Allied Health Professions Australia

Submission to ANAO Audit – Effectiveness of the National Disability Insurance Agency's management of assistance with daily life supports

October 2022

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

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Introduction

About Allied Health Professions Australia

Allied Health Professions Australia (AHPA) is the recognised national peak association for Australia's allied health professions. AHPA's membership consists of 26 national allied health associations and a further 12 affiliate members, each representing a particular allied health profession. AHPA collectively represents some 200,000 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.

Allied health professionals are a critical part of the National Disability Insurance Scheme ('NDIS'), providing a wide range of supports and services ('therapy supports') 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's Disability Working Group comprises policy and clinician representatives drawn from the range of AHPA's members that provide services in the NDIS. The Working Group is therefore informed by the views and experiences of both individual allied health professions and the allied health sector as a whole.

Overview

The allied health sector welcomed many of the changes resulting from the rollout of the NDIS across Australia, and supports a strong, effective NDIS. However, the Scheme's introduction was accompanied by a range of issues that continue to negatively affect the experiences of participants and providers.

Some of the most serious problems are the result of a shift from state-based services to a largely fee-for-service, market-based, highly bureaucratic system, together with reliance on shared responsibility across multiple governments, departments and agencies for policy, workforce development, regulation and pricing. Overlapping and at times uncertain responsibility for different aspects of the Scheme also makes it much more difficult to address these issues that hamper the effectiveness of the NDIS.

Many of AHPA's concerns apply to both Audit Questions #1 and #2, so we address them under the Question to which they most relate. AHPA also endorses the submission to this Audit from our member organisations, Speech Pathology Australia (SPA) and Occupational Therapy Australia. Our submission concludes with recommendations relevant to the Audit.

1. Does the NDIA effectively support National Disability Insurance Scheme participants who require assistance with daily life?

The short answer to this question is 'no'. Planning processes and support coordination are the greatest influences on inadequate outcomes for participants. As we submit in response to Question 2, some of this inequity is due to the reliance of the NDIS on a market model, and the problem is compounded by a continuing failure of the NDIA to address allied health NDIS workforce issues.

Planning and support coordination

Planners and support coordinators do not consistently recognise the unique value to participants provided by allied health professions, the evidence base for this value, the breadth of specialised allied health supports available, and what distinguishes each allied health profession from others.

This system failure contributes to inequities in plan funding and in support provision for participants with similar needs. This in turn means that participants' goals are less likely to be met.

Poor understanding of allied health

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 various roles and potential contributions of a broad range of supports, the impact of different types of intervention, and the value and functions of assistive technology.[1]

However, allied health providers regularly experience a failure of such understanding. This is particularly evident with regard to planning and coordinating supports for participants with complex needs. Members of AHPA's Disability Working Group receive regular accounts from their membership of planners and coordinators failing to approve or underfunding allied health supports, because they are seemingly not aware of their value and associated expertise.

Planners and support coordinators also too often regard distinct allied health professions as unproblematically interchangeable. For example, the distinctions between physiotherapists, occupational therapists, osteopaths and exercise physiologists are often elided, when some participants are professionally assessed as in need of more than one of these services.

We are also familiar with examples where planners have substituted a lower-priced good or service for a higher priced one, on the mistaken assumption that they are equivalent in quality and value. This may occur with assistive technology, or when, for instance, a decision is 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 or musculoskeletal allied health professional.

A similar process may occur with substitution of support workers in a misguided attempt to 'make a participant's plan go further'. Again, using support workers with no formal training and appropriate accreditation compromises quality and outcomes, and can be dangerous as well as in breach of codes of conduct.

