Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the Future of the NDIS

Allied Health Professions Australia

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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 130,000 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 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.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, and 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.

AHPA and its member associations are committed to ensuring that all Australians, regardless of disability, can access safe, evidence-based services to assist them to realise their potential for physical, social, emotional and intellectual development.

Introduction

AHPA and our members engage extensively with the National Disability Insurance Agency ('NDIA') and the NDIS Quality and Safeguards Commission on matters of policy and practice, and we welcome the opportunity to comment on current Scheme implementation and forecasting.

For the purposes of this submission and given time constraints, we focus first on the relevance to allied health of NDIS funding and expenditure issues. These are often described in NDIA, Ministerial and media communications as a 'crisis in financial sustainability', and also associated with a claimed need to manage what is depicted as a 'cost blowout' in spending on the Scheme.

It is AHPA's firm view that allied health professionals, as health workers aligned with a more holistic understanding of care and support, have a duty of care to support NDIS participants in advocating that they should receive the full range of evidence-based, clinically assessed allied health services that they require. Taking 'financial unsustainability' and 'cost blowouts' at face value imperils this vision of the Scheme.

Allied health providers have two main roles in the NDIS: contributing expertise to assessments for access to the Scheme and any subsequent reviews of participants' plans; and providing therapy supports under allocated plan funding. Discourse about 'financial sustainability' shapes both roles.

In the second and third parts of this submission we therefore draw attention to related ongoing issues for allied health providers with respect to current NDIS assessment and planning processes. The submission concludes with a brief comment on codesign.

AHPA also refers the Committee to our interim submission to this Inquiry (November 2021) and to other submissions and evidence that we have provided on a range of NDIS topics, many of which remain unaddressed by the relevant entities.[1]

NDIS funding and expenditure

The Annual Financial Sustainability Report 2021-22 ('AFSR') is key to the financial modelling and forecasting for the Scheme, and underpins current assertions about the lack of sustainability of the NDIS. Overall, our concern is that a very narrow economic view has been taken in the AFSR, and indeed, has been applied to the Scheme itself. This view relies on a flawed neoliberal market model together with uncosted – and therefore unpaid – inputs from outside the Scheme.

It also poorly defines the full range of benefits of the Scheme, and evinces scant commitment to addressing serious problems of underutilisation of therapy supports. However, the necessary public data and analysis necessary to try to counter the AFSR's conclusions are not available.

The narrow economic approach is at odds with the human rights and 'choice and control' commitments required under the current *NDIS Act 2013* ('the Act'), legislation, and which are further foreshadowed in future proposed reforms aimed at providing participants with holistic supports so that they can live their best lives.[2]

Market ideology

The modelling and forecasting of the Scheme set out in the AFSR rely on a flawed market philosophy.

For example, consultation in the presently ongoing NDIA 2021-22 Annual Pricing Review is underpinned by the 'unsustainable' assertion, and so it is claimed that there has been a 'failure' in setting price limits for therapy (largely allied health) supports at the 75th percentile.[3] In AHPA's view, however, any failure lies more in the AFSR's application of a pure market model to the provision of allied health supports in the Scheme – when therapy supports are needed in a market which is actually neither consistently competitive nor mature.

One illustration of our argument that an unmodified market model will never be consistently applicable across Australia is the existence of thin markets both inside and outside remote areas. Here demand exceeds supply, or some participants simply cannot access particular types of allied health services at all. Simply reducing pricing caps for therapy supports to push the relevant percentile upwards and 'save money' will then cut across the objectives of the Scheme.

We also note that the AFSR refers to the 'relative immaturity' of the Scheme,[4] 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.[5] This will affect demand and hence the market.

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[1] See eg AHPA's submissions to the Joint Standing Committee on the National Disability Insurance Scheme include to Inquiries into NDIS Planning (September 2019); the NDIS Workforce (May 2020 and August 2021); the operation of the NDIS Quality and Safeguards Commission (August 2020); and Independent Assessments (March and May 2021).
[2] See eg National Disability Insurance Scheme Act 2013 (Cth), s 3(1).
[3] NDIA, 2020-21 Annual Pricing Review Consultation Paper. AHPA's recommendations to this Review are appended to this submission.
[4] AFSR, 77.
[5] AFSR, 81.

