

# **ISSUES PAPER ON THE OBSERVED OUTCOMES OF THE NDIS**

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Context and History – Physiotherapist / Senior Physiotherapist IDSC / DFC 1995 – 2003; Senior Physiotherapist Disability Services North (Tasmania) 2003 – 2005 (Specialist Resource Team); Senior Physiotherapist / Clinical Lead Physiotherapist Minda Inc 2005 – 2021; Senior Physiotherapist DCSI 2005 – 2009 (ASSIST South Disability Services); Physiotherapist / Manual Handling Coordinator DCSI 2009 – 2014; Currently Contractor Disability Specialist / Manual Task Trainer. Overall, 25 years in Adult Disability SRF Context primarily. Development Spasticity Clinic CIDH, Development Recreation through Physio Program (Strathmont Centre), Development DHS Safe Work Instructions (DHS Website), Development Minda Hydrotherapy Program, Professional Support for amalgamation Disability SA; SA Health Leading Clinicians Program 2019.

## **KEY POINTS**

1. Older persons in South Australia with congenital or life-long disability ARE the most vulnerable citizens as they are mostly without significant Advocacy support from family or significant others.
2. NDIS funding is not objective and equal or consistent across Participants in the program.
3. NDIS funding is open to Political bias rather than individual Participant need.
4. NDIS has discrimination inbuilt at core – Agency Managed Participants DO NOT have access to providers of choice as Self and Plan Managed Participants do.
5. NDIS funding is determined by largely non-clinical NDIA Planners
6. NDIS Planning Meetings are provided often without true Multi-disciplinary collaboration and meetings are not minuted – minutes are not provided to Participants / Nominees as a true record of Planning Meetings.
7. NDIS Plans including Participant Profiles and Goals are quite often false or at least poor constituting effective fraud on behalf of a Commonwealth Officer.
8. Many Participants in SRF's have had effective funding reduction limiting access the same amounts of funding for Accommodation Support, Day Options / Programs and Therapy.
9. Most Participants (almost all) have lost the standard yearly Respite / Holiday away from the SRF due to insufficient funding for specialising or respite staffing
10. Participants in the Govt and NGO sector have had an effective cut in Support Coordination funding of about 75% per person as well as Service Coordinators being more disconnected.
11. Govt Accommodation Services or NGO's who were primary advocates for many Participants are now reduced to a position of conflict of interest in being the 'Service Provider'
12. Participants do not have easy and User-friendly access to NDIA support – the LAC system that was meant to be incorporated into the NDIS seems to have diminished.
13. Access is difficult and impersonal for contact with NDIA Agents (Planners etc.)
14. NDIS Satisfaction rating is possibly skewed toward those who have capacity to provide feedback. Experience and dialogue with participants would suggest that the advertised satisfaction rate is highly inflated either by demographic, method, or reporting. An overall satisfaction rate approaching 90% seems incredulous and inconsistent with participant feedback.

