CONSULTATION RESPONSE

Allied Health Professions Australia

Queensland Productivity Commission

Inquiry into the National Disability Insurance Scheme

Response to the Draft Report

February 2021

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Introduction

Allied Health Professions Australia (AHPA) thanks the Queensland Productivity Commission (QPC) for the opportunity to provide additional feedback to its ongoing inquiry into the National Disability Insurance Scheme (NDIS) in Queensland. AHPA is the recognised national peak association for allied health professions and works with its membership to work collectively represent some 130,000 individual allied health professionals. A significant proportion of those allied health professionals are involved in providing services to people with disability, people who may or may not be participants in the National Disability Insurance Scheme (NDIS). 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.

In responding to the recommendations in the draft report, AHPA notes the uncertain policy environment created by recent proposals in relation to early childhood intervention services and the introduction of independent assessments across access and eligibility and planning. While AHPA provides specific commentary on individual recommendations below, we cannot overstate the potential impact of these proposals, or the potential impact they will have on a range of different areas of inquiry. With consultation on these reforms still under way, it is not yet clear how they will impact participants and providers. Significant components of the proposals, including new planning processes and a proposed shift to flexible budgets, remain very unclear. As such we argue that the QPC will need to remain ready to adapt its recommendations as those proposed reforms are further developed and implemented.

AHPA also notes that the ongoing lack of a coordinated workforce strategy for allied health professionals has a significant impact on access to services in Queensland. While AHPA commends the recommendations in the report in relation to specific market interventions focused on thin markets, we argue strongly for the need to integrate education initiatives such as improved access to rural training and early career support and mentoring, initiatives focused on attracting rural allied health workforces through scholarships and similar, as well as opportunities to pool funding across multiple funding schemes to increase the viability of rural and remote allied health businesses. We note that the previous National Rural Health Commissioner recommended such approaches but these have not yet been progressed. With its large rural and remote population, a geographically distributed population, and a significant number of remote Aboriginal and Torres Strait Islander communities, Queensland will gain significant benefits from a dedicated focus on the allied health workforce pipeline.

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

Responses to the Draft Recommendations

In responding to the QPC Draft Report, AHPA has limited its responses to the recommendations of the greatest relevance to the allied health workforce. AHPA acknowledges the extensive work undertaken by the QPC and broadly supports the overall recommendations where no additional commentary has been provided.

Draft Recommendation 1

To improve the access of eligible people with a disability to the NDIS, the Queensland Government should:

- propose that the Disability Reform Ministers' Meeting oversight the development of the proposed national outreach strategy, including the preparation of a publicly available implementation plan and periodic public reporting on progress
- contribute to the development of the proposed national outreach strategy by:
    - evaluating the effectiveness of existing programs, and any overlaps or gaps between them
    - assessing which programs should be retained and refined
    - reviewing information about the population of potential participants in the scheme in Queensland
    - identifying barriers to potential participants to accessing the scheme and how to address them
    - considering the roles of the Queensland Government and the NDIA in delivering outreach programs
- propose the monitoring and evaluation of independent assessments, conducted independently of both the NDIA and the organisations selected to implement them
- suggest that the review of national advocacy and decision-making supports consider how the access process could be simplified, to enable and encourage more people with a disability to complete it without the need for these supports.

AHPA supports the proposals in Draft Recommendation 1. We recognise that access to the NDIS continues to be more limited for a range of cohorts and it will be important to carefully monitor the effectiveness of current initiatives. While supportive of the recommendation, AHPA argues that it will be important to focus particularly on potential barriers to access and how to address these. It will also be important to determine how best to address these, and which organisations may be best placed to provide support, including the National Disability Insurance Agency (NDIA) and the Queensland Government.

In commenting on this recommendation, we are pleased to see that the QPC has recognised the need to monitor and evaluate the introduction of independent assessments as the primary means of accessing the NDIS, and informing the planning policy. The proposal to introduce independent assessments has a number of positive features that AHPA and its members support. The recognition of the need to provide universal access to appropriately qualified and experienced allied health professionals as part of the access process is a positive, particularly in light of the findings of previous reviews in relation to the gaps in expertise and understanding of the NDIS delegate workforce. The potential increase in equity that may be achieved by shifting the funding of assessments from participants to the NDIS is also very much welcomed.

Yet under current proposals, there are also potential issues that may undermine the intentions of the reforms. We draw the Commission's attention to the NDIA proposal, as part of the introduction of independent assessments, to remove access lists and to require potential participants to provide

significant information as part of demonstrating pre-access eligibility in relation to their disability and its permanence. AHPA has significant concerns about the continuing impact on equitable access to the Scheme when potential users are required to fund reports from health professionals to demonstrate eligibility for an independent assessment by demonstrating both the nature and permanence of their disability.