AHPA strongly endorses SPA's submission to this Audit on allied health assistants (AHAs). Many allied health professionals work effectively with AHAs, but the structures to support this are not well developed. The value of AHAs can only be safely utilised under a nationally consistent supervision and delegation framework. This was a feature of early work on the NDIS National Workforce Plan but is absent from the Plan itself.[2]

[1] For more detail, see AHPA, Submission to the Joint Standing Committee on the NDIS Inquiry into NDIS Planning (September 2019).
[2] Compare State of Victoria, Department of Health, Supervision and Delegation Framework for Allied Health Assistants (2012).

The Final Report of the Senate Joint Standing Committee's Inquiry into NDIS Planning consistently documents the kinds of examples we refer to above.[3] They represent false economising, because allied health assistance with daily living is based on a person-centred, holistic approach to maximising function. Without these supports, participants' needs are likely to become more complex and costly in the future and their quality of life compromised.

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 compliance with the *NDIS Act 2013* ('the Act').

The medical/disability interface

A recent illustration of the impact of cost-cutting relates to the provision of psychological therapy supports. Changes in the wording of the NDIS Pricing Arrangements and Price Limits 2022-23 ('Pricing Arrangements') make it explicit that even if some aspects of a participant's care are 'related to, or a symptom of' their disability they will not be funded under NDIS if there is another health care scheme or insurance policy that would cover them.[4] In practice this may entail psychologists having to attempt to distinguish between the health services and disability supports that they provide to a single client, and then making separate payment claims to, for example, Medicare and the NDIS.

Our members, including particularly the Australian Association of Psychologists Inc, the Australian Psychological Society, the Australian, New Zealand and Asian Creative Arts Therapies Association and the Australian Music Therapy Association, are strongly opposed to this new approach, which compartmentalises a person's needs and care, rather than supporting care of the whole person. The disability sector has far greater capability and knowledge in applying the social model of disability to participants' care, whereas the health sector has less equivalent skills and experience in working under this model.

We are also concerned that this change will mean that participants will not be able to access the supports they need and that they know from their experience is effective – hence compromising NDIS principles of choice and control. A further negative ramification of this fragmentation of the provision of psychological therapy supports is the increased administration that will be required from therapists.

Failure of the planning process

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 and guidance provided to planners, together with a general unwillingness to formally engage with our sector concerning planning issues (see also 'Engaging with the NDIA' in our response to Question 2 below).

AHPA strongly endorses SPA's submission concerning participants' lack of control over their plans and the planning process. This situation drains resources and energy and creates stress for participants and allied health providers alike.

[3] See especially Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), Chapters 3 and 6–9.
[4] NDIS Pricing Arrangements and Price Limits 2022-23, p 32.

We also strongly endorse SPA's comments about delays to plan reviews. AHPA has had direct contact with a participant who had no option but to go through the review process to the Administrative Appeals Tribunal, and we are therefore acutely aware of the toll this takes on both participants and those allied health professionals who try to provide (unpaid) support to them throughout this process.

2. Does the NDIA effectively manage operational risks to the proper use of resources in administering assistance with daily life supports?

Again, the short answer to this question is 'no'. AHPA strongly endorses SPA's response to this Question.

Below we outline additional issues that we believe go directly to assessing the degree and nature of operational risks and NDIA's management of them. Workforce and pricing are both in scope for this Audit because they affect the availability of therapy supports to participants. Participant underutilisation of therapy supports is significantly greater than the participant underutilisation rate for the Scheme as a whole, yet has received little attention from the NDIA. Allied health providers' access to relevant NDIS data is also poor, despite that data being critical to addressing workforce and underutilisation problems.

In order to overcome these barriers to successful operational risk management, it is crucial that allied health peak bodies are able to easily and productively engage in collaboration with the NDIA and other relevant entities. Our response explains that although there appears to have been some recent improvement, this is generally not happening at present.

Workforce issues

Although allied health professionals contribute over 7% of workers and are key to the self-determination and reablement of most people living with a disability, the allied health workforce remains on the margins in NDIS workforce planning.[5]

This is despite an acknowledgment in the NDIS National Workforce Plan that a 40% increase in allied health professionals will be required to fulfil projected NDIS participant need.[6] This percentage could well be considerably higher given that such projections rely on incomplete data sources for allied health,[7] combined with the fact that they are also based, at least in part, on NDIA data on existing service use rather than estimation of actual participant needs (see 'Participant underutilisation of therapy supports' and 'Data implications' below).