15. NDIA Quality and Safeguards has failed to provide reasonable outcomes and has not faced any known consequences in the wake of the Annie Smith affair.
16. Govt COS Program Participants have extreme limitation with services only able to be delivered by one specific provider under agreement with SA Govt. The COS unit is somewhat obscure with very limited ease of contact and information to Participants.
17. NDIS Finance Committee has failed to appreciate market forces in relation to Therapy and the function and efficacy of Allied Health Assistants.
18. NDIS has failed to recognise the benefit of Govt and large NGO Agencies in promoting the rights and programs for people with a disability, for developing links and providing opportunities for tertiary education and research in disability, and for the progression of ethic driven behaviours, education and training in the disability sector.
19. NDIS' fiscal focus has resulted in wholesale changes and loss of morale and ethic across the disability sector where it was understood the objective was to provide a Person-Centred Approach rather than a fiscal centred approach.
20. Clinical Funding was previously prioritised by therapists familiar with the participant who would determine hours provided according to need at the time. Now Clinical prioritising is effectively approved by an NDIS Planner without Clinical registration (AHPRA) who in many cases has never met the Participant, and through a process that creates delay and increased risk to the Participant.
21. Rather than 1 CSTDSA battle per year and Each Provider battle with Disability Services for block funding each year the NDIS has reduced funding to thousands of individual battles with each Participant or their nominees
22. NDIS has increased the stress and understanding of many families, carers, nominees of people with a Disability who are mostly themselves limited or tired. It creates a system which is complicated and uses terminology and processes that is often confusing. It would be worth looking at family separation rates in this cohort.
23. NDIS has resulted in an overall decline of Lifestyle Planning, Care, and Support for many across the sector, especially those who lack advocacy.
24. The OPA in South Australia fails to appreciate in writing in it's Annual report the overall negative impact of the NDIS and although listing concerns provides descriptions that are slightly misleading and not clearly representing the issues.
25. The Majority of younger Participants have nominees that are dissatisfied with the processes and inconsistencies or injustices of the system. Some have seen significant increase in support however acknowledge that the process creates considerable increase in stress in families where there is already considerable pressure.
26. The NDIS has failed to enable the full utilisation of allocated funds resulting in \$6B returned to Treasury and not utilised where it was assessed that it was needed in the last financial year.
27. Many Disability Organisations both GOVT and NGO have lost asset base / income and suffered significant financial pressure as direct result of overall decreased funding through NDIS compared with the previous Block funding. This has resulted in significant rationalisation of services and training resulting in decreased quality of services and also increased risk to Participants.
28. Financial pressures on larger organisations have resulted in staff pressure and turnover, and specifically professionals leaving and operating as sole traders and managing the overheads that larger organisations can not manage.
29. NDIS focuses on the younger cohort and with the term 'Maintenance' not being supported in essence. NDIS considers it's role is to increase function rather than maintain it. Clinicians

with long term experience in the disability sector acknowledge that the majority of Therapy in the older person's context is about maintaining function and capability not about "Capacity Building". This leads to a 'disingenuous' attempt for Professionals to have to build programs and reports around the construct of development rather than maintenance. NDIS must recognise the concept of maintenance.

30. NDIS had failed to understand the intersect with Health. It is important that significant health and Rehabilitation supports can be provided by disability specific and experienced providers rather than that provided through normal SA Health programs.

#### **Additional points from consultations with other Providers**

31. Experienced provider estimates that split families rate is higher (potentially double normal statistic) in the disability sector and this raises issues for "duplication of supports". NDIS needs to understand that equipment may need to be provided for multiple residences for a child participant and also modifications to vehicles may be required to more than one vehicle as it unreasonable to expect that one guardian would have to take all transport responsibility.
32. Previous system was a "wrap around" system which meant that family issues were addressed with Social work and Psych. Current system is participant / child focussed and can ignore the needs of families / parents.
33. Interface with Health has been stated as an issue but also the interface with education and DCP and Housing has ongoing and exacerbated issues as a result of the NDIS.
34. Old systems created Capacity Building – NDIS creates Dependence. One provider feels that limitations in funding previously promoted maximising building capacity around the person whereas a fiscal system flooding the market in some areas creates dependence and increased use of therapy hours.
35. State V Federal funding responsibility conflicts. Example Housing HSA refuses to do home mods as "it is a disability issue". Before NDIS some mods ok but now it is a problem with changes noted 6-12 months ago. Provider believes that HSA has obligation as does Education DECD to provide Disability specific access / needs and it is not necessarily a NDIS responsibility.

#### **DISCUSSION OF KEY POINTS**

1. **Older persons in South Australia with congenital or life-long disability ARE the most vulnerable citizens as they are mostly without significant Advocacy support from family or significant others.**

It is often stated that children are the most vulnerable in our population and in some cases this may be true, however I wish to explain that it is actually some older adults with disability who are the most vulnerable. Children by nature often evoke a more sympathetic and emotive response and in most cases have younger and more energetic parents that can advocate strongly for them. They have potential and obvious weakness that creates the bias in this opinion. As a consequence of the nature of disability many older adults have no living parents, aged parents, limited or reduced numbers of siblings and usually no children and therefore lack advocacy. This cohort largely do not have the cognitive or language skills to be able to advocate for themselves. Many have no 'social cred' i.e. they may never have formed any significant social or emotional relationships, may never

have achieved any specific level of education or qualification, may never have experienced significant milestones or personal achievements that most of us take for granted. These are the ones with a voice and without voices specifically empowered for them. Disability Organisations were in many cases their effective advocate and ensured a fair go for them and a realisation of a near as normal life as possible. The ability to do this is directly related to the amount of funding directed at the support services and the Coordination of services / Lifestyle planning for a person.

