complex needs

4.10 Mr Terence Cleary, Executive Manager, Community Care and Access, Anglicare NT, explained that market failure is not just happening in the Northern Territory because of its remote areas but also elsewhere, where people with complex needs are not receiving appropriate services:

> These are not just issues in relation to the Territory—market failure is happening in Western Sydney, where people with complex needs are not having their needs met either because the services aren't there or because the nature of their issues are so complex that the market can't respond at the moment.[7]

4.11 Dr Adrienne McGhee, Principal Policy and Research Officer at the Office of the Public Advocate (Queensland), expressed their concerns:

> We're particularly concerned about what supports are being provided to individuals who have disability and complex needs who are currently residing in government operated facilities and whose transition to the NDIS will be largely dependent on how proactive these agencies are in supporting them to become participant.[8]

4.12 Ms Rachel Stephen-Smith, the ACT Minister for Disability, Children and Youth believes that there are issues with pricing of support for people with complex needs:

> The potential for market failure for people with high and complex needs. That does partly relate, I think, to adequate pricing. There are also potential

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4 See for example: Occupational Therapy Australia, *Submission 26*, p. 6; Mental Illness Fellowship of Australia, *Submission 44*, p. 10; Carers NSW, *Submission 55*, p. 6; Physical Disability Council of NSW, *Submission 56*, p. 3; Speech Pathology, *Submission 62*, p. 16.

5 Northern Territory PHN, *Submission 76*, p. 1.

6 National Disability Services, *Submission 12*, Attachment 1, p. 12.

7 Mr Terence Cleary, Executive Manager, Community Care and Access, Anglicare NT, *Committee Hansard*, 21 September 2017, p. 20.

8 Dr Adrienne McGhee, Principal Policy and Research Officer, Office of the Public Advocate, *Committee Hansard*, 26 September 2017, p. 1.

> cherry picking issues in the pricing models that are chosen, but I think, from the feedback we've had from providers, there are genuine issues with the appropriate pricing of support for people with high and complex needs.[9]

4.13 Other submitters raised concerns about the inadequate pricing of support for people with complex needs.[10] For example, Catholic Social Services Australia (CSSA) stated:

> CSSA also has significant concerns about the availability and consistency of services where insufficient price caps could lead to market failure for particular services or for Participants with complex needs.[11]

4.14 Submitters argued that inadequate pricing may lead to providers choosing not to accept clients with high needs.[12] For example, VCOSS is of the view that 'the NDIS risks creating disincentives to assisting Participants with complex needs or those perceived as 'difficult', such as people displaying challenging behaviour'.[13]

Funding approach

4.15 Overwhelmingly, submitters recommended that alternative funding models, including fixed or block funding must be made available in areas of thin and failing markets.[14]

4.16 Victorian Healthcare Association proposed models that could be considered:

- The introduction of price guide flexibility whereby additional funding could be allocated on a sliding scale to meet client needs and build capacity in services and communities. This could be achieved using the current quote based system that the NDIA already has in place.
- A trial of the multipurpose services (MPS) model, which is used in the aged care sector, as a solution to market failure in rural and remote areas. The model is based on the principle that MPS' can pool funds from previously separate Commonwealth and State aged care and health programs to provide a more flexible, co-ordinated and cost effective framework for service provision.[15]

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9 Ms Rachel Stephen-Smith, Minister for Disability, Children and Youth, ACT Parliament, *Committee Hansard*, 20 October 2017, p. 9.

10 See for example: Victorian Government, *Submission 54*, p. 18; VCOSS; Catholic Social Services Australia, *Submission 32*, p. 4; *Submission 65*, p. 5.

11 Catholic Social Services Australia, *Submission 32*, p. 4.

12 See for example: Catholic Social Services Australia, *Submission 32*, p. 10; cohealth, *Submission 34*, p. 7; VCOSS, *Submission 65*, p. 17.

13 VCOSS, *Submission 65*, p. 17.

14 See for example: cohealth, *Submission 34*, p. 8; VCOSS, *Submission 65*, p. 17; Mr Tom Symondson, CEO, Victorian Healthcare Association, *Committee Hansard*, 19 September 2017, p. 13.

15 Victorian Healthcare Association, *Submission 11*, p. 2.

4.17 Ms Noelene Swanson, State Manager, Northern Territory with National Disability Services, believes that some guarantee of demand for providers is required in rural and regional areas:

> The other thing we would like to recommend is the need for providers to enter into rural and regional areas is some guarantee of demand. […] To overcome that would be consideration of block funding or hybrid based funding until that demand has reached a point where it can be sustained.[16]

4.18 The Victorian Government argued that 'the most effective way to address thin markets is to ensure adequate pricing that takes into account the real cost of service delivery in these markets'.[17]

4.19 The Royal Australian College of General Practitioners (RACGP) pointed out that because primary health and disability services have areas of overlap, there is opportunity for cost savings by avoiding duplication:

> Integrating health and disability services would benefit rural communities, in which GPs have a wide reach. We see an opportunity for the NDIA, RACGP and other bodies involved in providing services to patients with disability to work together to identify areas of duplication and encourage sustainability.[18]

Provider of Last Resort

4.20 As market steward, the NDIA is responsible for the Provider of Last Resort (PLR) arrangements. In 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.

4.21 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. Over time, the NDIA will lead an integrated response jointly with states and territories as transition leads to full Scheme.[19]

4.22 The Northern Territory is the exception. Under Schedule K of the Bilateral Agreement between the Commonwealth and the Northern Territory, the NDIA is the responsible entity for ensuring provider of last resort services are in place for all Participants in the NT during transition.

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16 Ms Noelene Swanson, State Manager, Northern Territory, National Disability Services, *Committee Hansard*, 21 September 2017, p. 20.