More broadly, the 'unsustainable' argument and the AFSR itself are not transparent about their underpinning ideology, which pastes neoliberal economics onto the original foundation of a social constructionist understanding of disability, resulting in inconsistent claims and practices.

Hence the 'unsustainability' of the NDIS is attributed to taxpayer reluctance to fully fund any larger Scheme, with no definitive evidence for this. Messaging concerning 'spending too much' indicates a reluctance to move from a narrowly costed concept of episodic care and 'letting the market decide' to a model which properly supports participants by genuinely addressing complexity, cultural considerations and the need for wrap around supports.

However at the same time, 'choice and control' for participants is reiterated. To not take a more encompassing view of the Scheme's benefits and the costs of not having such an approach, risks the NDIS becoming the State/Territory 'welfare' model it is frequently claimed it was meant to avoid and improve upon.

Similarly, the NDIS – from its establishment – draws on insurance schemes and yet is importantly distinct from them. While one of the foundation documents of the NDIS, the Insurance Principles and Financial Sustainability Manual ('IPFSM'),[6] shows an appreciation of the important differences between the NDIS and a profit-making insurance scheme, this is not reflected in the AFSR approach.

The IPFSM states:

> '. . . it is suggested that the management of financial sustainability is likely to involve the support and management of perceptions and attitudes. That is, in seeking to manage financial sustainability, the Agency should be seeking to influence the perceptions of both participants and contributors (including broader community attitudes), through evidence of independence, outcomes and social participation, and both the immediate and longer term financial outlook of the scheme.[7]

And yet, while at least some of the costs of supports are enumerated, measurement of 'independence, outcomes and social participation' is the thinnest part of the AFSR.

Uncounted costs

Allied health practitioners' ethics and standards of care for their clients frequently leads to subsidising the supposedly 'pure' economic model, with health professionals providing unpaid or underpaid labour rather than compromising services or drawing more on funding from an insufficient plan to provide aspects of services that are not fully costed and paid for by the Scheme.

The range of items which are either underfunded or not funded at all include:

- 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;

[6] *Insurance Principles and Financial Sustainability Manual*, Version 5 (November 2016).
[7] *Insurance Principles and Financial Sustainability Manual*, Version 5 (November 2016), 18.

- pricing not taking into account time spent in additional consultations in complex cases or to ensure participant cultural safety; and
- lack of payment due to plan gaps.

Allied health providers also incur workforce-related costs that are neither directly nor indirectly reimbursable by the Scheme, because although they are not funded directly through the NDIA they are also not currently factored into the calculation of price limits.[8] Currently unmet costs of this type include 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 – currently 35% of active registered providers for therapy supports[9] – there is also a funding gap for upskilling of health professionals in areas of shortage via mentoring and supervision.

Other expenses include registration and administration in order to provide services under the Scheme, despite the fact that allied health professionals are already required to be registered either with the Australian Health Practitioner Regulation Agency or under an equivalent discipline-specific registration scheme. The costs and complexity of registration and audits are particularly onerous for sole practitioners and small practices.

Limited calculation of benefits

Weaknesses in the market approach are compounded by a lack of full transparency concerning the data and analysis underpinning the modelling and forecasting, meaning that there is limited opportunity to take issue with foundational assumptions, such as the cost-benefit ratio of the Scheme.[10]

As noted above, the evaluative research on participant outcomes is the weakest part of contributions to the AFSR, and therefore cannot be properly factored in to assessment of Scheme benefits.

Similarly, the AFSR fails to enumerate the social and economic costs of *not* funding supports, and to include these as a balance when assessing the costs of the NDIS and any 'blowout'.

As the IPFSM states:

> '. . . a one-dimensional financial focus appears unlikely to provide the only metric to indicate financial sustainability for the NDIS.'[11]

Underutilisation

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.

