Submission to National Disability Insurance Agency 2021-22 Annual Pricing Review

Allied Health Professions Australia

November 2021

This submission has been developed in consultation with AHPA's allied health association members.

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About AHPA and the allied health sector

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 140,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

Introduction

AHPA welcomes the opportunity to respond to the 2020-21 Annual Pricing Review Consultation Paper ('Consultation Paper'). Allied health professionals are a critical part of the National Disability Insurance Scheme (NDIS), providing a wide range of supports and services to help participants maintain and improve function, build their capacity to participate in community life, education and employment, and to access vital assistive technology.

In responding to the Consultation Paper, we have limited our responses to those questions of the greatest relevance to the allied health workforce.

Recommendations

That the NDIA:

Recommendation 1: Build flexibility into the pricing framework to allow for supports to be tailored to participants' needs, reflecting the complexity of therapy provision.

Recommendation 2: Develop specific pathways and culturally sensitive processes to address the needs of First Nations people with disability to enable greater service intensity and wrap around supports, with commensurate funding.

Recommendation 3: Work with the Regulatory Alignment Taskforce and the NDIS Quality and Safety Commission to simplify current provider registration and auditing processes.

Recommendation 4: Review reporting templates, report feedback and recording mechanisms.

Recommendation 5: Regularly share high level and up to date data with allied health peak bodies to enable future discussions.

Recommendation 6: Work with allied health peak bodies to investigate the current therapy market when considering benchmarking, and acknowledge the potential impacts of thin markets.

Recommendation 7: **Work with allied health peak bodies to publish clear and communication-accessible information on pricing, and to ensure this information is consistently provided to participants.**

Recommendation 8: **Increase the price limits for all allied health services so that they are consistent.**

Recommendation 9: **Ensure NDIA Pricing arrangements and price limits are GST exclusive for all therapy support providers.**

Recommendation 10: **Increase therapy support prices in line with inflation each financial year.**

Recommendation 11: **Work with allied health peak bodies to understand and address the issues impacting workforce recruitment, supervision and retention.**

Recommendation 12: **Increase allied health price limits to consider after hours loading.**

Recommendation 13: **Allow providers to bill the agency directly (so that participants do not have to cover the cost of these out of their plan budgets) or expand the list of non-participant-facing supports to include travel, time spent writing reports and participating in case conferencing and trust building.**

Recommendation 14: **Remove the current pricing cap on the provision of group supports, allowing these to be provided at a cost determined by the provider to enable them to be financially viable.**

Recommendation 15: **Provide capacity to secure pre-payment from group participants.**

Recommendation 16: **Increase access to interpreters to include all NDIS participants, regardless of how they are managed, or whether the provider is registered.**

Recommendation 17: **Remove travel caps for services provided in MMM4 & MMM5 areas, and allow the actual cost of travel to be charged.**

Recommendation 18: **Provide travel budgets for rural and remote participants that are separate to their therapy budget allocation.**

Responses to Consultation Paper Questions

Question 1

What changes could be made to the NDIS pricing arrangements to increase choice and control for participants; and/or reduce transactional costs for providers; and/or support innovation in the delivery of supports?

It is important to consider the interplay among the factors of participant choice and control, provider costs and support innovation.

In AHPA's view, to fully realise participant choice and control it is essential that participants have full access to the evidenced-based, quality-assured, allied health services that they require, and that these services are able to be provided in a manner and at a frequency that achieve optimal capacity building outcomes for participants – and which incorporates support innovation when that is consistent with these goals.

This is not currently the case. The latest NDIS Quarterly Report to Disability Ministers notes significant underutilisation of committed supports, with a total utilisation rate of 71%.[1] As our member Speech Pathology Australia has calculated for its submission to this Review, the rate of therapy utilisation across states and territories is significantly lower at 52%.

To be consistent with the object of choice and control in the *NDIS Act 2013* ('the Act'), underutilisation must continue to be addressed. In addition, the experience of allied health providers in the NDIS is that planners and support coordinators do not consistently recognise the unique value provided by allied health professions, the breadth of specialised allied health supports available, and what each of these supports has to offer participants.[2] This means that even the 52% utilisation rate for therapy supports is likely to be an overestimate.

Recommendation 1: Build flexibility into the pricing framework to allow for supports to be tailored to participant's needs, reflecting the complexity of therapy provision.

Recommendation 2: Develop specific pathways and culturally sensitive processes to address the needs of First Nations people with disability to enable greater service intensity and wrap around supports, with commensurate funding.