17 Victorian Government, *Submission 54*, p. 17.

18 Royal Australian College of General Practitioners, *Submission 15*, p. 1.

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

4.23 Overall, submitters found that the Provider of Last Resort framework remains unclear and incomplete.[20] For example, Victoria Legal Aid argued that 'in Victoria, provider of last resort measures or any real solution to address the very serious effects of market failure remain opaque, unclear and incomplete'.[21] It pointed out that the Victorian bilateral agreement is silent as to what will occur in the event of market failure and the Operational Plan provides no practical framework and only states:

> …the NDIA will lead on identifying and developing approaches to ensure that a provider of last resort is available, as well as support for Participants in crisis.[22]

4.24 The Victorian Government also identified a lack of clarity on the Provider of Last Resort arrangements and called for additional information about how these arrangements will function both during transition and under full Scheme.[23]

4.25 The Tasmanian Government submitted that the NDIA's Provider of Last Resort arrangements have not yet been negotiated with Tasmania.[24]

4.26 Mr Terence Cleary, Executive Manager, Community Care and Access with Anglicare NT stated:

> The bilateral agreement between the Australian government and the NT government on the transition of the NDIS is unique in that it's the only bilateral agreement that specifically refers to market failure, thin markets and this notion of a provider of last resort. So for the two or three years since we've had that in place, at every meeting I reckon I've just about got up and said, 'Could someone articulate for me and for us this framework of the provider of last resort?' And still, two to three years later, there's been nothing articulated at all. It was very heartening to see that the Productivity Commission in its latest papers has been calling for recognition of that.[25]

4.27 The Office of the Public Guardian NT recommended that 'the development of a clear framework for the Provider of Last Resort be prioritised to ensure Participants in remote and thin markets are protected'.[26] Similar recommendations were made by Victorian Legal Aid[27] and the Queensland Government.[28]

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20 See for example: Victorian Government, *Submission 54,* p. 18; Victoria Legal Aid, *Submission 79,* p. 7; Mr Terence Cleary, Executive Manager, Community Care and Access, Anglicare NT, *Committee Hansard,* 21 September 2017, p. 20.

21 Victoria Legal Aid, *Submission 79,* p. 7.

22 Victoria Legal Aid, *Submission 79,* p. 7.

23 Victorian Government, *Submission 54,* p. 18.

24 Tasmanian Government, *Submission 75,* p. 7.

25 Mr Terence Cleary, Executive Manager, Community Care and Access, Anglicare NT, *Committee Hansard,* 21 September 2017, p. 20.

26 Office of the Public Guardian NT, *Submission 63,* p. 6.

27 Victoria Legal Aid, *Submission 79,* p. 9.

28 Victorian Government, *Submission 54,* p. 18.

4.28 In its *NDIS Costs Study Report*, the Productivity Commission recommended the NDIA publicly release its Provider of Last Resort policy as a matter of urgency.[29]

Committee view

Thin markets

4.29 The lack of services and providers operating in rural and remote areas is not new or unique to the NDIS. However, the committee acknowledges that the transition to a market based system brings new challenges for delivering services in rural and remote areas. Arrangements to deal with thin markets need to be considered to ensure Participants can access the services they need.

4.30 The committee is concerned with reports of people with complex needs not being provided with adequate services. It appears that inadequate pricing may lead to service providers choosing not to accept clients with complex needs. The committee is troubled by the growing evidence of service providers 'cherry picking' clients, potentially leaving some of the most vulnerable NDIS Participants with no access to adequate services.

4.31 Greater clarity is required on how the NDIA intends to intervene in areas of thin markets. The committee recommends the NDIA develops a strategy to address thin markets. The committee will undertake further work on the issue of thin and failing markets within the context of its inquiry into market readiness.

Recommendation 17

4.32 The committee recommends the NDIA develop and publically release a strategy to address thin markets.

Provider of Last Resort

4.33 The committee is concerned that Provider of Last Resort arrangements still remain unclear and incomplete. It appears that negotiations between the NDIA and state and territory governments around Provider of Last Resort arrangements have not yet progressed. It appears that the NDIA will be responsible for these arrangements at full Scheme, so the committee urges the Agency to consider these arrangements well before transition is complete. Chapter Two of this report discusses the Provider of Last Resort arrangements with regard to the provision of crisis accommodation, and recommends that the responsibilities are clearly set out in bilateral and other agreements.

4.34 The committee also reiterates recommendation 18 of its report into the *provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.*

Recommendation 18

4.35 The committee recommends the NDIA publically release its Provider of Last Resort policy as a matter of urgency.

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29 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 54.

Service gaps

4.36 Inquiry participants reported that the transition to a market-based system combined with the transition of Commonwealth, state and territory programs have resulted in emerging service gaps in important areas.

Advocacy

4.37 As discussed in chapter 3, individual advocacy plays an important role during pre-planning, the planning process and at plan reviews. As described by VCOSS, advocacy is particularly important for people with complex needs or facing disadvantage, or those with limited informal supports or networks.[30]

4.38 Systemic advocacy is also critical to ensure the inclusion and full participation of people with disability by identifying and addressing issues on a larger scale than with individual advocacy.[31]

4.39 A recent cost-benefit analysis of independent disability advocacy showed that for every dollar governments invest in independent advocacy it saves $3.50 on systems. For examples, advocates do get people of hospital quicker and help keep people out of jail.[32]

4.40 Ms Mary Mallett, CEO of Disability Advocacy Network Australia, pointed out that 'advocacy is not funded by the NDIS' and 'was not designed to be'. However, state and territory funding for disability advocacy is being rolled into the NDIS as part of the bilateral agreements.[33]

4.41 On 9 August 2017, the Australian Government announced $60 million in funding to continue support for disability advocacy services. The Australian Government also called for states and territories to commit to ongoing support for advocacy both under the NDIS and outside the NDIS. The media release stated:

> This substantial Commonwealth commitment ensures disability advocacy services will now continue to be funded until 30 June 2020. […]A national system of disability advocacy support also requires ongoing investment from states and territories to ensure their citizens can resolve issues with state-run services, and advocates can participate effectively in state-based planning.[…] The Commonwealth calls on other states and territories to meet their commitments to people with disability through the NDS by committing to ongoing support for advocacy under the NDIS.[34]

30 VCOSS, *Submission 65,* p. 9.

31 Physical Disability Council of NSW, *Submission 56,* p. 7.

32 Ms Mary Mallett, CEO, Disability Advocacy Network Australia, *Committee Hansard,* 20 October, p.21.

33 Ms Mary Mallett, CEO, Disability Advocacy Network Australia, *Committee Hansard,* 20 October, p.18.

34 Minister for Social Services, The Hon Christian Porter MP, *Turnbull Government investing $60 million in disability advocacy,* Media Release, 9 August 2017.

4.42 This announcement was welcomed by a number of submitters as it brings some certainty to the sector and ensures that some advocacy work can continue at least until June 2020.[35] However, funding for advocacy at state and territory levels is uncertain beyond transition.