As we submit under 'Pricing and implications for the allied health workforce' below, the current scarcity of some types of therapy supports seems likely to intensify unless the full value of allied health services in the NDIS, and the present unpaid demands on many practitioners, are reflected in workforce planning, regulation and pricing.

Pricing and implications for the allied health workforce

While we acknowledge that NDIA pricing decisions are outside the Audit's direct remit, NDIA failure not only to raise the price caps for therapy supports, but to not even, for the third consecutive year, apply indexation, shows a lack of understanding of the unique challenges faced by allied

[5] For more detail see AHPA's Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the NDIS Workforce – National Workforce Plan (August 2021).
[6] NDIS National Workforce Plan 2021-2025, 11.
[7] Joint Standing Committee on the National Disability Insurance Scheme Workforce Interim Report (December 2020), 22 (fn 15), 25 (fn 32), 142.

health practitioners in the NDIS. These challenges are acute because many allied health practices providing NDIS services are not large, with 35% of active registered providers for therapy supports being sole traders.[8]

As a consequence, since the last Pricing Review, many allied health providers have reported needing to close their businesses and/or moving away from NDIS service provision into the private sector, thereby creating even more of a thin market in the disability sector.[9]

The current approach to allied health pricing and its consequent workforce impacts is inconsistent with the generally agreed upon role of allied health in disability support. There is widespread acceptance that NDIS participants get great value from allied health services, which not only enable everyday living but enhance the overall quality of their lives. The NDIA has also acknowledged that therapy supports have the potential to reduce long term costs in the NDIS.[10]

Further, the impacts of the NDIA's current approach to pricing therapy supports run counter to the Scheme's principles of choice and control, and management of risk, for participants concerning the purchase of services they need. This needs to be considered in the current context where participant utilisation of allied health supports is already significantly lower than the average utilisation rate for supports as a whole (see 'Participant underutilisation of therapy supports' below), and where 'thin markets' for allied health services are an ongoing vexed issue.

The present pricing logic also fails to appreciate both the raison d'être of the NDIS and the unique nature of the specialist supports it provides, which are intended to be more holistic and informed by a social rather than the medical model of disability prevalent outside the NDIS.

AHPA therefore submits that pricing, combined with direct NDIS funding, must build in: considerations of the highly specialised skill sets of those allied health professionals working in the Scheme; the fact that currently many allied health providers are in effect subsidising the NDIS through unpaid work; and the high compliance and administrative burden of the NDIS for allied health providers, particularly when compared to the private sector and other government schemes.

Unpaid work

At present there are various costs to allied health providers that are neither funded directly through the NDIA nor currently factored into the calculation of price limits reflected in NDIS pricing. Issues 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;
- pricing not taking into account time spent in additional consultations in complex cases or to ensure participant cultural safety; and

[8] NDIS Quarterly Report to Disability Ministers (30 September 2021), Table E.82. The proportion of sole traders also appears to be increasing. About half of all therapy providers had revenue from the NDIS in the first half of 2021-22 of less than $2000, accounting for less than 1.3% of all expenditure on therapy by the NDIS (NDIS Annual Pricing Review 2021-22 Final Report, p 112).
[9] National Disability Services, NDS Workforce Census Key Findings Report December 2021; https://www.nds.org.au/index.php/news/new-report-shows-critical-need-for-allied-health-workers-as-wait-lists-grow-across-the-country .
[10] NDIS Annual Pricing Review 2021-22 Final Report, p112.

- lack of payment due to plan gaps. [11]

Allied health professionals' ethics and standards of care for their clients mean that in many instances they provide unpaid or underpaid labour rather than compromising services or drawing more on funding from an insufficient plan.

