Victorian Healthcare Association
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Submission

31 October 2019

Improving the NDIS Experience: Establishing a Participant Service Guarantee and removing legislative red tape

About the VHA

The Victorian Healthcare Association (VHA) is the not-for-profit peak body supporting Victoria's public health and community services to deliver high quality care. The VHA represents Victorian public hospitals, registered community health centres, multi-purpose services, and bush nursing services.

On behalf of its members the VHA responds to system reform, helps shape policy and advocates on key issues. The VHA also supports the Victorian healthcare sector by providing sector development that builds capacity, governance and executive support as well as supporting innovation and collaborations that act as a catalyst for strengthening the Victorian health system.

Public sector provision of disability services in Victoria

In Victoria, the public sector delivers approximately 15 per cent of registered disability services. While not every hospital, health service, or community health centre in Victoria is registered to provide every support under the National Disability Insurance Scheme (NDIS), when the sector is looked at as a whole, the public sector is registered to deliver the full spectrum of NDIS supports.

Public hospitals, health services and community health centres delivering these services have a considerable footprint in regional and rural areas and often provide services to people living with high and complex needs. In many cases they are the only NDIS provider for vulnerable people in their catchment, acting as a safety net for those who may otherwise struggle to access services that meet their need in, or near, their homes, families and communities.

Response

The VHA welcomes the opportunity to respond to the Commonwealth Government's review *Improving the NDIS Experience: Establishing a Participant Service Guarantee and removing legislative red tape* (the Review).

This submission provides the Department of Social Services with input that highlights the experience of NDIS providers in Victoria. We note that improving access to the Scheme and the experience of its participants is a primary aim of the Review, however, given the VHA's remit and membership, this submission focuses on issues specific to providers.

Health sector interface and coherence with state and territory arrangements

The recent shift in policy that allows the NDIS to fund a limited suite of supports that were previously defined as 'health' responsibilities is a positive change that has improved how clients with dual health and disability needs can interact with both public hospitals and their NDIS provider, particularly those which require additional support for dysphagia, diabetes management, continence supports, wound and pressure care supports and respiratory supports. This adjustment is commended by the VHA.

Despite the expanded view of the types of health supports that will be funded by the NDIS, health services continue to report concerns about how these changes will apply in practical terms, particular in relation to the prevailing policy, funding and enterprise bargaining agreement (EBA) arrangements in state-managed health services.

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For example, there is a disparity between the role definitions for community nurses set out in the Victorian Public Sector Nurses EBA and the definitions for the five key nursing roles that have been set out in the NDIS Price Guide and Support Catalogue 2019-20. This plays out in a number of ways:

- The price guide provides for an increased allowance for afternoon/evening shifts commencing at 8pm, however, the Victorian EBA allows for afternoon/evening shift allowances from 6pm, leaving the employer to cover the shortfall for each shift
- According to the Victorian EBA, nurses working on weekends are entitled to a 50 per cent penalty loading, however, the price guide has set out a different rate for each day
- Under the Victorian EBA, continence nurses are categorised as Clinical Consultant Grade 4B, which attracts approximate 15 per cent higher rate than the equivalent Grade 2, Year 4 Allied Health practitioner, yet the NDIS unit price is approximately 35 per cent less than the Allied Health unit price.

In each of these examples, the health service is faced with an ongoing shortfall in funding that can only be met if it is cross-subsidised from other health service activities, which is an unsustainable approach to long-term budget management and contributes to the widespread concerns about the financial viability of the NDIS.

Recommendation

- The NDIA should proactively align the unit price for health and allied health services with existing EBA arrangements for public hospital and community health centre staff.

Escalation of plan review

The VHA is concerned about health service clients whose care needs and funding arrangements will change as their health supports are transitioned to their NDIS care plans. In many cases an urgent plan review and adjustment is required, which in cases where the client's health is potentially at risk, speed and responsiveness on the part of the NDIA must be assured.

Currently the Act requires the CEO of the NDIA to decide whether or not to conduct a review of a participant's plan within 14 days of receiving a request, followed by another 14 day period within which a review must commence. The Act also provides the NDIA with the option of extending the first period, which can result in an extensive delay between the original request for a plan review and the final adjustment to a participant's plan.