4.43 For example, the NSW Government will cease advocacy funding after June 2018.[36] Ms Mary Mallett, CEO of Disability Advocacy Network Australia explained the situation:

> The immediate critical area is in New South Wales. The funding of advocacy by states and territories has always been part of their disability funding. It makes sense—it's for people with disability. It got rolled into their bilateral agreements to fund the NDIS. That funding has been signed over and will disappear as the NDIS fully rolls out. In New South Wales $10.9 million annually of advocacy funding will disappear at the end of June next year, plus another couple of million which is for disability peaks that represent the voice of people with disability.[37]

4.44 Physical Disability Council of NSW (PDCN) argued that the Commonwealth funding guaranteed until June 2020 is only for organisations currently funded under the National Disability Advocacy Program (NDAP) and this will leave a majority of NSW state funded organisations under or completely unfunded after June 2018.[38]

4.45 PDCN also stated:

> PDCN's opinion is that continued funding for peak organisations to provide systemic advocacy, independent information and representation for people living with disability in New South Wales is essential to meet the objectives of the NDIS.[39]

4.46 The situation varies in other states. During transition, the Victorian Government is increasing its funding for advocacy through the Disability Advocacy Innovation Fund. This year, it provided an additional $1.5 million on top of its base investment in advocacy, which is $2.9 million, recognising a need to build the capacity of people with disability to navigate the Scheme.[40]

4.47 However, the Victorian Government identified the need for greater clarity on how systemic and legal advocacy will be delivered in a national consistent way.[41]

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35 See for example: Office of the Public Advocate , *Submission 37*, p. 5; Family Advocacy, *Submission 52*, p. 4; VCOSS, *Submission 65*, p. 9.

36 Family Advocacy, *Submission 52*, p. 4.

37 Ms Mary Mallett, CEO, Disability Advocacy Network Australia, *Committee Hansard*, 20 October 2017, p. 18.

38 Physical Disability Council of NSW, *Submission 56*, p. 6.

39 Physical Disability Council of NSW, *Submission 56*, p. 6.

40 Ms Kym Peake, Secretary, Department of Health and Human Services, Victorian Government, *Committee Hansard*, 19 September 2017, p. 2.

41 Victorian Government, *Submission 54*, p. 10.

4.48 In light of the loss of advocacy funding because of the transition of state and territory funding to the NDIS, People With Disability Australia 'urges the Committee to draw attention to the critical gap in advocacy services that will be left after state funding ceases'.[42]

4.49 VCOSS recommended ongoing funding for independent advocacy so every NDIS participant can access advocacy support to navigate the system and obtain the right support in their Plans.[43]

4.50 Ms Mary Mallett, CEO of Disability Advocacy Network Australia also called for action:

> This week the Productivity Commission's report came out. Everybody's paying attention to that. It says advocacy is important. The first annual report of your joint standing committee said that advocacy is important and must be fixed. […]We're pleading with your committee to take it seriously and to do whatever you can and to use whatever levers are available to get the state governments to take their responsibility.[44]

Assertive Outreach

4.51 The issue of assertive outreach has been explored by this committee in its inquiry into the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*. The committee found that with the transitioning of Commonwealth, state and territory funded programs, there is a risk of emerging gaps in outreach services.[45]

4.52 In its submission, Mental Health Australia reiterated the concerns raised by the sector during the inquiry into the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition* about the future of funding for assertive outreach under the NDIS:

> In the long term, without specific new policy and funding arrangements, there is a major risk assertive outreach for people with severe mental illness and complex needs will no longer be delivered at all, either through the NDIS or elsewhere.[…] the lack of a strategy for funding specialist assertive outreach is a critical loss to the system of supports for people with psychosocial disability and a major concern for mental health stakeholders.[46]

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42 People With Disability Australia, *Submission 77*, p. 4.

43 VCOSS, *Submission 65*, p. 9.

44 Ms Mary Mallett, CEO, Disability Advocacy Network Australia, *Committee Hansard*, 20 October 2017, p. 19.

45 Joint Standing Committee on the NDIS, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017, p. x.

46 Mental Health Australia, *Submission 50*, p. 12.

4.53 VCOSS called for dedicated funding for assertive outreach to help locate and connect people experiencing isolation or disadvantage with the NDIS.[47]

4.54 Refugee Council of Australia recommended increasing assertive outreach programs to help people from refugee and CALD backgrounds, stating:

> These programs should be designed to help them understand changes to the disability support sector in the transition to the NDIS and what this means for their individual situation, including services both in and outside the NDIS and the interface between these two sectors. This support would include accessible information about individuals' rights and responsibilities as an NDIS participant or as a user of ILC services.[48]

Support Coordination

4.55 Anglicare highlighted the importance of support coordination to assist Participants in understanding and enacting their Plans.[49] The Office of the Advocate (Victoria) also observed that 'support coordination is one of the key determinants of the successful implementation of an NDIS plan'.[50]

4.56 Can:Do Group is of the view that the traditional coordination role has been lost with the introduction of the NDIS:

> […] service providers have stepped back and are only providing what they are being asked to provide by the family as they are only being paid for that service. This negates the importance of coordination, collaboration and navigation alongside families – yet outside of most initial Plans which do have some support coordination no one is being paid for this, nor has resourcing to do so at no charge, so it is not being done.[51]

4.57 Many submitters reported that the lack of funded support coordination in Plans is resulting in Participants not knowing how to use their Plans and delays in Plan implementation.[52]

4.58 Mrs Leanne Varga, Systemic Advocate and Campaigns Manager with Family Advocacy told the committee that 'people are asking for support coordination or plan management and they are not receiving it'.[53]

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47 VCOSS, *Submission 65,* p. 8.

48 Refugee Council of Australia, *Submission 59,* p. 6.

49 Anglicare Australia, *Submission 8,* Attachment 1, p. 5.

50 Office of the Public Advocate, *Submission 69,* p. 23.

51 Can:Do Group, *Submission 25,* p. 4.

52 See for example: Multiple Sclerosis Australia, *Submission 31,* p. 5; Physical Disability Council of NSW, *Submission 56,* p. 5; Dr Nick Collyer, Systems Advocate, Queensland Advocacy Inc., *Committee Hansard,* 26 September 2017, p. 3.

53 Mrs Leanne Varga, Systemic Advocate and Campaigns Manager, Family Advocacy, *Committee Hansard,* 3 October 2017, p. 3.