Funding full access to allied health should never come at the expense of other funded supports a participant may require under a plan. Given the current underutilisation of even those supports written into plans, and projected increased numbers of participants, it may be tempting to consider lowering price caps or even deregulating markets on the assumption that the level eventually settled upon might be lower than current prices.

We strongly emphasise that either of these strategy would be counter-productive to the Scheme and contrary to the *NDIS Act 2013* ('the Act'). The Act cannot permit simply denying reasonable and necessary supports to participants, but if it became even less attractive to provide NDIS services, this would be the result.

We use the phrase 'even less attractive' due to the costs and complexity of registration, regulation and pricing arrangements, particularly for sole practitioners, who comprise 35% of active registered providers for therapy supports.[3] As members of AHPA have submitted to this Review, allied health professionals' ethics and standards of care for their clients also mean that in many instances they provide unpaid or underpaid labour rather than compromise services or draw more on funding from an insufficient plan.

Recommendation 3: Work with the Regulatory Alignment Taskforce and the NDIS Quality and Safety Commission to simplify current provider registration and auditing processes.

Recommendation 4: Review reporting templates, report feedback and recording mechanisms.

One strategy to cut costs is already being reported by our members, who cite examples of planner or coordinator substitution of other workers for allied health professionals in an attempt to 'make a participant's plan go further'. However, using support workers with no formal training and

[1] NDIS Quarterly Report to Disability Ministers (30 September 2021), Table N.52.

[2] And see Recommendation 17, NDIA, Review of Therapy Pricing Arrangements (March 2019): 'The NDIA should investigate issues raised during consultations regarding practices that do not align with policies (for example, planners not building plans in line with agency-dictated best practice).'

[3] NDIS Quarterly Report to Disability Ministers (30 September 2021), Table E.82.

qualifications, or allied health assistants without appropriate delegation and supervision, compromises quality and outcomes and can be dangerous and in breach of codes of conduct.

While this Price Review is not the forum in which to exhaustively debate the rationale and assumptions of the Annual Financial Sustainability Report 2021-22 ('AFSR'), some of the Consultation Paper questions are clearly underpinned by the AFSR, notably the focus on the 'failure' of setting therapy supports price limits at the 75th percentile.

In AHPA's view, and consistent with submissions to the Review from our members, the 'failure' lies more in the application of a pure market model to disability therapy supports, which are at least currently provided in a market which is neither consistently competitive nor mature. We address these issues further in our response to Question 16.

This misapplication is compounded by a lack of full transparency about the data and analysis underpinning modelling of the Scheme itself, meaning that there is limited opportunity to take issue with foundational assumptions, such as the cost-benefit ratio of the Scheme.[4]

Recommendation 5: Regularly share high level and up to date data with allied health peak bodies to enable future discussions.

Recommendation 6: Work with allied health peak bodies to investigate the current therapy market when considering benchmarking, and acknowledge the potential impacts of thin markets.

Questions 2 & 3

How can the content and structure of pricing arrangements be simplified, while maintaining their integrity?

How can the pricing arrangements be communicated in a simpler way?

AHPA continues to receive feedback about tension between participants and providers concerning what is appropriate in terms of charging for travel, report-writing and other non-clinical components of service delivery.

AHPA would like to work with the NDIA as part of a process of developing participant education around pricing, to ensure that there is a consistent understanding by providers and participants of appropriate charging.

See also our response to Question 17.

Recommendation 7: Work with allied health peak bodies to publish clear and communication-accessible information on pricing, and to ensure this information is consistently provided to participants.

Question 14

Are the current price limits for therapy supports appropriate? If not, why not? Please provide evidence.

Many of AHPA's members have provided evidence to this Review that current price limits are not appropriate. Consistent with our response to Question 1, AHPA strongly supports raising price limits so that therapy supports do not vary in price depending on the type of therapy provided,

[4] Cf *False Economy: The economic benefits of the National Disability Insurance Scheme and the consequences of government cost-cutting*, Per Capita (November 2021). See also Exercise & Sports Science Australia's submission to this Review which argues that spending money on capacity building can ultimately reduce the cost of core supports.

and do not vary in terms of whether services are subject to GST. Price limits must also be indexed to inflation.

Recommendation 8: Increase the price limits for all allied health services so that they are consistent.

Recommendation 9: Ensure NDIA Pricing arrangements and price limits are GST exclusive for all therapy support providers.

Recommendation 10: Increase therapy support prices in line with inflation each financial year.