**2. NDIS funding is not objective and equal or consistent across Participants in the program.**

As Clinical Professionals our acumen is built around science and objectivity. It is incredulous the inconsistency across the scheme where we appreciate that two individuals with similar needs may have significant disparity in funding simply according to which NDIS Planner has been allocated the person or how the Support Coordinator or others have performed in the Planning process. It is not so much about the person but it seems to be the system that decides outcomes. As Clinical Professionals across the adult and child context it is evident the clear disparity or trend for increased funding for younger Participants and the opposite reduced funding for older Participants. It has been the experience that in some cases some high needs individuals have received NO Therapy services when they had been receiving services in previous years and have reports submitted indicating high needs from relevant Therapists.

**3. NDIS funding is open to Political bias rather than individual Participant need.**

It is understood and experienced that a family or an individual with strong ability to influence or advocate and a presence with their Members of Parliament can and will result in a more favourable funding outcome than someone that does not – this is UN-AUSTRALIAN. Previous Block funding meant that this sort of disparity was able to be managed diplomatically with Clinicians and Service Coordinators who understood the Participant's needs and the context and the needs of others in the service. This meant services were calibrated or regulated against others in the service. Now an external person influenced by the Federal Body / Ministry if need be has the ability to arbitrarily set the funding for people and do this according to political bias rather than a set clinical standard.

**4. NDIS has discrimination inbuilt at core – Agency Managed Participants DO NOT have access to providers of choice.**

Participants who are Agency Managed can ONLY access Equipment / Services from Registered Providers rather than a Provider of Choice. Self-managed or Plan-Managed Participants can access any Provider of Choice. This seems a strangely configured setting where one might even expect the opposite whereby Agency-Managed (this shows as NDIA-Managed on plans – there is often switched use of terminology to confuse Participants) would seem to have greater Agency scrutiny and therefore could provide increased flexibility, however it is the other way around. Agency management has not been seen to improve outcomes but decrease outcomes in my experience and results in more complexity around managing funds. All Participants should have free access to any professional of choice that is AHPRA registered or otherwise qualified under Australian Law to deliver those services. Why would you set up discrimination inherently between classes of people in a new Disability System?

**5. NDIS funding is determined by largely non-clinical NDIA Planners**

My experience has demonstrated NDIS Planners are not clinically competent or have knowledge, skills, or registration to make the clinical decisions. Funding decisions are clinical decisions. The current arrangement is akin to Centrelink Officers deciding who should receive their Hip replacements and when and with what equipment subject to the Orthopaedic surgeons submitting their reports and plans but the NDIA Officer having the final say. This would not be tolerated in the parts of our society where people are truly empowered and have a voice / advocacy. I have had Planners arguing efficacy and outcomes and between Signs and symptoms and specifics of conditions and function when they have not been Registered with AHPRA and clearly should be illegal for them to do so.

**6. NDIS Planning Meetings are provided often without true Multi-disciplinary collaboration and meetings are not minuted – minutes are not provided to Participants / Nominees as a true record of Planning Meetings.**

Historically this cohort (generally older in SRF's) have been supported with yearly Life Planning meetings with the person, family, key supports and therapists meeting together and discussing plans and then minutes of these meetings were dispersed to all parties as a record of what took place. It is my understanding that in practically all cases of Planning Meetings which have often occurred over the phone during more recent COVID events and in some cases without the nominees / others being fully aware that the phone call has effectively been a 'NDIS Planning Review Meeting', there is no provision of meeting minutes with discussions and outcomes or agreed goals and details. In cases I have been personally privy to, Profiles are often misleading in terms of truly understanding the person and Goals can be constructed opposite to the discussion or wishes of a nominee. Plans are a legal document and where they provide substantively incorrect information or statements / goals that were not agreed or provided as the Participants goals this is fraudulent activity. In any case the minutes of any official meeting should be provided to relevant key stakeholders and agreed for transparency and accountability.