Other unmet costs include support for professional development of practitioners, involving students in consultations as part of their training, and improving capacity to provide student placements.

Training of allied health professionals and students, including exposure to disability settings and clients, is crucial. Clinical placements and work experience in disability directly influences allied health recruitment into disability positions.

However, NDIS placements are increasingly limited,[12] and while the public health sector provides training placements in collaboration with the universities, since the rollout of the NDIS it no longer manages disability clients in any substantial way. It will therefore require NDIA funding for NDIS providers to be able to take allied health students on placement.

Given the significant and likely growing proportion of sole practitioners, there is also a funding gap for upskilling of health professionals via mentoring and supervision, in areas of particular shortage such as rural and remote locations or in particular disciplines.

Regulatory costs

There are significant cost and time burdens imposed on NDIS therapy providers by the requirement to register with the NDIS Quality and Safeguards Commission if intending to provide supports to self-managed participants.[13] This requirement is despite the fact that allied health professionals are already, by virtue of our professions, regulated either under the Australian Health Practitioner Regulation Agency or via an individual professional body, many of whom meet the requirements of the National Alliance of Self Regulating Health Professions.

The costs and complexity of registration and audits are particularly onerous for sole practitioners and small practices, making it harder to remain financially viable. Even for those therapy providers who do not register with the NDIS Commission, and thus are generally restricted from providing services to NDIA-managed participants, the associated administration is still a considerable burden, particularly for sole traders.[14]

Participant underutilisation of therapy supports

For participant choice and control to be fully realised, 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 outcomes for participants.

Currently this is not the case. There is significant overall underutilisation of committed supports, with a total utilisation rate of 71%.[15] As our member Speech Pathology Australia has calculated, the average rate of therapy utilisation across states and territories is strikingly lower at 52%. Given

[11] Further examples of costs being only partially funded are documented in the Joint Standing Committee's NDIS Planning Final Report (December 2020), Chapter 9.
[12] NDIS National Workforce Plan 2021-2025, 16.
[13] See eg NDIS Annual Pricing Review 2021-22 Report on Consultations, pp 68-71, 81-82.
[14] NDIS Annual Pricing Review 2021-22 Report on Consultations, pp 71-79, 87-91. As an indication, the disability support worker utilisation rate (the proportion of worker time spent on direct support rather than, say, administration), is 79%, whereas the equivalent figure for therapy providers is 47-53% (Consultations Report, p8).
[15] NDIS Quarterly Report to Disability Ministers (30 September 2021), Table N.52.

the issues in 'Planning and support coordination' above, even the 52% utilisation rate for therapy supports is likely to misrepresent the relationship between participant needs and allied health services actually provided.

Consistency with the object of choice and control in the Act is not the only rationale for actively investigating and addressing participant underutilisation. 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.[16]

Data implications

The lack of detailed data is an enduring barrier to matching participant needs with allied health service provision. In some cases, we are not sure whether the data has been collected by the NDIA or Government department and is simply not being made available to us or the general public, or whether it simply does not exist. These uncertainties are compounded by the difficulties allied health peak bodies experience when attempting to engage with the NDIA (see below).

Availability of data

For example, the allied health underutilisation figure (see above) was only obtainable via laborious calculations by SPA using multiple appendices from the NDIS Quarterly Report to Disability Ministers.

As another illustration, AHPA and its individual peak association members are currently in discussion with the NDIA concerning allied health input into design of the Information Gathering for Access and Planning (IGAP) project. Despite persistent inquiries from us, it appears that the NDIA does not collect, or at least have in accessible form, data on the number of NDIS supports provided by individual allied health professions under particular categories of support – let alone how that might relate to participant characteristics such as type of disability, age and location. That level of information is a basic essential for addressing workforce shortages.