While this period of grace for decision making and commencement of a review may make sense from the perspective of the NDIA as an entity, enabling the complex task of managing the 289,000 Scheme participants and their diverse needs to be made more efficient, it also creates a potential medical risk for participants whose health support needs change, and requires health services to resource the care needs of these clients from non-NDIS sources until participants' plans are reviewed and confirmed.

Case study:

Meredith* has been a client of her local public hospital for five years. During this time she has been receiving daily nursing support to help her with medication management following an acquired brain injury. To-date this has been resourced by the Commonwealth Home Support Program, which has transitioned to the NDIS. Without the nursing support, Meredith is at risk of experiencing unintended overdoses when she self-manages her medications. This has happened on previous occasions, risking Meredith's health and requiring inpatient admissions to the hospital.

Technically Meredith is no longer eligible for her existing funding under the CHSP and the NDIS has assumed responsibility for her care, however this transition of funding responsibility is reliant on an urgent plan review as her current package does not include the necessary nursing support for her medication management.

While Meredith waits for her initial request to be heard, and then for the review itself to be initiated, conducted and confirmed, her health supports are unfunded and require the hospital to manage her nursing needs from external sources.

> Regardless of the outcome of the review, if the health service were to cease service provision in light of Meredith no longer having access to funding to support home nursing services to support her medication needs, it is likely that she will experience another overdose, requiring urgent hospital care.

In cases such as Meredith's, the formal plan review process must be able to be expedited to ensure clients with specific health needs related to their disability are prioritised and confirmed as quickly as possible. This would entail legislative amendments to reduce the mandatory periods for decision making and plan review commencement from 14 days to seven days respectively.

Beyond amendments to the Act or Rules, the VHA suggests that existing state-based insurance schemes such as those provided by WorkSafe Victoria and the Transport Accident Commission provide a flexible and workable model for how health services and participants with health needs that are transitioning to NDIS funding can be supported while plans are under review.

Under these schemes, health services provide WorkSafe and TAC with the client's details and the care that is required, which allows them to immediately commence care.

In the context of an existing NDIS client with specific health needs, it is important that they are able to have their care appropriately funded by the NDIA, rather than by the health services themselves.

Recommendations

- Reduce the mandatory periods of considering a plan review request and commencement of the review to seven days.
- Allow public hospitals and community health centres to commence providing in-scope health supports, followed by an expedited plan review process.

Identifying and responding to thin markets

The VHA is concerned about the long-term viability of providers in rural Victoria. Detailed research has been undertaken that identifies significant risks to the financial viability of providers operating in areas designated as 'thin markets', with the majority of rural Victorian providers being assessed as unviable when operating in towns with populations fewer than 10,000 people.

People living in rural and remote areas have similar needs for services as those living in metropolitan settings, however, rural communities face additional difficulties associated with accessing supports. There are often fewer services available close to where people live, and the services that do exist may limited in scope and scale due to higher costs or lack of transport.

The move to individualised funding under the NDIS requires providers to have sufficient economies of scale to operate sustainably. In the experience of the VHA, often it is public hospitals and community health centres that are the sole organisations that can offer a readily deployable workforce in rural Victoria. But even in these cases, there is insufficient market depth to support an appropriate economy of scale. The Productivity Commission study into NDIS costs[1] recognised the need for appropriate government intervention in areas where a fully competitive, market-based and individualised funding model will not operate effectively, including a consideration of block funding as a means of addressing thin markets.

The NDIA has also acknowledged that even in a mature NDIS marketplace, 'weak' or 'thin' markets exist, primarily in rural, regional and remote areas due to insufficient local demand, limited service delivery, workforce shortages and lack of infrastructure. This may result in poorer outcomes for participants including less choice, higher prices and/or lower quality supports and services.

[1] Productivity Commission 2017, *National Disability Insurance Scheme Costs,* Study Report, Canberra https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf

The existence of thin markets in remote and very remote areas is recognised by the NDIA through additional price loadings for participants living in these areas. This is commendable, however, despite actions to address the risk of market failure in these areas, rural Victoria's public hospitals and community health centres are facing persistent financial challenges in the face of dispersed participant populations and a pricing structure that makes no distinction between a participant living in central Melbourne, and one who lives in an area of rural Victoria.

Data gathered by the VHA from its members indicates that 76 per cent of those providing NDIS services are unlikely to achieve a surplus result for their NDIS activity in 2019-20. While budget variations across different service delivery areas can be managed in the context of the broader hospital or community health centre budget, these organisations are public or not-for-profit, and any activities that operate in deficit may be cross-subsidised from other business units, or potentially be supported by an organisation's cash reserves; neither of which are sustainable long-term practices.