**7. NDIS Plans including Participant Profiles and Goals are quite often false or at least poor constituting effective fraud on behalf of a Commonwealth Officer.**

As per point above the Plans are a legal document and must be statements that are true and actual statements / intentions of the Participants / Nominees. Anything more or less is fraudulent activity as it is worded as the Participant stating their goals. Profiles must correctly reflect the person and their abilities and relationships and provide context for understanding the person.

**8. Many Participants in SRF's have had effective funding reduction limiting access the same amounts of funding for Accommodation Support, Day Options / Programs and Therapy.**

NDIS transition has led to the loss of effective therapy hours according to what has been provided in the funding level. The funding that should have been provided should have had a "no worse off"

principal applied and ensure that clinically recommended services currently being received were sustained. In Most cases this had not occurred with the hundreds of Participants I had been privy to. I have also witnessed and seen effects of reduced staffing and increased staffing pressures across residential accommodation facilities in Govt and NGO sector. I have specific knowledge of many participants having reduced access to Day Options / activity programs due to lack of provided funding. This can be supported as required by other Senior and long-term Clinicians and Accommodation Support Leaders / Mangers.

**9. Most Participants (almost all) have lost the standard yearly Respite / Holiday away from the SRF due to insufficient funding for specialising or respite staffing**

It was usual that Participants (when they weren't Participants but prior to NDIS transition) would experience opportunities for 'holidays' and respite away from the SRF which included short stays away at places such as Victor Harbor, Port Elliott, Wallaroo etc. Staff were available (funding) for supporting these activities outside of the Accommodation environment. This was also the case for staff who were supported to go on outings and to events with people. The support for these activities has been significantly affected. To my knowledge only a few people have been supported for a holiday out of hundreds of individuals I am privy to.

**10. Participants in the Govt and NGO sector have had an effective cut in Support Coordination funding of about 75% per person as well as Service Coordinators being more disconnected.**

Historically both Govt and NGO Services had provided a Program Service Coordinator who was imbedded in the Accommodation context / unit, who knew the Participant and often physically provided PSW support to, who knew the Environment, other Participants, dynamics, Staff, Management, Services (Day Programs / Therapists). This PSC would have approx. 2 weeks effectively per client for coordination of services on average each year. Some would require more / some less. Now the average / normal Service Coordination / Specialist Service Coordination funding is about \$2200 per person. This equates to about ¼ of funding as under previous block funded Services and with Service Coordinators who are now often external to the agency and without significant background knowledge. So they have a harder job with about ¼ the time to do it. This is very disappointing and possibly a large factor in the overall degradation of services and the failure to obtain satisfactory plan funding and supports.

**11. Govt Accommodation Services or NGO's who were primary advocates for many Participants are now reduced to a conflict of interest being the 'Service Provider'.**

The Accommodation Service Agencies are effectively a Service Provider and therefore it is seen as a conflict of interest for a Service Provider to be the Advocate for the person and creates a perceived adversarial model with NDIA as they attempt to push for increased funding.

**12. Participants do not have easy and User-friendly access to NDIA support – the LAC system that was meant to be incorporated into the NDIS seems to have diminished.**

The Local Area Coordinator (LAC) system as developed by Eddie Bartnik in WA Disability Services and Productivity Commission tested and taken on as a good Person-centred approach for Disability was initially spoken of and intended to be a part of the NDIA system. Instead of a local accessible contact with face to face access, most Participants indicate the great difficulties involved in communicating with a Planner. Planners are generally First name and initial (or Number) people hidden behind the PRODA wall of concealment.

**13. NDIA Agents hide behind PRODA barrier and access is difficult.**

NDIA staff do not reveal full names – There is no easy access to Planners or Supervisors.