More broadly across care and support sectors, AHPA has consistently argued that it is impossible to plan for future allied health service provision, including identifying specific shortfalls and particular practice and sector gaps, without having a workforce dataset that aggregates all current data sources, including the NDIA, to form a meaningful picture of the Australian allied health workforce at national, regional and local levels.[17] Lack of allied health services for NDIS participants can only be addressed through a model that draws upon this dataset to focus on more active stewardship of the allied health disability workforce, including more innovative and flexible funding solutions.

Data for NDIS financial planning

The Act requires Scheme planning and related policy to consider financial sustainability. The NDIA's Annual Financial Sustainability Report ('AFSR') is key to the financial modelling and forecasting for the Scheme, and underpins various public assertions about the lack of sustainability of the NDIS.

Our overall concern is that the AFSR takes a very narrow economic view of the Scheme which relies on a flawed neoliberal market model together with uncosted – and therefore unpaid –

[16] Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020), 46-47, 263-6.
[17] See eg Report for the Minister for Regional Health, Regional Communications and Local Government by the National Rural Health Commissioner, *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* (June 2020), Recommendation 3.

inputs from outside the Scheme. AHPA submits that the AFSR poorly defines the full range of benefits of the Scheme, evinces scant commitment to addressing underutilisation of therapy supports (indeed, its costings assume full utilisation), and is inconsistent with other principles and objects in the Act.[18]

However, the public data and analysis necessary to try to counter the AFSR's conclusions are not available. For example, the 2020-21 AFSR is based on assumptions that are not elaborated upon, and data summaries are not unpacked sufficiently to be able to answer many queries about what is claimed about the Scheme, such as its cost-benefit ratio.[19]

Engaging with the NDIA

While individual employees of the NDIA can be compassionate and do their best to assist, participants and providers alike often experience the NDIA as an opaque bureaucratic labyrinth whose practice, as our member SPA notes, 'at times appears to border on obfuscation'. Under this model, when stakeholders often do not know how to obtain information and action, and from whom, transparency is rare and accountability unlikely.

It is largely unnecessary here to detail AHPA's and others' experience of engaging with the now discredited and abandoned independent assessment model.[20] Nevertheless an associated apposite example concerns a report which we were contracted by the NDIA to provide in September 2020, and which considered the development of the credentialing, training and quality assurance aspects of an independent assessor role for allied health practitioners. AHPA provided this report to the NDIA on the assumption that the assessment information obtained would only inform decision making related to access to the NDIS.

We never received a response from the NDIA to this work. Instead, we discovered via the public realm that allied health practitioners would be contracted to provide independent assessment under the model – since rejected by the Minister for Disability and the NDIS – and our report was cited in the Evaluation of the Second Independent Assessment Pilot as having informed the Pilots, despite no further communication with us.[21]

We note that due to efforts by AHPA and individual dedicated NDIA staff, there have been some recent indications of improvements, so that on some issues at least, we are more likely to have the right Branch or person in the room to engage in discussion.

However, overall we continue to experience considerable difficulties in even getting allied health onto the NDIS policy 'radar', let alone being genuinely consulted in this process. For example, there were a number of errors and ambiguities in the NDIS Pricing Arrangements and Price Limits 2022-23 ('Pricing Arrangements') upon initial publication of that document on 22 June 2022. One of these mistakes was subsequently publicly corrected and clarified with a brief apology, but other issues required considerable member engagement with the Agency before they were addressed and publicised.

These issues particularly concerned music therapy, early childhood therapy supports, and changes to the Pricing Arrangements concerning the types and associated qualifying criteria of

[18] For more detail see AHPA's submissions to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the Future of the NDIS (November 2021 and February 2022).
[19] Compare *False Economy: The economic benefits of the National Disability Insurance Scheme and the consequences of government cost-cutting*, Per Capita (November 2021).
[20] Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021), especially Chapters 8 and 9.
[21] This reference to AHPA's report has since been deleted at our request.

therapists able to make claims for therapy support items.[22] They caused considerable stress for our members, and in turn for their provider members anxious about immediate and drastic impacts on their livelihoods.

