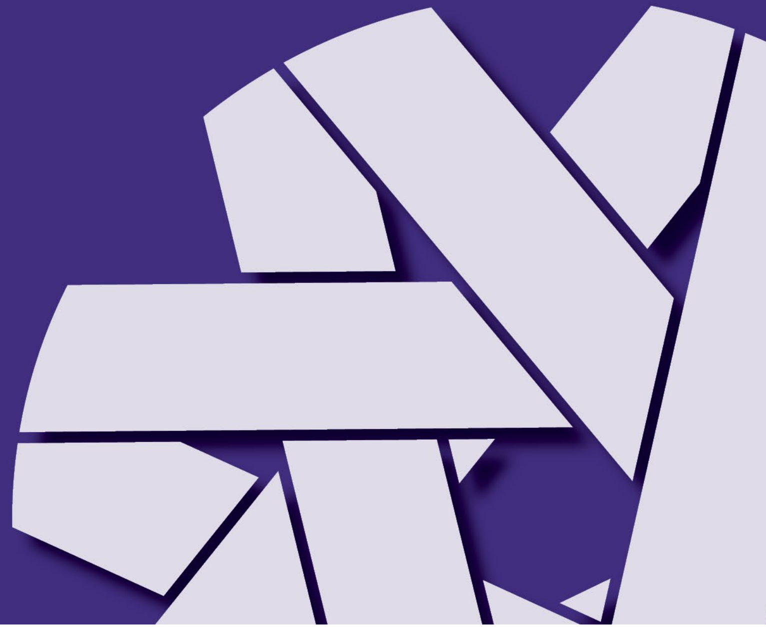
# Submission to Independent Review of the National Disability Insurance Scheme

February 2023

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

Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
www.ahpa.com.au
office@ahpa.com.au



## About Allied Health Professions Australia and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing allied health professions. Allied health is Australia's second largest health workforce, and allied health professionals work across a diverse range of locations and sectors. 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.

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.

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.

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 welcomes the opportunity to make a submission to the NDIS Review. We note that our individual members are better placed to address some important themes such as the NDIS approach to early childhood, and to assistive technology, so we do not address those here.

Where the Review has not already accessed them, we also refer to relevant submissions. In particular, we refer the Review to our October 2022 submission to the Australian National Audit Office (ANAO) which canvasses many of the themes we refer to below and lists recommendations https://ahpa.com.au/advocacy/ahpa-submission-to-the-australian-national-audit-offices-ndia-audit/ .

This current submission focuses first on the current status of allied health professionals and services in the NDIS, with particular reference to assessment, access and planning issues, underutilisation of therapy supports, and the ongoing impacts of a dysfunctional NDIS culture.

We then turn to other present obstacles to maximising the value of allied health to NDIS participants. These include unnecessary and onerous regulation, current approaches to pricing, and inadequate allied health data.

AHPA considers that some improvements are also required to the NDIS as a whole, with respect to how financial sustainability and participant outcome measurement are conceptualised and operationalised.

Finally, we address the persistent problem of siloes. Different aspects within the NDIS must be better harmonised, but even more significantly, there is urgent work to be done to integrate both

the NDIS and the allied health sector with other national sectors and current federal policy priorities and initiatives, such as workforce planning and digital systems.

## Status of allied health professionals and services in the NDIS

Under the current NDIS, allied professionals and the services we provide are not always given appropriate status and recognition. This means that NDIS participants are not receiving the full value of allied health services that they need and deserve.

### Assessment, access and planning

The NDIS's lack of recognition of the value of allied health is most profoundly illustrated by the experiences of allied health professionals and participants in assessment, access and planning processes. 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.

The Review already has AHPA's 2021 submission to the Parliament of Australia, Joint Standing Committee on the NDIS Inquiry into Current Scheme Implementation and Forecasting for the NDIS. See also https://ahpa.com.au/advocacy/submission-to-senate-joint-standing-committee-on-the-ndis-inquiry-into-current-scheme-implementation-and-forecasting-for-the-ndis/ ; https://ahpa.com.au/advocacy/ahpa-submission-to-the-australian-national-audit-offices-ndia-audit/ .

The above submissions document regular failures of assessors, planners, support coordinators and Local Area Coordinators to understand and approve otherwise recognised and evidence-based allied health professions as providing valuable services for participants.