**14. NDIS Satisfaction rating is possibly skewed toward those who have capacity to provide feedback and even so is a very low figure. Systems with very low satisfaction ratings should be disbanded or completely overhauled.**

NDIS Satisfaction rating is reported as being around 90% however the cohort being represented in this paper cannot provide effective feedback and it is anticipated if they were able to then the satisfaction / outcome rating would be much lower. This providers interaction with Participants and their nominees would indicate a much lower satisfaction rating and it is questionable how the rating statistics have been obtained as this does not seem to match the actual stories and dialogue from participants. It is expected that an overall satisfaction of lower than 30% would be a reality with the younger participants that this provider has worked with. It is anticipated that the older participants who cannot provide this feedback would likely provide even lower satisfaction given that their needs have not been met as consistently as for the younger and more highly advocated for groups.

**15. NDIA Quality and Safeguards has failed to provide reasonable outcomes and has not faced any known consequences in the wake of the Ann Marie Smith affair.**

Media pressure has appeared to be focussed toward the Providers in specific instances of failed care and it appears that due responsibility and accountability has been levelled at the Q&S that should have ensured safety for the Participants. Usually when a Quality Control System fails then it is not the system or operation only that is brought under scrutiny. This does not appear to have been overtly the case through general media outlets. I am interested to know exactly what level of accountability has been examined at CEO and executive and operational levels of the NDIA.

**16. Govt COS Program Participants have extreme limitation with services only able to be delivered by Minda Incorporated under agreement with SA Govt. Obscure unit with very limited ease of contact and information to Participants.**

Existing DHS Customers receiving Therapy Services through DHS ASSIST services had been transferred to COS Contract with Minda 2 years ago. These people cannot access both a Provider of Choice OR any other Registered Provider but are limited to having Minda provide their care. Further comment is possible on this point but will not provide as this may be subject to privileged information and repercussion, but suffice to say that there are concerns held.

**17. NDIS Finance Committee has failed to appreciate market forces in relation to Therapy and the function and efficacy of Allied Health Assistants.**

Allied Health Assistants cost organisations approx. the full amount of what the NDIS pay. This makes them cost neutral and unable to provide any margin / income in order to support other parts of large Organisational business models in Disability. Historically 25 years ago the ratio of Physiotherapists to Allied Health Assistants could be 1 : 4 and due to lack of fiscal benefit this ratio has been all but reversed. Organisations make large profit margins from therapists than Assistants so therefore they will tend to use them. There is no benefit from a profit loss sheet that looks at the ability to provide 3 times the services for the same amount. This means that AHA staff availability declines and then Therapists need to cover more of the actual programs rather than mostly assessing, developing, and reviewing, leading to overall loss of hours of service and increased pressure on funding so that a Therapist can cover off the interventions. This is a strange thing to consider that the NDIS with it's seemingly highly qualified Academic Market Business Committee fails to see that the Price Catalogue creates these Market forces and affects what services are delivered, by whom, and for how much. Increasing Physiotherapist hourly rate might seem advantageous to the Physio however then the Participant / Nominee would prefer that an OT or an Exercise Physiologist (EP) could cover similar work for a lesser cost. It must be understood that setting Prices will have an affect on the construct of the industry and who is employed doing what and then on the outcomes for Participants.

Also as there is no distinction in level of expertise of the Therapist and the remuneration rate then Organisations are benefitted from having lower paid less experienced staff cover off the required services. It is a disincentive to pay double for a much more Senior staff and reduce you effective margin. This is also more of a problem when there is less choice so that Service Quality becomes less of a factor in the choice of provider.