4.59 Anglicare believes that the lack of funding for support coordination is contributing to Plan underutilisation, and is creating hidden costs to the Scheme.[54] For example, Multiple Sclerosis Australia and Physical Disability Council of NSW also reported that some Participants do not know how to activate and use theirs Plans due to not having any support coordination to assist them.[55]

4.60 Additionally, Anglicare Australia identified that lack of funded support coordination in Plans needs to be addressed, as currently service providers are picking up this cost.[56]

Loss of funding for support coordination

4.61 Multiple Sclerosis Australia reported that some Participants are losing their support coordination funding at plan reviews.[57] Making Connections Together also noted that 'support coordination is considered irrelevant after the first 12 months of a plan'.[58]

4.62 In its study report on NDIS Scheme Costs, the Productivity Commission also found evidence that support coordination is being provided to Participants for only a fixed period of time and is of the view that 'the NDIA should allocate support coordination based on need, rather than time'.[59]

Guidelines and funding recommendations

4.63 Some inquiry participants believe the guidelines for support coordination are unclear. Family Advocacy stated:

> Currently, the NDIS website does not provide clear guidelines as to when a participant is eligible for support coordination. For this reason, greater transparency is required in relation to the eligibility for support coordination.[60]

4.64 The Victorian Government is of the view that 'there has been inconsistent information about the expectations of support coordination as well as limited training of support coordinators to support people with complex and specialist needs'.[61]

4.65 The Office of the Public Advocate (Victoria) argued that the current format of support coordination is too limited and that the NDIA should introduce 'intensive

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54 Anglicare Australia, *Submission 8,* Attachment 1, p. 5.

55 Multiple Sclerosis Australia, *Submission 31,* p. 5; Physical Disability Council of NSW, *Submission 56,* p. 5.

56 Anglicare Australia, *Submission 8,* Attachment 1, p. 13.

57 Multiple Sclerosis Australia, *Submission 31,* Attachment 1, p. 4.

58 Making Connections Together, *Submission 43,* p. 2.

59 Productivity Commission, *National Disability Insurance Scheme (NDIS) Costs Study Report*, October 2017, p. 39.

60 Family Advocacy, *Submission 52,* p. 25.

61 Victorian Government, *Submission 54,* p. 9.

support coordination' as a funded service based on the traditional comprehensive case management model.[62]

4.66 The Summer Foundation believes that 'proactive, effective and ongoing support coordination should be provided when required to respond to complex and changing needs'.[63]

Committee view

4.67 The transition of Commonwealth, state and territory funded programs into the NDIS as well as the transition to individualised funding for NDIS Participants have disrupted the way advocacy, outreach and support coordination services were historically funded and delivered. The committee is cognisant of the service gaps in these areas through previous inquiries, including the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition.*

Advocacy

4.68 The committee is concerned that state and territory governments are not putting strategies and resources in place to address the identified gaps in funding for advocacy. Overall, it is unclear how individual advocacy will be funded beyond transition. This issue must be urgently addressed. The committee recommends the Council of Australian Governments (COAG) Disability Reform Council work with the Department of Social Services to address the expected funding shortfalls for advocacy services beyond transition.

Recommendation 19

4.69 The committee recommends the Council of Australian Governments (COAG) Disability Reform Council work with the Department of Social Services to address the expected funding shortfalls for advocacy services beyond transition.

Assertive outreach

4.70 During its inquiry into the *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition,* the committee identified that the Department of Social Services and the NDIA needed to collaboratively develop a plan outlining how assertive outreach services will be delivered beyond transition to ensure people who are hard-to-reach can effectively engage with the NDIS and other support programs. The evidence received during this inquiry reinforces the urgent need for such a plan.

Recommendation 20

4.71 The committee recommends the Department of Social Services and the NDIA develop and publically release a plan outlining how assertive outreach services will be delivered beyond transition to ensure people with disability who

62 Office of the Public Advocate (Victoria), *Submission 69,* p. 24.

63 Summer Foundation, *Submission 22,* p. 27.

are hard-to reach can effectively engage with the NDIS and / or other support programs.

Support coordination

4.72 The committee is of the view that support coordination plays a major role in the enactment and implementation of Participants' Plans, especially for people with complex needs. The committee is concerned with reports of Participants not knowing how to use their Plans because of a lack of funded support coordination in their Plans.

4.73 The committee also recognises that support coordination should not be limited to a fixed period as some Participants may need ongoing support coordination. The committee agrees with the Productivity Commission's view that the NDIA should allocate support coordination based on need rather than time.

Recommendation 21

4.74 The committee recommends the NDIA ensure support coordination is adequately funded in Plans to meet Participants' needs and not limited to a fixed period.

People from CALD backgrounds

4.75 People from culturally and linguistically diverse (CALD) backgrounds make up the second largest group of people living with disabilities. Yet, they are significantly under-represented in disability support services, and had very low NDIS participation rates during the NDIS trial phase.[64]

4.76 The Public Advocate (Queensland) shared the concerns of AMPARO Advocacy about the current NDIS participation rates of people with disability from CALD backgrounds being significantly below what some groups in the CALD service delivery sector have anticipated.[65]

4.77 VICSERV and others drew the attention of the committee on issues around engaging with the NDIS for people from CALD backgrounds.[66]

Provision of interpreter services

4.78 One of the reasons put forward for the low engagement of people from CALD backgrounds is the lack of interpreter supports. Queensland Advocacy Inc.[67] and other groups[68] argued that the NDIA will not fund interpreters. The Office of the Public Advocate (Queensland)[69] said that Plans do not consistently address interpretation and translation needs.

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64 Refugee Council of Australia, *Submission 59,* p. 1.

65 Office of the Public Advocate (Queensland), *Submission 37,* Appendix 2, pp.1-3.

66 See for example: Queensland Advocacy Inc, *Submission 21,* p. 5; VICSERV, *Submission 33,* p. 8; VCOSS, *Submission 65,* p. 18.

67 Queensland Advocacy Inc, *Submission 21,* p. 5.

68 Queensland Government, *Submission 72,* p. 13.

69 Office of the Public Advocate (Queensland), *Submission 37,* p. 7.

4.79 However, at a public hearing in Brisbane, Mr Yuu Matsuyama, Senior Legal Officer, Office of the Public Advocate provided some encouraging news about interpreter supports:

> Our office was part of a consortium of agencies that advocated strongly on the issues of interpreter supports for people with disability from CALD backgrounds so that they can communicate with local area communicators, planners and service providers to enact their NDIS Plans. We've been advised since that the NDIS signed a memorandum of understanding with the Commonwealth government's Translating and Interpreting Service to assist Participants from CALD backgrounds with implementing their Plans. The Queensland government has also committed to continue to provide interpreter services to Participants with disability from CALD backgrounds until 30 June 2019. On that front, the Public Advocate congratulates both the Commonwealth and the Queensland government for responding to that issue.[70]

4.80 The Office of the Public Advocate (Queensland) warned that 'by not implementing policies supporting the provision of interpreter services and other mechanisms for people from CALD backgrounds to overcome barriers accessing the NDIS the NDIA, and its disability provider partners, are vulnerable to complaints of racial discrimination'.[71]

4.81 VCOSS recommended employing CALD workers and resourcing and working with local CALD communities to develop engagement strategies, undertake outreach, and deliver services, could help increase NDIS access and participation for people from CALD backgrounds.[72]

Data collection

4.82 In a letter to the NDIA dated 3 April 2017, the Public Advocate (Queensland) recommended that accurate data about participation of people from CALD backgrounds, including countries of origin, be collected for the following reasons:

> Failure to collect adequate data about this group will impact on the NDIA's ability to monitor the participation rates of people from CALD backgrounds, inform targeted strategies with diverse communities, and ensure effective policy development and planning.[73]

4.83 In its reply to the Public Advocate, the NDIA explained the current limitation of data collection:

> With regard to CALD data; as recognised in the report to the Council of Australian Governments Disability Reform Council for Quarter 2 of Year 4 of the NDIS, there are some current limitations to the data available in

70 Mr Yuu Matsuyama, Senior Legal Officer, Office of the Public Advocate (Queensland), *Committee Hansard*, 26 September 2017, p. 2.