It is essential that the National Disability Insurance Agency (NDIA) institute processes to foster respect for the distinct value and roles of allied health in supporting participants, and for the clinical judgment of our practitioners. NDIA practices must routinely require and provide appropriate training for delegates and other personnel, including ensuring that qualifications and skills of allied health professionals in NDIS decision-making roles remain up to date.

### Allied health under-utilisation and other inequity

NDIS participants utilise significantly fewer allied health supports than they are entitled to under their plans. Utilisation rates (ratio of actual payments to approved supports in a plan) are also much lower for allied health services than for overall plan utilisation.[1]

For example, overall national utilisation is 77%, but for Capacity Building – Daily Activities (the category in which the majority of in-person allied health services are classified – described as 'therapy supports') it is 56%.

[1] NDIS Quarterly Report to Disability Ministers Q1 2022-2023 (September 2022). Statistics in this section of our submission are derived from this report.

Given the issues in assessment, access and planning referred to above, even the 56% utilisation rate for therapy supports is likely to overstate the degree of consistency between participant needs and the amount and range of allied health services actually provided.

The difference in utilisation rates also varies across Australia.[2]

| State | Capacity Building – Daily Activities (therapy supports) utilisation | Overall plan utilisation | Difference between allied health and overall utilisation |
|---|---|---|---|
| NSW | 57% | 78% | 21% |
| VIC | 53% | 74% | 21% |
| QLD | 57% | 77% | 20% |
| WA | 58% | 74% | 16% |
| SA | 60% | 77% | 17% |
| TAS | 47% | 79% | 32% |
| ACT | 57% | 78% | 21% |
| NT | 45% | 77% | 32% |

Although there has been improvement in overall plan utilisation rates in most States, the gap between allied health and overall plan utilisation continues to widen, with the difference now up to 32% in the Northern Territory and Tasmania.

Participants such as First Nations peoples and those in rural and remote areas have particularly low utilisation rates, both overall and specifically for allied health.

Despite the glaring inequities, allied health utilisation receives little attention in NDIS data and analysis. For example, we need to know more about allied health use in geographical utilisation 'hot spots', and also to disaggregate utilisation by allied health profession and by participant characteristics and types of plan management, to enable development and implementation of solutions which address these equity and access challenges. Other data issues are outlined below.

### NDIS culture

The NDIS, particularly the NDIA, has until very recently been characterised by a defensive, non-communicative, mistrustful and overly bureaucratic culture. The flow-on effects to allied health provision are that allied health has tended to be excluded from equal partnership in NDIS policy and practice development. In turn this has reinforced current problems in assessment, access and planning; and contributed to the NDIA's failure to address significant underutilisation of allied health by participants (as outlined above), and marginalising of allied health professionals in NDIS workforce strategies.[3]

[2] Table derived by Erin West, Senior Adviser, Speech Pathology Australia.
[3] See eg AHPA's 2021 submission to the Joint Standing Committee on the NDIS Inquiry on Current Scheme Implementation and Forecasting for the NDIS; AHPA's 2021 submission to the Joint Standing Committee on the NDIS Inquiry into the National Workforce Plan.

The ANAO submission referred to in our Introduction documents AHPA's experience during NDIA development of the now abandoned Independent Assessments model. Our Report referred to in that discussion, NDIA Scheme Access: Independent Assessment Project – Credentialing, Training and Quality Assurance Final Report, is attached separately.

AHPA has advocated for some time for genuine partnership in the development of initiatives that directly affect allied health providers. While fully supporting the developing concept and practice of participant codesign with the NDIA, we also continue to advocate for regular collaborative opportunities among the NDIA, providers, participants and Disability Representative Organisations.[4]

AHPA therefore welcomed recent communication from the NDIS Quality and Safeguards Commission (the Commission) that restructuring of their currently separate Industry Consultative Committee and Disability Sector Consultative Committee is being considered.

Similarly, we have been pleased to be involved, following our request, in the NDIA's current Information Gathering for Access and Planning (IGAP) project. Our involvement is in its early stages and so ongoing collaboration with the IGAP team will be critical.

In AHPA's view, regular enhanced engagement will not result unless there are genuine NDIA and Commission commitments to NDIS cultural change and evaluation of associated strategies and achievements.