**18. NDIS has failed to recognise the benefit of Govt and large NGO Agencies in promoting the rights and programs for people with a disability, for developing links and providing opportunities for tertiary education and research in disability, and for the progression of ethic driven behaviours, education and training in the disability sector.**

Organisations like Minda and also Disability Services (DHS) Accommodation Services have played key roles in the past in development and training and in provision of Student Placements and in Innovative programs in the disability sector. Now there is no specified funding or portion of each Participants plan that is apportioned to these areas and including staff training. Consequently, some of these areas have completely fallen away and are not sustainable or feasible. Some training that was considered training is becoming optional or not required. It is understood that in some cases direct services staff are no longer required by Organisations to hold valid Senior First Aid Certificates, besides they drop off in other training around disability, person-centred care, communication and signing, Behaviour management, etc. Some value-added programs such as Advocacy Group programs and even Crisis Support programs are no longer supported as there is no available funding. In many cases NGO's are understood to have had to utilise asset base to cover losses in operational funding due to lack of Participant funding / revenue stream and fallen into Financial Stress. It was understood that the number of Registered Disability Organisations had significantly decreased across Australia since inception of the NDIS, albeit that a number of smaller Organisations HAD SPRUNG UP to capture part of the market with little or no overheads that the large Organisations had. These Organisations have complex Quality Control and Staffing systems and therefore require

large cost per unit to run. Unfortunately, due to the speed of transition some Organisations had also made poor choices or failed to properly change systems and maintained older less efficient ways of operating.

**19. NDIS' fiscal focus has resulted in wholesale changes and loss of morale and ethic across the disability sector where it was understood the objective was to provide a Person-Centred Approach rather than a fiscal centred approach.**

There has been significant change in emotional attachment of employees to their work across the sector during the years that I have been employed. In the early years in both Govt and NGO it was commonplace to notice that staff worked before and after their shift times voluntarily and also would volunteer to take people out for events or outings and for holidays even in some circumstances. As long as costs were covered staff often readily gave time for the cause. This has changed and the norm has become more "work to rule". Staff have generally felt less valued and less empowered due to a lot of factors but one of these is the impersonal nature and fiscal centred nature of the NDIS which is at deference to the notions that were posited at the beginning of the program. Person Centred Programs were sweeping across Disability through early 2010's and most workers thought the NDIS was an outcome of this rather than understanding it was merely a Cost-saving, 'budget sustainability' program initially suggested by DIG at the 2008 'Rudd 2020 summit'. The dialogue was no so much as per the reports and Treasury interest which was the financial sustainability of Disability Services in Australia into the future, but most workers thought and rallied for it as they understood it was about 'proper funding' for a 'fair go for all'. We thought that it would enable those who through no fault of their own were born without the privilege of language and function to be able to stick up for themselves, and to be provided with proper housing according to their age and not their condition, to be provided with proper equipment without having to beg for Public Trustee funds to be released to be able to buy a wheelchair, to be able to have the individual supports that other people received when they had proper Insurance for their Acquired or Motor Vehicle Accident related loss.

**20. Clinical Funding was previously prioritised by therapists on the ground who would determining hours provided according to need at the time. Now Clinical prioritising is effectively approved by an NDIS Planner without Clinical registration (AHPRA) and through a process that creates delay and increased risk to the Participant.**

Organisations had block funding and set budgets would cover X FTE of Therapy Staff according to yearly understood need – never quite enough but we had to make do because we didn't have the funding that SGIC or other Insurances might provide its participants. Then the FTE for Physiotherapy would then be divided up by the Therapist according to Clinical need. If Mr Jones needed more any given week then he would get it – without paperwork or a Change of Circumstances application process. Therapy hours and the determination of how much a person gets is a Clinical decision and has no business being decided by a person without Clinical qualification and also by a person in many cases in this cohort has never even met the Participant face to face.

**21. Rather than 1 CSTDSA battle per year and Each Provider battle with Disability Services for block funding each year the NDIS has reduced funding to thousands of individual battles with each Participant or their nominees**

Divide and conquer. Rather than a clear amount of block funding to keep track of now thousands of Plans can be fluctuated in funding with a significant net effect and without being able to be as overtly tracked. Rather than the admin time of a few meetings at the higher levels now the national time spent in bureaucracy has completely ballooned. This is maddening to see the wastage that the NDIA represents without any added value other than a gate keeper of funding. Additional costs incurred for further battles through legal avenues is also a huge waste and the net loss to the Participants at the coal face who could all benefit from these funds wasted elsewhere is palpable.