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[8] For example, supervision and professional development costs – see AHPA's submissions to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the NDIS Workforce (May 2020 and August 2021).
[9] NDIS Quarterly Report to Disability Ministers (30 September 2021), Table E.82. Further examples of costs being only partially funded are documented in the Joint Standing Committee's NDIS Planning Final Report (December 2020), Chapter 9.
[10] Cf *False Economy: The economic benefits of the National Disability Insurance Scheme and the consequences of government cost-cutting*, Per Capita (November 2021).
[11] *Insurance Principles and Financial Sustainability Manual*, Version 5 (November 2016), 15.

Currently this is not the case. The latest NDIS Quarterly Report to Disability Ministers notes significant underutilisation of committed supports, with a total utilisation rate of 71%.[12] As our member Speech Pathology Australia has calculated, the rate of therapy support utilisation across states and territories is significantly lower at 52%.

It would appear to add participant insult to injury that the costings in the AFSR assume full utilisation while being used as the basis for cost cutting arguments. To be consistent with the object of choice and control in the Act, underutilisation must be addressed as a matter of urgency. As outlined below, the planning process must also be improved, suggesting that even the 52% utilisation rate for therapy supports is likely to be an overestimate.

There is also an ongoing risk that planners under pressure to reduce expenditure will take a participant's underutilisation of supports at face value and use it as a justification to cut supports in subsequent plans.[13]

The dangers of reducing allied health 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 projected increased numbers of participants, increased average plan funding and the 'financially unsustainable' refrain, it may therefore be tempting for policymakers to consider: lowering therapy support price caps; deregulating markets on the assumption that the level eventually settled upon might be lower than current prices; or simply reducing the number and quality of allied health services in a participant's plan (outlined further below).

We strongly emphasise that any of these strategies would be counter-productive to the Scheme and contrary to the Act. The legislation also cannot permit simply denying reasonable and necessary supports to participants, but if it became even less attractive for allied health practitioners to provide NDIS services, this would be the result.[14]

AHPA also respectfully appreciates the Committee's acknowledgment of the life-changing and world-first value of the NDIS, and expression of the Committee's preliminary views on the financial sustainability claim, in its Report of the Inquiry into Independent Assessments.[15] We welcome the associated recommendation – so far with no response from Government – that the Commonwealth Government implement the National Disability Insurance Scheme Reserve Fund as soon as practicably possible.[16]

[12] NDIS Quarterly Report to Disability Ministers (30 September 2021), Table N.52.
[13] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), 46-47, 263-6.
[14] Therapy providers are exiting other schemes with lower prices (eg Veterans Affairs), suggesting that provider shortages in the NDIS are likely to be exacerbated if those schemes are taken as an indicator.
[15] Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021), 139-141.
[16] Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021), Recommendation 1.

NDIS assessment processes and allied health

AHPA does not propose to go over already well-covered ground concerning the now discredited and abandoned independent assessment model. We have previously provided evidence to the Committee concerning Government and NDIA lack of appropriate consultation of allied health professionals in the development of that model,[17] and we welcome the findings of the Committee's Report of its Inquiry into Independent Assessments.[18] Nevertheless, it is clear that the independent assessment model was based at least in part on the 'financial unsustainability' claim,[19] as are some of the problematic decisions by planners discussed below.

Reforms to the present assessment process are certainly needed in order to improve fairness and consistency in decision making and ensure that expert evidence and assessment carry appropriate weight. Accordingly, AHPA particularly supports the Committee's Recommendations 3 and 5 that consultations with medical and allied health professionals for the purposes of access to the Scheme and to support requests for items in NDIS plans be, where appropriate and available, holistic, multidisciplinary, carried out by health professionals nominated by the participants, and (subject to Government consideration) bulk billed.

We also welcome Recommendations 4 and 5 that where it is not possible for those consultations to be carried out by health professionals nominated by the participants, there should be an accreditation process for appropriate bulk billed alternative professionals, and that the NDIA should implement specific strategies to ensure that particular cohorts are not disadvantaged by such a process.