71 Office of the Public Advocate (Queensland), *Submission 37,* p. 8.

72 VCOSS, *Submission 65,* p. 18.

73 Office of the Public Advocate (Queensland), *Submission 37,* Appendix 2, p. 3.

> relation to the proportion of Participants that are culturally and linguistically diverse. This is due to the data warehouse of the new Customer Relationship Management (CRM) system being under development. Ongoing enhancements to the CRM, data warehouse and business practices will address these issues.[74]

CALD strategy

4.84 The Public Advocate (Queensland) pointed out that the NDIA is yet to release the NDIS CALD strategy.[75] The Queensland Government believes that the delay in releasing the NDIS CALD strategy poses the risks of continued underrepresentation of people from CALD backgrounds in the NDIS.[76]

4.85 In a letter to the Public Advocate (Queensland) dated 22 May 2017, the NDIA stated that the 'NDIA is developing a CALD Strategy to articulate how the NDIA will ensure the needs of people from culturally and linguistically diverse backgrounds with disability are met in the design, development and implementation of the NDIS'. It indicated the 'the Strategy will be endorsed and published mid to late 2017'.[77]

Committee view

4.86 The committee is concerned with reports that the current NDIS participation rates for people with disability from CALD backgrounds are significantly below what some groups in CALD service delivery sector have anticipated. The committee notes the lack of data being collected and made publically available about the participation rates for people from CALD backgrounds. This impedes on the NDIA's ability to monitor the participation rates of people from CALD backgrounds and develop targeted strategies. The committee recommends the NDIA ensure its Customer Relationship Management (CRM) system is modified to enable collection of accurate data about participation of people from CALD backgrounds.

Recommendation 22

4.87 The committee recommends the NDIA ensure its Customer Relationship Management (CRM) system is modified to enable collection of data about participation rate of people from CALD backgrounds.

4.88 The committee was pleased to hear that progress has been made toward the inclusion of interpreters' services in people's Plans. However, the committee believes that more needs to be done to ensure that people with disability from CALD backgrounds can fully engage with the NDIS. For example, the committee notes the recommendation to employ CALD workers to increase NDIS access and participation. The committee understands that the NDIA has been working on the development of a CALD Strategy for some time and anticipated to publically release it by mid to late 2017. The CALD strategy is yet to be published.

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74 Office of the Public Advocate (Queensland), *Submission 37,* Appendix 3, p. 2.

75 Office of the Public Advocate (Queensland), *Submission 37,* Appendix 2, p. 2.

76 Queensland Government, *Submission 72,* p. 13.

77 Office of the Public Advocate (Queensland), *Submission 37,* Appendix 3, p. 1.

Recommendation 23

4.89 The committee recommends the NDIA urgently publically release its NDIS CALD Strategy.

Aboriginal and Torres Strait Islander communities

4.90 At a public hearing in Darwin, Mr John Paterson, CEO of Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) provided some background information about Aboriginal and Torres Strait Islanders and disability:

> In 2016 Census data showed just how significant the issue of disability is for Aboriginal and Torres Strait Islander communities. At least 60,000 Aboriginal and Torres Strait Islanders across Australia live with a severe or profound disability, which is at least twice the prevalence rate of other Australians. In 2014-15, six per cent of disability service users were Aboriginal and Torres Strait Islander people, with 84 per cent of those aged under 50. Disability is often compounded by other challenges in Aboriginal communities, such as lack of cultural competence of mainstream services, poverty, comorbidities and, for remote people, a serious lack of access to services.[78]

4.91 The Australian Medical Association (AMA) explained that 'the high prevalence of disability within Indigenous communities is due, in part, to poor health care and nutrition, an increased exposure to violence and psychological trauma'.[79]

4.92 Mr Paterson acknowledges that the NDIS could offer some real opportunities but holds 'serious concerns that these opportunities will not be realised without significant reforms to the current NDIS framework'.[80]

Engagement with the NDIS

4.93 Community Mental Health Australia (CMHA) identified that 'Aboriginal and Torres Strait Islander people are the least engaged in the NDIS and experiencing particular challenges'.[81]

4.94 Dr Nick Collyer, Systems Advocate at Queensland Advocacy Inc. reported that knowledge of the NDIS rollout is poor amongst Aboriginal and Torres Strait Islander communities and stressed the importance of pre-rollout conversations rather than distribution of written materials to raise awareness about the NDIS in these communities.[82]

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78 Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard,* 21 September 2017, p. 1.

79 Australian Medical Association, *Submission 1*, p. 7.

80 Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard,* 21 September 2017, p. 1.

81 Community Mental Health Australia, *Submission 3*, p. 4.

82 Dr Nick Collyer, Systems Advocate, Queensland Advocacy Inc., *Committee Hansard*, 26 September 2017, p. 9.

4.95 The Office of the Public Guardian NT found that Participants, their families and service providers are not well prepared to understand and interact with the new Scheme. It recommended:

> […] resources be allocated for culturally-appropriate pre-transition preparation initiatives to ensure families and carers are able to provide the necessary support to Participants throughout the planning process.[83]

4.96 Submitters described poor planning practices and outcomes in communities.[84] For example, AMA drew the committee's attention to anecdotal reports about inconsistent and unacceptable NDIS planning practices occurring in Aboriginal and Torres Strait Islander communities:

> The AMA has been told of instances where Indigenous people have been 'assessed' from a car parked outside a residence. We have heard of a person with otitis media whose forms were 'lost' and the young man and his family forced to travel 500 kilometres to a specialist to provide the correct medical paperwork.[85]

Culturally appropriate pathways

4.97 AMSANT[86] and the Office of the Public Guardian NT[87] raised concerns about the cultural competency embedded in NDIS systems and NDIA staff who are unaware of culturally respectful ways of engaging with Aboriginal and Torres Strait Islander people.