**22. NDIS has uncreased the stress and understanding of many families, carers, nominees of people with a Disability who are mostly themselves limited or tired. It creates a system which is complicated and uses terminology and processes that is often confusing.**

Most Participants with whom I've had contact (even the ones with good funding outcomes) indicate the stress the system has placed on themselves and their families. This is not acceptable of a Social Services Assistance System.

**23. NDIS has resulted in an overall decline of Lifestyle Planning, Care, and Support for many across the sector, especially those who lack advocacy.**

NDIS does not have a proper Objective, Consultative Planning process in place with accountable recording of meetings and outcomes with Participants. People who don't have any Advocates can be overridden in the system and no-one is now able to step into that space to challenge, unless the OPA is invoked. It is noted that recently there have been significant increase in cases being referred to the OPA. There are a very large cohort of Participants without effective advocacy and of whom the OPA has no involvement with.

**24. The OPA in South Australia fails to appreciate in writing in it's Annual report the overall negative impact of the NDIS and although listing concerns provides descriptions that are slightly misleading and not clearly representing the issues.**

The OPA has written that there has been increase in satisfaction of the NDIS in the last Annual Report but fails to observe that the satisfaction rating is still well less than half the Participants are happy and this cannot include feedback from the cohort advocated for in this paper.

The OPA goes on to say that most Participants prefer the NDIS system and would not like to return to the previous block funded model. I would suggest that this is incorrect. It is illogical for a system that has an overall disapproval rating to have this suggestion posited. This is unfortunate Annual Reporting as Senior levels of Government are clearly misinformed by statements such as this.

They do list a number of issues with the system which I would agree with all and raise a heap more. The OPA has a somewhat limited base and limited ability to scope the cohort that is represented by this paper.

**25. The Majority of younger Participants have nominees that are dissatisfied with the processes and inconsistencies of the system. Some have seen significant increase in support however acknowledge that the process creates considerable increase in stress in families where there is already considerable pressure.**

Experience over recent years has included both older and child Participants and it is fair to say that younger more energetic and capable parents have consistently indicated their distress and dissatisfaction with the whole process, even where there have been significant positive therapy outcomes in terms of funding. I call them then 'lucky ones' as they have the resource available at hand to advocate for them even though this is taxing and uncomfortable. Many families are subject to increased breakdown of relationships and it is important that a Disability system understands that it's role must be to support and make easier the task of being a parent for a person with a disability. A personalised system is likely to be more inconsistent but this should not vary in extent so much that it is seen as an injustice.

**26. The NDIS has failed to enable the full utilisation of allocated funds resulting in \$6B returned to Treasury and not utilised where it was assessed that it was needed in the last financial year.**

Flexibility and additional ease of access and utilisation of funding – what is the risk? Net risk of over-servicing versus underservicing. Any Clinician with experience will tell you which will cost the most in the long term. Not having the equipment or services easily and when required can increase the overall cost and cause pain, suffering, increased disability and loss of function, affects Carers and families and increased cost to both disability and State Health services. Saved money back to Treasury should be understood as compounded lost money in the future.

It is hoped that the new introduction of NDIA secured / tendered Insurance Independent Assessors who only have to have 1 year experience in a clinical field and using set tools and coming in to quickly carry out eligibility or suitability assessments is not a further method to recover further funding back to Federal Treasury, however it is the significant concern of most experienced long term Therapists in Disability that no longer trust the Agency that it certainly isn't about properly funding under funded plans.

**27. Many Disability Organisations both GOVT and NGO have lost asset base / income and suffered significant financial pressure as direct result of overall decreased funding through NDIS compared with the previous Block funding. This has resulted in significant rationalisation of services and training resulting in decreased quality of services and also increased risk to Participants.**

This is a reality as many Organisations have lost Staff and working Capital, Experience, Programs, Training, had to sell assets to manage cash flow, had to amalgamate or fold. There was no promise of ensuring that funding was sufficient to cover the current status quo. There was little or poor investigation of what was the status quo. It is impossible to continuously improve Quality when you consistently reduce funding for service and also require higher standards of reporting and recording at the same time. It would be good to see breakdown of provider satisfaction ratings for large and smaller providers. It is clear that the vast majority of responses come from smaller providers with staff less than 10.