Given the experience of allied health practitioners in the previous independent assessment debacle, it is particularly important that all relevant assessment tools are subject to rigorous consultation with all key stakeholders at the earliest stage of their proposed development (Recommendation 6).

Having previously considered the development of the credentialing, training and quality assurance aspects of an independent assessor role for allied health practitioners, including in NDIA-contracted work, AHPA and its members seek to centrally participate in the reform process once Government has responded to the Committee's Report.

NDIS planning processes and allied health

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.[20]

Individual allied health providers and allied health peak associations have consistently sought to engage with the planning process in a constructive and collaborative manner. However, these efforts have been hampered by a lack of transparency about the planning process and the training

[17] AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into the NDIS Workforce – National Workforce Plan (August 2021).
[18] Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021), especially Chapters 8 and 9.
[19] Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021), 59-66.
[20] And see the acknowledgment in Recommendation 17 from 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).'

and guidance provided to planners, together with a general unwillingness to formally engage with our sector concerning planning issues.

Both NDIA planning and support coordination roles require not only a sophisticated understanding of the needs of the person with disability, but also a strong understanding of the broader disability sector. This must include an appreciation of the roles and potential contributions of a broad range of supports, the impact of different types of intervention, and the value of assistive technology.[21]

However, allied health providers regularly experience a failure of such understanding. This is particularly evident in relation to planning and coordinating supports for participants with complex needs. AHPA's Disability Working Group is aware of repeated examples where planners and coordinators have failed to approve specific types of evidence-based allied health services or have underfunded allied health supports, because they are seemingly not aware of their value and do not appreciate important distinctions among different kinds of allied health services.

We are also familiar with examples where planners have substituted a lower-priced service for a higher priced one, on the mistaken assumption that they are equivalent in quality and value. For example, a decision may be made to fund personal training services rather than exercise physiology. Personal training is not an allied health profession and its personnel do not have the training, credentials and competencies required of any NDIS exercise therapist. A similar process may occur with regard to selection of assistive technology.

Another example of false economising and associated risks concerns 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 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.

The Committee's Final Report on its Inquiry into NDIS Planning (December 2020) consistently documents these kinds of examples.[22]

AHPA is particularly concerned that if the NDIA and Government response to the claimed cost 'blowout' of the Scheme is to try to cut the average cost of supports, these examples will proliferate and thereby risk further compromising the ethos of the NDIS.

As the Final Report on NDIS Planning notes, participants, advocacy groups and the sector have been calling for reform in the planning arena for years.[23] Evidence also suggested that planners may be ignoring or changing expert recommendations provided by allied health practitioners about the supports that are appropriate for a particular participant.[24]

Of particular relevance to the issues raised in this submission are the Committee's Recommendations 10, 12-13, 16, 18-21, 30-31, 33 and 42.

Recommendation 10

5.107 The committee recommends that the Australian Government ensure that the resourcing for the National Disability Insurance Agency and its Partners in the Community is

[21] For more detail, see AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into NDIS Planning (September 2019).
[22] See especially Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), Chapters 3 and 6–9.
[23] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), xi.
[24] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), xii.

sufficient to enable planners to collaborate effectively with different service systems throughout the planning process.

This was supported by the Government with some commitment in the 2020-21 Budget, and the statement that 'the Government has and will continue to monitor and adjust resources to meet the needs of the NDIS and the people it supports',[25] including ensuring 'positive experiences for every person with disability.'[26]

Recommendation 12

5.111 The committee recommends that the Australian Government amend the National Disability Insurance Scheme Act 2013 to clarify that where the CEO of the National Disability Insurance Agency (or their delegate) considers that a support would be more appropriately funded or provided through another system of service delivery or support services, the CEO must be satisfied that this support is in fact available to the participant and that they are likely to be eligible and able to access it.

This recommendation was simply noted by Government, with the statement that 'the NDIS is not the default provider when other systems do not meet their responsibilities to provide supports for people.'[27] In AHPA's view this silo approach is inconsistent with a genuine commitment to meeting the needs of people with disability with funding from a national tax pool.