To maintain quality and meet the needs of participants, particularly in thin markets, workforce development must also be addressed. The 2019 NDIS Pricing Strategy remains relevant to allied health professionals as well as disability support workers:

> 'The expansion of disability support supply within the NDIS and progression towards deregulation of markets requires that barriers to entering or growing the markets for disability goods and services are addressed which, in turn, requires the enabling of facilitating factors, such as:
>
> > appropriate employment, education and immigration pathways to ensure adequate levels of positions and training for disability support workers, and recruitment and retention of appropriate staff in the sector; and
> >
> > appropriate support infrastructure for the sector, such as digital platforms for their industry interfaces and networks.'[5]

Currently unmet allied health provider costs include funded support for professional development of practitioners, improving capacity to provide student placements, and including students in consultations.

Given the significant and likely growing proportion of sole practitioners, there is also a funding gap for upskilling of health professionals in areas of shortage via mentoring and supervision.

Boosting the capacity of the provider workforce must either be factored into the price limit or funded directly through the NDIA.

Recommendation 11: Work with allied health peak bodies to understand and address the issues impacting workforce recruitment, supervision and retention.

Question 16

What considerations should be taken into account when comparing NDIS arrangements for therapy supports to Australian Government and state government schemes and the private market?

Our members' submissions explain why it is not appropriate or useful to compare NDIS therapy support arrangements to those in other schemes or the private market.[6] Those submissions also point to the fact that therapy providers are exiting some schemes with lower prices, suggesting that provider shortages in the NDIS are likely to be exacerbated if those schemes are taken as a model.

[5] NDIS Pricing Strategy (August 2019), p23.
[6] See also Consultation Paper, p36.

Only two years ago, the NDIS Pricing Strategy stated:

> 'Critically, higher prices are needed to both maintain current supply volumes and enable greater volumes of disability support, as this provides an incentive to redirect the allocation of resources to the NDIS from other sectors in the economy. Without price growth, supply side shortages will likely exist. . .there has been some evidence of potential under-supply in the markets for disability goods and services (low plan budget utilisation, even for participants who have been in the NDIS for some time). . . The implication of this analysis is that to avoid shortages in the short and longer term, NDIS prices might need to rise significantly in the short term.'[7]

We also note that the AFSR refers to the 'relative immaturity' of the Scheme,[8] and to 'considerable uncertainty' in relation to projections, including lack of clarity about when the numbers of new entrants to the Scheme will stabilise and at what level.[9] This will affect demand and hence the market.

Question 17

Are there any other issues with the pricing arrangements for therapy supports? For example, would a "per consultation" billing approach be more appropriate for therapy supports? Are the travel and non-face-for billing arrangements appropriate for therapy supports? Please provide evidence.

Our members have provided considerable evidence to the Review concerning a range of items which are either underfunded or not funded at all, including: few or no pathways to claim for non client-facing items; inappropriate limitations on travel funding; insufficient pricing for delivery of group programs, including where participants cancel; lack of reimbursement for consumables; and lack of payment due to plan gaps.

Recommendation 12: Increase allied health price limits to consider after hours loading.

Recommendation 13: Allow providers to bill the agency directly (so that participants do not have to cover the cost of these out of their plan budgets) or expand the list of non-participant-facing supports to include travel, time spent writing reports and participating in case conferencing and trust building.

Recommendation 14: Remove the current pricing cap on the provision of group supports, allowing these to be provided at a cost determined by the provider to enable them to be financially viable.

Recommendation 15: Provide capacity to secure pre-payment from group participants.

Recommendation 16: Increase access to interpreters to include all NDIS participants, regardless of how they are managed, or whether the provider is registered.

Questions 20 & 21

Are the costs of delivering supports in outer regional, remote and very remote areas higher than in metropolitan areas? If yes, why and by how much? Please provide evidence.

[7] NDIS Pricing Strategy (August 2019), p29.
[8] AFSR, p77.
[9] AFSR, p81.

Are any amendments required to the NDIS pricing arrangements to better recognise the costs of delivering services in regional, remote and very remote areas? If yes, please provide details and evidence.

Provision of therapy supports in regional and remote areas must be fully costed.

The presence of intractable thin markets both inside and outside remote areas means that the Consultation Paper's stated long-term goal of removing market regulatory mechanisms (eg p16) can never be achieved consistently across all of Australia – some areas will need alternative commissioning in the long term.

Recommendation 17: Remove travel caps for services provided in MMM4 & MMM5 areas, and allow the actual cost of travel to be charged.

Recommendation 18: Provide travel budgets for rural and remote participants that are separate to their therapy budget allocation.