Even when allied health peak bodies are invited to comment within a timely framework, the consultation paper or questions is too often framed as a one-size-fits-all document or consultation that claims to encompass all of the interests and understanding of providers, participants and the general public. It consequently fails to satisfy most stakeholders. This state of affairs is exacerbated when another Government department, such as the Department of Social Services, takes on the coordinating role, as with the NDIS National Workforce Plan, or when focus groups are contracted out to paid consultancy firms, especially if there is no detailed document provided for discussion.

As a consequence, AHPA and our members spend inordinate amounts of time trying to respond to issues that are framed at too high a level of generality, or that appear to be 'reinventing the wheel'. The impact of this process on the capacity of modestly funded peak bodies has been exacerbated by the sheer volume of consultations issuing from the NDIA.

We continue to engage with these processes because they are one of the few conduits through which to try to make allied health perspectives heard. It is therefore especially discouraging when the NDIA responds to our and others' efforts by claiming to have incorporated submitters' views, but provides no clear rationale for the policy or model selected – making it difficult not to conclude that the decision was already made.

It is essential that allied health providers be meaningfully engaged at all stages of relevant NDIS policy and practice development, implementation and evaluation, in a manner which acknowledges our various roles in the Scheme and our specialist knowledge. To date there has been no regular consistent mechanism to facilitate such engagement, and instead there is over-reliance on the goodwill and effort of specific individuals, whose roles may change.

Engaging with other relevant entities

AHPA endorses the submission from SPA concerning a lack of communication and alignment between the NDIA and the NDIS Commission. AHPA sits on the key committee for each entity (the NDIA's Industry Chief Executive Forum and the NDIS Commission's Industry Consultative Committee), and our experience is that many of the planning issues we have raised above 'fall between two stools' when it comes to the question of which body is responsible. This is despite our view that as these are planning matters that also impact on quality of services, both entities should be actively involved in responding to our concerns.

AHPA has also repeatedly suggested at both forums that although we appreciate that there are times where it is appropriate that providers and participant representatives meet separately (as they currently do in relation to both entities), there are other matters that would be more usefully addressed by joint meetings. For example, AHPA continues to receive feedback about tension between participants and providers concerning therapy support pricing, including what is appropriate in terms of charging for travel, report-writing and other non-clinical components of service delivery.[23] AHPA would like to work with participants and the NDIA as part of a process of

[22] NDIS Pricing Arrangements and Price Limits 2022-23, pp 20-21.
[23] And see eg https://www.smh.com.au/politics/federal/shorten-vows-to-stop-price-gouging-as-providers-charge-more-for-ndis-funded-clients-20221005-p5bnc2.html .

encouraging a more consistent understanding of participant and provider understanding around pricing concerns and appropriate charging.

Recommendations

1. Many of the issues we have identified under both Question 1 and Question 2 have been canvassed and been the subject of recommendations by the Senate Joint Standing Committee on the National Disability Insurance Scheme. The Appendix to our submission lists and supports the recommendations most relevant to the Audit,[24] and notes their status in terms of Government response and implementation.

In addition, AHPA makes the following recommendations:

2. The proposed Ministerial review of the operation of the NDIS includes early and ongoing collaborative engagement with therapy support providers, including small providers, including in the development of terms of reference.
3. The NDIA and the Department of Social Services work with allied health peak bodies to understand and address the issues impacting workforce recruitment, supervision and retention.
4. The Commonwealth works with States and Territories to nationally embed an Allied Health Assistant Delegation and Supervision Framework.
5. The Commonwealth Government funds development and implementation of a national minimum allied health workforce dataset.
6. The NDIA regularly collects and shares detailed and up to date NDIS allied health data with allied health peak bodies to enable future discussions and policy development.
7. The Commonwealth Government, the inter-Departmental Regulatory Alignment Taskforce and the NDIS Quality and Safety Commission work with allied health peak bodies to simplify current allied health provider registration and auditing processes and eliminate duplicate regulation.
8. The NDIA reviews its decision not to apply indexation to therapy supports in 2022-2023.
9. In consultation with allied health providers, the NDIA codifies the application of annual indexation of provider payments, to be at minimum in line with the consumer or wage price index.
10. The NDIA undertakes early and ongoing collaborative engagement with therapy support providers, including small providers, in any future NDIA work on the alignment of pricing arrangements across various funding programs and insurance schemes, and on ensuring an adequate supply of therapists and other support providers, including in the development of terms of reference.
11. The NDIA consults with the allied health sector to investigate the basis for errors and ambiguities in the Pricing Review 2021-22 and ensure efficient and effective future communication.

[24] See especially Recommendation 16, Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020).

Appendix: Relevant Inquiries by the Senate Joint Standing Committee on the National Disability Insurance Scheme

Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments (October 2021)

Note: To date, Government has not responded to these recommendations.

AHPA supports the following recommendations:

Recommendation 1

The Commonwealth Government implement the National Disability Insurance Scheme Reserve Fund as soon as practicably possible.

Recommendation 3

Consultations with medical and allied health professionals for the purposes of access to the National Disability Insurance Scheme and to support requests for items in NDIS plans be:

- carried out by health professionals nominated by participants and/or their nominees, where appropriate and available;
- holistic, taking into account medical reports and other contextual information as appropriate; and
- multidisciplinary, involving consultation with multiple experts who treat and have treated the person.

Recommendation 4

Where consultations with medical and allied health professionals for the purposes of access to the National Disability Insurance Scheme or to support requests for items in NDIS plans cannot be carried out by appropriate professionals nominated by a participant and/or their nominee:

- The National Disability Insurance Agency implement an accreditation process for appropriate professionals to carry out consultations for those in the circumstances described above;
- The National Disability Insurance Agency ensure that these assessments are holistic and multidisciplinary; and
- The National Disability Insurance Agency implement specific, targeted strategies to ensure that particular cohorts are not disadvantaged by such a process.

Recommendation 5

The Australian Government consider funding bulk-billed consultations with medical and allied health professionals for the purposes described in Recommendation 3 and Recommendation 4.

Recommendation 6

All assessment tools that the National Disability Insurance Agency proposes, for the purposes of funded assessments to access the National Disability Insurance Scheme and to help inform funding decisions, should be subject to rigorous consultation with people with disability, Disability Representative Organisations, and relevant health and allied health practitioners before the National Disability Insurance Agency decides to implement them.

Joint Standing Committee on the National Disability Insurance Scheme NDIS Planning Final Report (December 2020)

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

Comment

This Recommendation was supported by 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]

In AHPA's view the Recommendation has not been implemented.

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.

Comment

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, and the Recommendation has not been implemented.

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).

Comment

This recommendation was 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]

[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.

In AHPA's view 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.

Comment

This recommendation was simply noted. In AHPA's view the Government Response should be read in the following context.

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.

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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.

Comment

This recommendation was 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).

Comment

Recommendation 19 was 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]

In AHPA's view the Recommendation has not been implemented.

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.

Comment

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 and the Recommendation has not been implemented.

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.

Comment

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]

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[34] Australian Government Response to the Joint Standing Committee on the National Disability Insurance Scheme Final Report: Inquiry into NDIS Planning (February 2021), 11.
[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.

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]

In AHPA's view, 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 otherwise avoidable planning reviews concerning allied health supports.

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.

Comment

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.

In AHPA's view the Recommendation has not been implemented.

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.

Comment

This was supported by Government 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

[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.
[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.

these organisations are sufficiently funded to support participants throughout the Administrative Appeals Tribunal process.

Comment

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.

Comment

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]

AHPA submits 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.

[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.