Recommendation 13

5.113 The committee recommends that where the CEO of the National Disability Insurance Agency (or their delegate) is satisfied that a support is more appropriately funded or provided by another system of service delivery or support services, the National Disability Insurance Agency be required to provide written reasons for this view (and also in an alternative format where appropriate).

This recommendation was also simply noted, with the Government Response referring to the then new Participant Service Charter and Participant Service Improvement Plan, including commitments to giving participants clear reasons for decision-making.[28] An evaluation of whether the Charter, Plan, related recent legislative reform and participant experience actually satisfy the Committee's recommendation should be undertaken.

Recommendation 16

6.100 The committee recommends that the National Disability Insurance Agency publish clear and detailed information about its Technical Advisory Branch and expert teams on the National Disability Insurance Scheme website.

This recommendation was, again, simply noted, and the Government Response should be read in the following context.

[25] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 8.
[26] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 7.
[27] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 8.
[28] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 9.

The Committee's Final Report referred to a report by the Australian National Audit Office ('ANAO') on decision-making controls for NDIS participant plans (October 2020) which noted that an internal audit of the NDIA in February 2020 had identified 'weaknesses in system controls that support' Technical Advisory Branch processes, with a large proportion of plans which met the mandatory criteria to be referred to the Technical Advisory Branch not being referred.[29]

The NDIA supported the ANAO's recommendation that the NDIA review and update its information and communication technology (ICT) controls for recording decisions on participant plans 'to align the system processes with internal policy requirements and to better support planning processes for reasonable and necessary decision-making'.[30] The NDIA's response referred to a program in design phase that would address the ANAO's recommendation.[31]

AHPA is not aware of the current status of this program. The Government Response to the Final Report's recommendations simply refers to the fact that the NDIA Technical Advisory Branch:

> 'may consult with NDIA planners, Partners in the Community and delegates, when they are unsure about particular support types or what supports might be appropriate for a participant. These advisors may also assist a delegate to consult with allied health providers to better understand a participant's support needs and to gain information as required to ensure informed decisions can be made.'[32]

The Response also qualifies the Technical Advisory Branch as:

> 'internal enabling teams only. . .Staff in these teams are not decision making delegates and do not have any participant facing functions and their details are therefore not published on the website.'[33]

Recommendation 18

6.111 The committee recommends that the Australian Government amend the National Disability Insurance Scheme (Supports for Participants) Rules 2013 to require the CEO of the National Disability Insurance Agency (or their delegate) to take into account any expert advice developed specifically for a participant when deciding whether a support would, or would likely, be effective and beneficial for that participant.

This recommendation was, again, simply noted, with the matter deferred to the planned role of the then mooted and now jettisoned independent assessments model (see above).[34]

Recommendation 19

6.114 The committee recommends that where a participant's plan does not reflect expert advice developed specifically for that participant, the National Disability Insurance Agency be required to provide written reasons for this decision at least one week before any joint planning meeting (and also in an alternative format where appropriate).

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[29] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), 134.
[30] Ibid.
[31] Ibid.
[32] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 10.
[33] Ibid.
[34] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 11.

Recommendation 19 was also simply noted, with the Government Response referring to the reasonable and necessary provisions under the Act, and their role in the proposed independent assessment scheme. [35]

Recommendation 20

7.72 The committee recommends that the National Disability Insurance Agency publish information about the training it provides to planners, Local Area Coordinators and Early Childhood Early Intervention partners on the National Disability Insurance Scheme website in an easily accessible location.

The Government Response supported this recommendation but stated that the information was already available in the NDIA's Corporate Plan and Annual Reports published on the NDIA website.[36] In AHPA's view this information is insufficient.

Recommendation 21

7.74 The committee recommends that when conducting recruitment processes for planners, the National Disability Insurance Agency give greater preference to candidates with experience or qualifications in allied health or disability-related areas.