4.98 AMA pointed out that there is no Aboriginal and Torres Strait Islander representatives on the NDIS Independent Advisory Council (IAC). Given the prevalence of disability amongst Aboriginal and Torres Strait Islander people and the current challenges faced by this cohort with the transition to the NDIS, the AMA believes there is a need to have an Aboriginal and Torres Strait Islander person appointed to the IAC.[88] CMHA made a similar recommendation stressing that 'it is vital that the formal structures advising the NDIS process reflects this diversity and the associated challenges'.[89]

Service gaps and funding approach

4.99 Significant service gaps exist in many communities and submitters reported that purely market based models simply will not provide the stability or support

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83 Office of the Public Guardian NT, *Submission 63,* p. 5.

84 See for example: MJD Foundation, *Submission 7,* p. 12; Office of the Public Guardian NT, *Submission 63,* p. 4; Queensland Government, *Submission 72,* p. 10.

85 Australian Medical Association, *Submission 1,* pp. 7 and 8.

86 Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard,* 21 September 2017, p. 1.

87 Office of the Public Guardian NT, *Submission 63,* p. 5.

88 Australian Medical Association, *Submission 1,* p. 8.

89 Community Mental Health Australia, *Submission 3,* p. 4.

required to improve the lives of people living with a disability in Aboriginal and Torres Strait Islander communities.[90]

4.100 AMSANT recommended that changes be made to the criteria for NDIS providers to make it more feasible for the Aboriginal community controlled health sector and other Aboriginal organisations to become providers.[91]

Aboriginal disability workforce

4.101 The Queensland Government believes that 'the employment of appropriate Aboriginal or Torres Strait Islander people (male and female) by the NDIS would facilitate the integration of NDIS into the community and is likely to lead to improved outcomes for clients'.[92] VCOSS made a similar observation and recommended employing Aboriginal workers and working with Aboriginal organisations to deliver services.[93]

4.102 Ms Noelene Swanson, from National Disability Services, believes there is an opportunity to grow a local Aboriginal workforce:

> We have a real opportunity here: we have the youngest people in Australia living in rural and remote areas. We have a workforce capacity that is now equivalent to the age of the industrial revolution. So there's a real opportunity to grow a local Aboriginal workforce as well as businesses and services.[94]

4.103 Mr John Paterson, CEO of AMSANT, expressed concerns 'about the lack of real strategy for the development of an Aboriginal disability workforce'[95] and subsequently recommended 'that an Aboriginal workforce strategy be developed by the NDIA in consultation with Aboriginal organisations and the Aboriginal community controlled health sector as a priority action'.[96]

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90 See for example: Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard*, 21 September 2017, p. 2; Ms Noelene Swanson, State Manager, Northern Territory, National Disability Services, *Committee Hansard,* 21 September 2017, pp. 19–20; Mr Terence Cleary, Executive Manager, Community Care and Access, Anglicare NT, *Committee Hansard*, 21 September 2017, p. 21.

91 Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard,* 21 September 2017, p. 2.

92 Queensland Government, *Submission 72,* p. 11.

93 VCOSS, *Submission 65,* p. 18.

94 Ms Noelene Swanson, State Manager, Northern Territory, National Disability Services, *Committee Hansard,* 21 September 2017, p. 20.

95 Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard,* 21 September 2017, p. 2.

96 Mr John Paterson, CEO, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *Committee Hansard,* 21 September 2017, p. 2.

Initiatives to increase engagement and improve outcomes

4.104 State governments have put in place initiatives to engage with Aboriginal and Torres Strait Islander people and communities. For example, the Queensland Government described how the Queensland's participant readiness initiatives, augmented by Sector Development Funding, have increased the rate of participation of Aboriginal and Torres Strait Islander people over the last two quarters, particularly in North Queensland. Aboriginal and Torres Strait Islander peoples represent 4.22 per cent of Queensland's population and now represent 9.5 per cent of Queensland NDIS Participants with approved Plans.[97]

4.105 At a public hearing in Melbourne, Mr Arthur Rogers, Special Adviser NDIS with the Department of Premier and Cabinet, Victorian Government, explained that the Victorian Government's workforce plan includes promoting employment within the disability sector for groups that are underrepresented, including people from Aboriginal and Torres Strait Islander backgrounds.[98]

4.106 The NDIA has acknowledged the challenges of delivering ILC activities in Aboriginal and Torres Strait Islander communities. The NDIA indicated it is 'currently preparing to undertake a grants round that primarily targets remote areas, including Aboriginal and Torres Strait Islander communities, to build the foundations required for ILC to be delivered in those areas from 2019–20 when ILC is rolled out nationally'.[99]

Committee view

Engaging with the NDIS

4.107 The committee is aware that Aboriginal and Torres Strait Islander people are experiencing additional challenges to engage with the NDIS. The committee believes that pre-rollout and pre-planning engagement activities are essential and must be prioritised by the NDIA. The committee noted the Queensland Government's efforts to increase engagement and the rate of participation of Aboriginal and Torres Strait Islander people. The committee encourages other jurisdictions to undertake targeted initiatives.

Recommendation 24

4.108 The committee recommends the NDIA ensure culturally appropriate pre-rollout and NDIS engagement activities are in place in Aboriginal and Torres Strait Islander communities at least six months before rollout date.

Cultural competencies

4.109 The committee is concerned about reports of lack of cultural competencies of NDIA staff when engaging with Aboriginal and Torres Strait Islander people. Given

97 Queensland Government, *Submission 72,* p. 10.

98 Mr Arthur Rogers, Special Adviser NDIS, Department of Premier and Cabinet, Victorian Government, *Committee Hansard,* 19 September 2017, p. 8.

99 NDIA, *Submission 41,* p. 8.

the prevalence of disability amongst Aboriginal and Torres Strait Islander people and the current lack of engagement of this cohort with the NDIS, the committee agrees with the recommendation made by submitters that an Aboriginal and Torres Strait Islander representative be appointed to the NDIS Independent Advisory Council (IAC).

Recommendation 25

4.110 The committee recommends the Minister for Social Services appoint an Aboriginal and Torres Strait Islander representative on the NDIS Independent Advisory Council (IAC).

Workforce and services

4.111 The committee sees growing the disability workforce in Aboriginal and Torres Strait Islander communities as a priority to ensure supply of services. The committee understands that the First People's Disability Network is working with Aboriginal and Torres Strait Islander communities, employment agencies, training organisations and other local stakeholders to increase the number of Aboriginal and Torres Strait Islander people working in the disability sector.[100] However, the committee believes that a comprehensive Aboriginal and Torres Strait workforce strategy would benefit the sector.