**28. Financial pressures on larger organisations have resulted in staff pressure and turnover, and specifically professionals leaving and operating as sole traders and managing the overheads that larger organisations cannot manage.**

The last Therapy team I work for has lost 90 – 95% of its entire staff of about 90 people in 2 years. Other parts of the Organisation have also suffered large losses of significant staff and experienced staff both to other newer smaller Organisations with lower overheads and also to Private practice where they can provide the same services and have the same unbillable portion of time spent and be remunerated at 5 x the rate of the salary they were on.

It is ethically wrong I think to expect a public benevolent organisation or charity to have to sell assets off to manage to cover operational expenses, and especially of the organisation already provides housing for disability saving the State and Commonwealth Govt from doing so for hundreds of individuals. It is poor that any Organisation can also allow this to happen.

One must also understand the changes in Management across the Disability Sector. 25 years ago most CEO / Administrators / Executives in Disability were long term invested staff with Disability / Mental Health Deficiency Nursing / Psychology / Physio / Care Work background, or even had affected children and they were willing to push Government agencies for the required funding. We also had an Independent Council (IDSC) in SA to push Govt for the needs of this cohort. Today Many people in Senior Positions have more Business acumen and little investment in the sector and generally see each position as a stepping stone to the next. As such they are not prepared to face up to Authorities and Systems but rather attempt to manage down through their area of control and extract more from below. This may be seen as a lacking generalisation, but it is an observation that a number of colleagues have agreed with.

Staff across various organisations are tending to suffer with KPI's and expectations. Some Organisations also have failed in managing and acquiring correct models and business tools which has made the transition infinitely harder.

**29. NDIS focuses on the younger cohort and with the term 'Maintenance' not being supported in essence. NDIS considers its role is to increase function rather than maintain it. Clinicians with long term experience in the disability sector acknowledge that the majority of Therapy in the older person's context is about maintaining function and capability not about "Capacity Building". This leads to a 'disingenuous' attempt for Professionals to have to build programs and reports around the construct of development rather than maintenance. NDIS must recognise the concept of maintenance.**

Everyone deteriorates after 25 years of age. If you do not have a disability you are generally accepted as having the power and capacity to recognise and implement what you must to 'maintain' your fitness. If you have a disability then you require supports potentially in order to enable you to maintain for fitness and function. This is not about gaining or improving but about maintaining and not losing what you value. This is an expectation of life and should be considered a right such as the right to adequate nutrition (if you require a PEG feed) and housing (if you require specialised facility). The idea of Capacity Building is discriminatory toward the younger developmental cohort and is not inclusive of all people with a disability. The NDIS must adopt and include the concept of maintenance as part of inclusivity and the needs of all individuals for Quality of Life.

**30. NDIS had failed to understand the intersect with Health. It is important that significant health and Rehabilitation supports can be provided by disability specific and experienced providers rather than that provided through normal SA Health programs.**

Battles rage over what can be funded or not because it is or isn't related to a person's disability. Prior to NDIS transition Disability Services and NGO's provided significant Rehabilitation and Hospital Step-down options which were disability specific. As a Physiotherapist in this space I would probably have spent 30% of my FTE in this area. People don't plan to fall and break their ankle but if you have a disability and do so, then in many cases a specialist with disability experience may be of greater help than a generic hospital or SA Health therapist. Hospital Services also discharge people thinking that there are Therapists in the Organisation so they can continue care not understanding that there had been no funding in the Plan set months earlier for the acute health issue and that it is no longer supported by NDIS funding or billable. Lack of flexibility and obvious disconnect between State and Commonwealth funding buckets become issues that were not there before. This was raised at the very beginning of the NDIS and supposedly it was being addressed with those setting things up and perhaps it was but the outcome was poor in terms of the supports for people with disability and who should best provide these.