The Committee's Interim Report on NDIS Planning (December 2019) recommended that the NDIA ensure that additional training and skills development is provided to all persons involved in the planning process to ensure that all such persons are familiar with a number of relevant areas, including allied health expertise (Recommendation 9). The Government supported this recommendation,[37] but the Committee's Final Report demonstrates that little appears to have changed.[38]

The Government response to Recommendation 21 above was to support it in principle, but simply emphasised the need to identify and forecast 'skills mix changes' to 'ensure the NDIA has the right capability and resource capacity to deliver the NDIS.'[39]

Accordingly:

> 'The NDIA also considers formal qualifications in allied health or disability and lived experience of disability to be highly desirable in planner recruits. Some planners, such as those within the Early Childhood Early Intervention (ECEI) stream, are required to have allied health qualifications, such as Psychology and Occupational Therapy."[40]

A detailed analysis of the qualifications, training and professional development of NDIA planners with regard to knowledge of allied health is required. To avoid paying more for better qualified and trained planners would be another example of false economy when we consider the time, resources and participant trauma currently spent in avoidable planning reviews concerning allied health supports.

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[35] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 11-12.
[36] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 12.
[37] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), 11-12.
[38] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), Chapter 6.
[39] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 12.
[40] Ibid.

Recommendation 30

8.146 The committee recommends that the National Disability Insurance Agency develop and implement a mechanism to encourage planners to develop specialisation in particular types of disability or particular groups of participants.

Again, this recommendation is only noted, with the NDIA being said to support 'planners and others involved in the planning process being well versed in a broad range of disability types rather than specialising in particular types of disability or particular groups of participants.'[41] The Government Response also referred to the support available from the Technical Advisory Branch,[42] previously discussed in relation to Recommendation 16.

Recommendation 31

9.46 The committee recommends that the National Disability Insurance Agency review its Rural and Remote Strategy 2016–19 and, as part of this process, examine practical solutions to the issues outlined in this report regarding planning for participants in rural and remote areas.

This was supported in principle, with reference made to the release of a position paper in 2021 articulating the NDIA's approach to service delivery in remote Australia, and the NDIS Community Connectors Program.[43] Given the ongoing thin state of rural and remote markets, AHPA submits that this recommendation should be revisited.

Recommendation 33

10.83 The committee recommends that the Australian Government review the amount of funding that it provides to advocacy organisations through the NDIS Appeals program and ensure that these organisations are sufficiently funded to support participants throughout the Administrative Appeals Tribunal process.

The Government Response simply notes this recommendation and refers to the existing NDIS Appeals program.[44] It is AHPA members' experience that participants trying to contest decisions about allied health supports are struggling to find affordable legal representation, and so this issue must be addressed as a matter of urgency.

Recommendation 42

12.108 The committee recommends that the National Disability Insurance Agency co-design new metrics for measuring participant satisfaction with people with disability and advocacy organisations.

While the Government supports the recommendation, its response refers to development of a new, independent and more comprehensive participant satisfaction survey following Recommendation 24 of the Tune Review, with the results to be included in quarterly reports to disability ministers.[45]

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[41] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 16.
[42] Ibid.
[43] Ibid.
[44] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 17.
[45] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 20-21.

We submit that the NDIA should clearly elaborate on the progress of this work, and how it will affect reporting of outcomes and benefits in the next Financial Sustainability Report.

Where is co-design?

As outlined in our interim submission to this Inquiry, and as found by the Committee in its Report on Independent Assessments,[46] there are significant flaws in the NDIA's current consultation and engagement process.

At times, allied health professions continue to experience a complete failure to consult with us about significant policy and administrative changes, as with the development of the independent assessment model.

It is essential that allied health providers be meaningfully engaged at all stages of relevant policy and practice development, implementation and evaluation, in a manner which acknowledges our various roles in the Scheme and our specialist knowledge. Issues that centrally involve participants, allied health providers and NDIA staff, such as design of best practice assessment and planning models, should include forums where different stakeholders can discuss, together, their various roles and expectations from the processes.

To date there has been no regular mechanism to facilitate such engagement, and there is still no specificity about what 'co-design' means and entails.

[46] Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021), especially Chapters 8 and 9, and Recommendations 2 and 6.