## Other barriers to maximising the value of allied health in the NDIS

### Over-regulation

Allied health providers are required to register with the Commission if intending to provide supports to self-managed participants, and in other circumstances if providing some specific types of supports.[5] 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.

Our concerns are that NDIS registration requirements are onerous and unnecessary because they duplicate existing professional requirements (see also 'Pricing' below). The Review already has AHPA's 2020 submission to the Joint Standing Committee on the NDIS Inquiry into the Operation of the NDIS Quality and Safeguards Commission.

Further, it is our members' view that the NDIS is a two-tiered system where, because many participants are moving away from Agency-managed plans, more non- allied health providers are choosing not to register (see also 'Data' below). Workers for these unregistered providers are not even mandated to undertake Worker Screening Checks, which in our view leaves participant consumers with insufficient guarantees of effective, safe and appropriate services.

A fair NDIS would ensure universal safety standards and support participants to exercise their consumer rights, while also taking a more balanced approach to risk management and associated compliance requirements when the provider in question is already subject to another regulatory process.

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[4] See further https://ahpa.com.au/advocacy/submission-to-senate-joint-standing-committee-on-the-ndis-inquiry-into-current-scheme-implementation-and-forecasting-for-the-ndis/ .

[5] See eg NDIS Annual Pricing Review 2021-22 Report on Consultations, pp 68-71, 81-82.

Collaboration among key stakeholders to support these priorities would also be greatly assisted if relevant allied health data was collected, published and analysed (see 'Data' below).

### Under-pricing

Pricing issues also affect the availability of therapy supports to participants. 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 health practitioners in the NDIS. These challenges are acute because many allied health practices providing NDIS services are small, with 31% of active registered providers for therapy supports being sole traders.[6]

At present, many allied health providers are in effect subsidising the NDIS through unpaid work. Direct and indirect costs flow from the high compliance-related and administrative burden for allied health providers, particularly when compared to the private sector and other government schemes (see 'Over-regulation' above). Other financial pressures include inconsistencies in the application of GST, and failure of the NDIS pricing scheme to recognise the true costs of providing services under a social model of disability.

The NDIS is also increasingly out of step with allied health workforce costs, because it makes no allowance for funding of training, supervision and student placements. This exacerbates existing challenges in recruitment and retention, particularly in professions such as speech pathology, occupational therapy, psychology, physiotherapy and dietetics (see also 'Workforce' below).[7]

As a consequence of the above factors, 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.[8]

In addition to our aforementioned 2021 submission to the Inquiry into Current Scheme Implementation and Forecasting for the NDIS, AHPA refers the Review to our submission to the NDIA 2021-22 Annual Pricing Review https://ahpa.com.au/advocacy/national-disability-insurance-agency-2021-22-annual-pricing-review/ , and our separately attached Response to the NDIS Pricing Review (July 2022).

### Workforce

Although allied health professionals contribute over 7% of NDIS 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.[9]

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.[10] That percentage could also well be considerably higher, given that such projections rely on incomplete

[6] NDIS Quarterly Report to Disability Ministers Q1 2022-2023 (September 2022), Table E.109. 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).
[7] https://ahpa.com.au/advocacy/national-disability-insurance-agency-2021-22-annual-pricing-review/ ; National Disability Services, State of the Disability Sector Report 2022 https://www.nds.org.au/about/state-of-the-disability-sector-report .
[8] 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 .
[9] 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).
[10] NDIS National Workforce Plan 2021-2025, 11.

data sources for allied health,[11] combined with the fact that, as noted above, they are also based, at least in part, on NDIA data on existing service use rather than estimation of actual participant needs.

As we submit under 'Pricing', 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 incorporated into workforce planning, regulation and pricing.

### Data

Access to allied health-related NDIS data is poor, despite it being critical to addressing problems such as workforce availability and under-utilisation. The lack of detailed data is therefore 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 Commission or Government department, and is simply not being made available to the allied health sector or the general public, or whether it simply does not exist.

For example, the allied health utilisation figures discussed above were only obtainable via laborious calculations using multiple appendices from the NDIS Quarterly Report to Disability Ministers.

It also 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.[12] This is particularly important for those professions that can claim payments across different categories, such as psychologists and dieticians, because the numbers under Capacity Building are not accurate.