When asked if the financial sustainability of their NDIS business would have an impact on their long-term participation in the Scheme, five per cent of respondents indicated that their participation as a provider would continue regardless of the financial outcomes of their NDIS business. All others indicated that their participation in the Scheme was either reliant on a viable financial result, or that continued deficits would result in a review of their participation in the Scheme.

Troublingly, of surveyed members, only six per cent indicated that there was an alternative NDIS provider in their catchment with the scale and capacity to take on additional participants should the health service cease providing NDIS services. All others were either the sole provider, or operated in areas where there are a range of small-scale providers that lack the scale to take on additional NDIS clients.

The imperative for the NDIA, DSS and Commonwealth Government to proactively identify and respond to existing and potential thin markets is real.

Without a clear policy guiding how service providers in these areas can be supported and incentivised to remain in the Scheme, there is a legitimate risk that many will withdraw their registration and cease providing services.

Rather than adopting a passive approach to market stewardship and assuming the necessary depth of providers will develop over time, the VHA suggests that a more direct approach should be adopted for supporting existing providers in thin markets and regions at risk of becoming thin markets. Primarily, the VHA recommends trialling a mixed funding model for public hospital and community health centre NDIS providers in thin markets that combines existing participant budgets with a bundled availability payment that recognises the additional costs of maintaining service access to rural participants.

Rather than devising a new funding structure, the VHA recommends adapting the existing approach to funding multi-purpose services (MPS), which are health services in areas with populations too small to support an operation based on activity or individualised funding.

This type of model ensures core services remain available in areas of thin or failing markets by pooling state and Commonwealth funding to account for low volumes of patients and small, dispersed populations. Beyond sustaining a platform for the delivery of NDIS services into isolated rural areas and regions with low participant populations, the mixed funding model advocated by the VHA allows NDIS participants to continue to access state-funded health and community services within their local communities.

In addition to the funding response, the VHA recommends assessing and adjusting a number of the core policy settings used to guide the NDIS market.

The first priority for government is to adopt a proactive approach to managing market risk. Currently the NDIA has published its *Growing the NDIS Market and Workforce* policy, however in the face of widespread provider budget deficits, additional confidence must be injected by developing a clear policy that goes beyond acknowledging the risk of thin markets, to one that outlines how thin markets will be identified and managed.

The VHA acknowledges that rural areas may not have the same depth and breadth of service options as metropolitan areas, but we believe there should be a prescribed minimum level of access to services regardless of a participant's

location, enabled by the legislative framework, then resourced to enable the market to respond and deliver to this level of service.

Currently the funding arrangements for therapeutic services would support one allied health full time equivalent across a single discipline (for example, speech pathology or occupational therapy) in small towns. Compounding the existing challenge of recruiting and retaining staff in country areas, the lower NDIS participant numbers means health services and their staff must perform a significant juggling of employee availability for state-funded primary and sub-acute services, and those funded by NDIS participants. The flow-on effect for participants in these areas is a market that prices out a diversity of allied health supports, minimising participants' access to the depth and choice of providers and service types available in larger regional cities or metropolitan areas.

Underpinning many of the challenges rural providers face is a funding model that fails to appropriately recognise the higher costs of service delivery in rural areas.

As the foundation for assessing price loadings for participant plans, the Modified Monash Model (MMM) is failing to accurately identify and respond to rural areas of need. Using the MMM as a baseline, a coherent and complementary tool that is purpose built and specific to the unique needs of the NDIS should be developed, that maps geographic classifications that are based on existing and modelled participant populations and service provider coverage, ensuring the NDIA and DSS have an accurate appraisal of market depth and the tools to proactively adjust price loadings.

Recommendations

- Develop a market strategy for managing thin markets in regional and rural areas.
- Introduce and trial a sustainable NDIS funding model for rural public hospitals and community health services in areas identified as thin markets, based on the existing multi-purpose service model, which pools funding to provide a flexible, coordinated, cost-effective framework for service provision in rural and remote areas.
- Develop a purpose-built NDIS geographic classification based on service coverage areas, mapping geographic classifications based on participant population and coverage, so appropriate loadings can be applied to the price controls.
- Develop a set of principles that outline a minimum standard of allied health access in small towns.

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