Recommendation 26

4.112 The committee recommends the NDIA develop, in collaboration with Aboriginal and Torres Strait Islander organisations and the Aboriginal community controlled health, an Aboriginal and Torres Strait Islander Workforce Strategy.

Hon Kevin Andrews MP

Chair

Senator Alex Gallacher

Deputy Chair

100 NDIA, *Increasing the number of Indigenous Australians working in the disability sector*, https://www.ndis.gov.au/people-disability/connecting-mainstream/careers-disability-sector.html (accessed 19 December 2017).

Appendix 1
Submissions and additional information

Submissions

1. Australian Medical Association
2. Child and Family Health Nurses Association NSW Inc.
3. Community Mental Health Australia
4. Name Withheld
5. Multiple Sclerosis Network of Care
6. Allied Health Professions Australia
7. MJD Foundation
8. Anglicare Australia
9. Prader-Willi Syndrome Australia
10. Australian National Audit Office
11. Victorian Healthcare Association
12. National Disability Services
13. Australian Blindness Forum
14. The Royal Australian and New Zealand College of Psychiatrists
15. Royal Australian College of General Practitioners
16. Scope Australia
17. The Australian Psychological Society
18. Royal Children's Hospital
19. Mental Health Council of Tasmania
20. Assistive Technology Suppliers Australasia
21. Queensland Advocacy Inc
22. Summer Foundation
23. Firstchance
24. Vision Australia
25. Can:Do Group
26. Occupational Therapy Australia

27. Department of Premier and Cabinet NSW
28. Macular Disease Foundation Australia
29. Department of Social Services
30. Municipal Association of Victoria
31. Multiple Sclerosis Australia
32. Catholic Social Services Australia
33. VICSERV
34. cohealth
35. Royal Institute for Deaf and Blind Children
36. Dietitians Association of Australia
37. Office of the Public Advocate
38. KU Children's Services
39. AMIDA
40. Autism Spectrum Australia
41. National Disability Insurance Agency
42. Victorian Autism Specific Early Learning and Care Centre
43. Making Connections Together
44. Mental Illness Fellowship of Australia
45. ATEND
46. The Shepherd Centre for deaf children
47. Family Planning NSW
48. Spinal Cord Injuries Australia
49. IDEAS
50. Mental Health Australia
51. Carers Australia
52. Family Advocacy
53. Business Council of Co-operatives and Mutuals
54. Department of Premier and Cabinet, Victoria
55. Carers NSW
56. Physical Disability Council of NSW
57. Australian Services Union
58. ACT Government

59. Refugee Council of Australia
60. JFA Purple Orange
61. Australasian Newborn Hearing Screening Committee
62. Speech Pathology Australia
63. Office of the Public Guardian NT
64. Department of Education and Training
65. VCOSS
66. City of Greater Bendigo
67. Australian Red Cross
68. Australian Federation of Disability Organisations
69. Office of the Public Advocate
70. Office of the Public Guardian QLD
71. Mr David Roche and Ms Kaye Manners
72. Queensland Government
73. Name Withheld
74. VALiD Inc.
75. Department of Premier and Cabinet, Tasmania
76. Northern Territory PHN
77. People With Disability Australia
78. Wellways Healthcall
79. Victoria Legal Aid
80. Dr John Whiting
81. ME/CFS Legal Resources
82. Western Australian Government

Additional information

1. MJD Foundation, Opening remarks to joint standing committee hearing on transition to NDIS, additional information received 21 September 2017
2. AMSANT, APO NT partnership principles for working with Aboriginal organisations and communities in the Northern Territory, additional information received 22 September 2017
3. Queensland Advocacy Inc, NDIS and intersectional challenges for Australia's Aboriginal people's, additional information received 26 September 2017
4. Valid Inc, Keep Clyde Street Open for kids with disabilities, additional information received 26 September 2017
5. Speech Pathology Australia, Speech Pathology Australia briefing paper: mealtime support, additional information received 8 November 2017

Answers to questions on notice

6. Department of Health and Human Services- QON's arising from Public hearing- 19 September, Melbourne
7. NDIA- QON's arising from Public Hearing- 20 October 2017, Canberra
8. RACGP- QON's arising from Public Hearing- 20 October 2017, Canberra. Received 9 November 2017
9. National Disability Services- QON's arising from Public Hearing 20 October 2017- Received 14 November 2017
10. NDIA- QON's arising from Public Hearing 20 October 2017. Received 17 November 2017: Performance indicator target for ECEI Partners
11. NDIA- QON's arising from Public Hearing 20 October 2017. Received 17 November 2017: Pathway review consultation
12. NDIA- QON's arising from Public Hearing 20 October 2017. Received 17 November 2017: Provision of NDIA offices
13. NDIA- QON's arising from Public Hearing 20 October 2017. Received 17 November 2017: Aboriginal and Torres Strait Islander children with NDIS plans in the ACT
14. Occupational Therapy Australia, QON's arising from Public Hearing 8 November 2017 Melbourne- Received 24 November 2017
15. Office of the Public Advocate QON's arising from Public Hearing 8 November 2017 Melbourne- Received 24 November 2017
16. Attachment 1: in relation to, Office of the Public Advocate QON's arising from Public Hearing 8 November 2017 Melbourne- Received 24 November 2017

17. Attachment 2: in relation to, Office of the Public Advocate QON's arising from Public Hearing 8 November 2017 Melbourne- Received 24 November 2017
18. Speech Pathology Australia QON's arising from Public Hearing 8 November 2017 Melbourne- Received 27 November 2017

Tabled Documents

1. Tabled by DANA Public Hearing 20 Sep- Cost benefit analysis of Australian independent disability advocacy agencies
2. Tabled by DANA Public Hearing 20 Sep- Funding Independent Advocacy is a Good Deal for People with a Disability and for Government
3. Tabled by DANA Public Hearing 20 Sep- Real Government direct services delivery expenditure
4. Tabled by DANA Public Hearing 20 Sep- Independent cost benefit analysis of Australian Independent disability advocacy agencies
5. Tabled by DANA Public Hearing 20 Sep-NDIS Survey 2016-17
6. Tabled by Dietitians Association of Australia Public Hearing 20 Sep- Case Study
7. Tabled by Dietitians Association of Australia Public Hearing 20 Sep- Disproportionate regulation for registration of NDIS providers: verification and certification
8. Tabled by Dietitians Association of Australia Public Hearing 20 Sep- Guide to Suitability
9. Tabled by Dietitians Association of Australia Public Hearing 20 Sep- Walking, Talking Harrison