That level of information is a basic essential for overcoming workforce shortages. 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.[13]

As we outline above, in order to address other inequities in participant access, it is also important to be able to analyse data that examines allied health utilisation rates against a range of participant characteristics.

In addition, AHPA would like to see reporting of data in such a way that the relationship of allied health supports to broader identified trends is made clear. For example, within Capacity Building spending, it is important to distinguish between therapy supports used by participants over 7 years old and those provided to children under 7 (so called 'Early Childhood Supports'). These age ranges have been delineated by the Commission as requiring registration for different supports, and indeed a different registration process. It is vital to capture the true therapy spend for registered providers under Early Childhood Supports, as this is reported to be a thin market.

Similarly, it would be valuable to produce a report and analysis that 'drills down' into the profile of allied health support use amongst First Nations and CALD participants.

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[11] Joint Standing Committee on the National Disability Insurance Scheme Workforce Interim Report (December 2020), 22 (fn 15), 25 (fn 32), 142.
[12] The main source for our comments on NDIA-related data issues is the NDIS Quarterly Report to Disability Ministers Q1 2022-2023 (September 2022). Any page numbers in the main text refer to that document.
[13] 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.

Data on plan management types (eg pp 85-88) and plan managers (pp 90-93) should be cross-referenced with allied health data, to enable investigation of whether trends in provision of allied health supports are also affected by these changes. For example, there has been a significant shift toward participants using a plan manager rather than being Agency-managed, with proportions of participants who use a plan manager increasing from 43% to 57%, while use of an Agency-managed plan decreased from 26% to 13%.

Many supports provided under a plan that is not managed by the NDIA do not require the participant to use a registered provider. However, we do not know whether and how the trend in plan management is affecting participants' use of registered allied health providers. For instance, in terms of payments for Capacity Building – Daily Activities (therapy supports), while only 11% of funds spent required the use of registered providers (p87), almost 63% of funds spent actually went to registered providers (pp90-92).

If it is the case that the proportion of participants using registered allied health providers has also decreased, and this is a growing trend, there are further considerations for implementing a compliance system that is less burdensome than registration but also guarantees at least a minimum baseline of provider regulation, participant safety and quality supports.

Market concentration statistics (pp 103-104), discussion of average and median payment trends (pp 114-118) and discussion of average plan budget trends (pp 119-126) should also specifically delineate allied health providers, and by type of profession. For example, if there is an average increase in payments, is there a comparable trend in therapy support payments? Similarly, it is important to know whether use of allied health support increases, with successive plans, at the same rate as utilisation overall.

Where appropriate, the NDIA should collect and analyse data in collaboration with the Commission. As part of canvassing the over-regulation issue above, if it is to effectively support policy and practice that enhances the delivery of participant supports, the Commission must also collect and analyse more granular data on the compliance record of registered and non-registered allied health providers.

## Improvements required to the NDIS as a whole

Analysis and planning for the future of the NDIS needs considerable improvement.

### Understand financial sustainability and measure participant outcomes

The Review has AHPA's 2021 submission to the Joint Standing Committee on the NDIS Inquiry into Current Scheme Implementation and Forecasting for the NDIS, which includes our critique of the dominant approach to the issue of financial sustainability.

See also https://ahpa.com.au/advocacy/submission-to-senate-joint-standing-committee-on-the-ndis-inquiry-into-current-scheme-implementation-and-forecasting-for-the-ndis/ , which calls for more extensive measurement and evaluation of participant outcomes, including thorough costings of the benefits to Australia of NDIS participation.

### Harmonise and integrate

The operation of the NDIS is compromised by both internal and external siloes. Internally, there must be a stronger and clearer relationship between the NDIA and the Commission. AHPA views allied health support planning problems such as those referred to above as a quality issue. As allied health providers have not been able to obtain traction with the NDIA on this matter, AHPA

has attempted to raise it with the Commission – but the response has been that there is insufficient resourcing and that it is an NDIA issue.

It also makes increasing sense that the NDIS is integrated and harmonised with the broader support and health sectors, including aged care, primary care and veterans’ care. This would assist in promoting consistency in approaches such as regulation. Important, common sense aspects of this process are for allied health providers, who frequently provide services in more than one sector, to be under one umbrella such as a (long overdue) National Allied Health Workforce Strategy (see ‘Data’ above), and a national system that facilitates digital interoperability and ‘joined up’ data collection.