Appendix 2
Public hearings and witnesses

Tuesday 19 September 2017–Melbourne

Department of Health and Human Services, Victorian Government
Ms Kym Peake, Secretary
Ms Janine Toomey, Project Director, NDIS

Department of Premier and Cabinet, Victorian Government
Mr Arthur Rogers, Special Adviser NDIS

Multiple Sclerosis Australia
Mr Andrew Giles, National Policy Officer

Prader-Willi Syndrome Association of Australia
Mr James O'Brien, President

Refugee Council of Australia
Dr Christina David, Lecturer in Social Work and Centre for Applied Social Research member
Dr Christopoher Maylea, Early Career Research Lead

Summer Foundation
Dr George Taleporos, Policy Manager
Miss Grace Poland

VALID
Mr Kevin Stone, Chief Executive Officer

Victorian Healthcare Association

Mr Tom Symondson, Chief Executive Officer
Ms Emma Liepa, Director of Policy

Thursday 21 September – Darwin

Aboriginal Medical Services Alliance of the Northern Territory
Mr John Paterson, Chief Executive Officer
Ms Karrina Demasi, Public Health Policy Officer

Anglicare NT
Mr Terence Cleary, Executive Manager, Community Care and Access

Keep Moving
Mr Cameron Croker, Chief Executive Office

Miwatj Health Aboriginal Corporation
Dr Lucas DeToca, Chief Health Officer

MJD Foundation
Ms Nadia Lindop, Chief Executive Officer

National Disability Services
Ms Noelene Swanson, State Manager, Northern Territory

Office of the Public Guardian, Northern Territory
Ms Beth Walker, Public Guardian

Somerville Community Services
Ms Deborah Brampton, Service Development Manager and Administrator, Disability Services,

Sunrise Health Service
Ms Anne Taylor, National Disability Insurance Scheme/Personal Helpers and Mentors Service— Men's Healing Program Coordinator

Tuesday 26 September – Brisbane

Mental Illness Fellowship of Australia
Mr Tony Stevenson, National Chief Executive Officer

Office of the Public Advocate
Ms Natalie Siegel-Brown, Public Guardian
Dr Adrienne McGhee, Principal Policy and Research Officer
Mr Yuu Matsuyama, Senior Legal Officer

Queensland Advocacy Inc.
Mr Byron Albury, President
Dr Nick Collyer, Systems Advocate

Wednesday 27 September 2017–Adelaide

BaptistCare
Ms Sarah Pastro, Team Manager, Disability Care

Can:Do Group
Ms Heidi Limareff, Deputy Chief Executive
Ms Jena Mayne, General Manager, Group Service Development

JFA Purple Orange
Mr Robbi Williams, Chief Executive Officer

Private capacity
Ms Jackie Hayes

Royal Society for the Blind
Mr Tony Starkey, Government Relations and Accessibility

Tuesday 3 October 2017 – Sydney

Assistive Technology Suppliers Australasia
Mr Geoff Purtill, President of Committee
Mr David Sinclair, Executive Officer

Business Council of Co-operatives and Mutuals
Ms Gillian McPhee

Family Advocacy
Mrs Leanne Varga, Systemic Advocate and Campaigns Manager
Mrs Linda Hughes, Committee Member

Family Planning NSW
Mr Rob Hardy, Manager Health Promotion
Ms Ee-lin Chang, Senior Health Promotion Officer

People with Disability Australia
Ms Jeanette Ruse, New South Wales Manager, Individual Advocacy and National Disability Insurance Scheme Appeals
Dr Megan Clement- Couzner, Senior Policy Officer, National Disability Insurance Scheme

Physical Disability Council of New South Wales
Ms Serena Ovens, Executive Officer
Ms Ellen Small, Policy Officer

Royal Institute for Deaf and Blind Children
Professor Greg Leigh, Director, Renwick Centre
Mr Bart Cavalletto, Director of Services

Spinal Cord Injuries Australia
Mr Greg Killeen, Senior Policy and Advocacy Officer
Mr Tony Jones, Policy and Advocacy Officer

Supported Independent Living Co-operative
Ms Faen Burrows, Operations Manager

Wednesday 4 October 2017 – Hobart

Department of Health and Human Services, Tasmania
Ms Ingrid Ganley, Director, Disability and Community Services, Housing, Disability and Community Services

Department of Premier and Cabinet, Tasmania
Mr Andrew Rayner , Director, Intergovernmental Relations

Mental Health Council of Tasmania
Ms Elinor Heard, Sector Reform Lead

North West Tasmania Autism Specific Early Learning and Care Centre
Ms Kathryn Fordyce, General Manager

Friday 20 October 2017 – Canberra

ACT Parliament
Ms Rachel Stephen- Smith, Minister for Disability, Children and Youth

Australian Blindness Forum
Ms Jennifer Grimwade, Executive Officer

Community Services Directorate, Australian Capital Territory
Ms Ellen Dunne, Director, Office for Disability
Ms Wendy Kipling, Senior Manager, Office for Disability

Department of Social Services
Mr Sasha Dordevic, Director, NDIS Transition Oversight, Financial
Mr Michael Lye, Deputy Secretary, Disability and Carers
Mr John Riley, Branch Manager, NDIS Market Oversight

Dietitians Association of Australia
Ms Claire Hewat, Chief Executive Officer
Ms Annette Byron, Senior Policy Officer
Mrs Carmel Curlewis, National Disability Insurance Scheme Provider and Accredited Practising Dietitian

Disability Advocacy Network Australia
Ms Mary Mallett, Chief Executive Officer

National Disability Insurance Agency
Ms Sarah Johnson, Scheme Actuary
Mr Scott McNaughton, General Manager, Participant Pathway Design

National Disability Insurance Scheme Launch Transition Agency
Ms Margaret McKinnon, Acting Deputy Chief Executive Officer, Governance and Stakeholder Relations
Ms Vicki Rundle PSM, Acting Deputy Chief Executive Officer, Markets and Supports

National Disability Services
Dr Ken Baker, Chief Executive
Ms Philippa Angley, Executive Officer to the Chief Executive

Royal Australian College of General Practitioners
Dr Sharma Rashmi, Member, RACGP Expert Committee, General Practice Advocacy and Funding

Wednesday 8 November 2017– Melbourne

Occupational Therapy Australia
Ms Rachel Norris, Chief Executive Officer
Mrs Andrea Douglas, Industry Adviser

Office of the Public Advocate (Victoria)
Ms Colleen Pearce, Public Advocate

Speech Pathology Australia
Mr Timothy Kittel, Vice President (Communications)
Ms Catherine Olsson, National Advisor (Disability)

Victorian Council of Social Service
Ms Emma King, Chief Executive Officer
Ms Carly Nowell, Policy Adviser