We argue that some of those cohorts called out as being underrepresented in the scheme—people from a CALD background, rural and remote Australians, and those with psychosocial disability—are likely to continue to struggle to gain access if these requirements remain in place. This is due to well-documented issues relating to access to health services, differences in socioeconomic status, and the potential additional complexity involved in demonstrating permanence and impact for some disabilities such as psychosocial disability. We note that the current plan provides little scope for variation in how assessments are undertaken, despite potentially significant variation in how different cohorts will respond to the interview style approach of the proposed assessments, particularly when these are administered by a previously unknown independent assessor. We note our view that the requirement to use an independent assessor, rather than a known and trusted (allied) health professional, will particularly impact Aboriginal and Torres Strait Islander people and people who may have existing psychosocial issues like trauma.

Our view, based on extensive discussions with experts from within the allied health professions and with participant representatives, is that a range of cohorts may respond far more effectively if there is capacity to provide a standardised assessment in potentially non-standardised ways, such as by varying the amount of time allocated to the assessment and consideration of a less formal interview structure where needed. AHPA also argues strongly for the need to consider carefully the impact of the aforementioned pre-access requirements and the potential to significantly reduce their impact either by building them into the independent assessment process, or by establishing funded access to appropriate and timely assessments (noting the long waiting lists for most public services). We note that this expanded and more flexible independent assessment process would go some way to simplifying the access process as recommended by the QPC.

We recommend that in addition to proposing monitoring and evaluation of independent assessments, the Queensland Government and/or the QPC engage with the NDIA in relation to the outcomes of current consultations and the adequacy of provisions within the independent assessment process to meet the needs of all cohorts of people with disability. We further argue that in establishing a process for the independent monitoring and evaluation of independent assessments, the Queensland Government does so in conjunction with the Disability Ministers of the states and territories with a view to establishing a national oversight panel. This should include strong representation from allied health professionals and participants. We argue that it may be appropriate to establish a separate sub-committee to oversee evaluation and to provide clinical and participant input into the assessment process itself, recognising that this is a new and largely untested process that will impact any person with disability seeking to access the scheme, or receiving funding under the NDIS.

Draft Recommendation 2

To improve NDIS plan creation, the Queensland Government should:

- propose that the Disability Reform Ministers' Meeting develop a statement on the definition of 'reasonable and necessary supports' and the meaning of 'choice and control'
- complete preparatory work to enable it to make an effective contribution to the development of the statement
- contribute to the NDIA's review of draft plans

- propose that the NDIA:
    - review options for enabling and encouraging participants to access information about the planning process before the planning meeting
    - develop, implement and report on a strategy to remove barriers to self-managed plans, when it is within the capacity of the participant.

AHPA strongly supports the need to define both 'reasonable and necessary supports' and the meaning of 'choice and control'. AHPA members frequently report that a lack of clear definition of reasonable and necessary hampers the decision-making process in relation to both service supports provided by allied health practitioners, and the prescription of assistive technology. In particular we argue for the need to have more rigorous processes in place for determining reasonable and necessary where this is not clear, even after additional work is done to define this.
We note for example the frequently cited example of planners partly or fully rejecting prescriptions of assistive technology on the basis of these not being reasonable and necessary. The allied health sector strongly argues against what are in effect clinical decisions being made by a workforce that lacks health professional training. AHPA is of the view that there should be a process of clinical validation of any rejection of clinical prescriptions, either through the use of an external health professional or through the introduction of internal review processes that use appropriately qualified staff from the Technical Advisory Team.

Defining choice and control will be increasingly important in the context of the proposed use of independent assessments to inform plan budgets. Under these proposals, there will be increasing standardisation of plan budgets and it is not yet clear how that will impact participant's ability to have choice and control over their plans. AHPA members and participant representatives have indicated strong concerns about the impact of this process on individual choices by participants and their ability to identify goals that may impact the size of their individual plan budgets. AHPA also notes that the definition of choice and control has a potentially significant impact on the extent to which the NDIA and Australian governments have responsibility towards ensuring access to an adequate workforce.

AHPA strongly supports additional engagement by the Queensland government with the NDIA draft plan review. We support the proposed areas of review for the NDIA, noting that AHPA has previously made submissions to government inquiries arguing for increased involvement of participants and appropriate providers at the draft plan stage to reduce the high rates of plan review arising from poorly developed plans.

Draft Recommendation 3

To improve plan utilisation, the Queensland Government should propose that:

- the NDIA's selection, role description and training for planners and LACs include a 'coaching' role to enable participants to develop their capabilities to increase their independence
- the NDIA's progress in introducing additional flexibility in plan budgets be monitored and evaluated, to ensure that progress is consistent with the desired improvement in performance outcomes
- the NDIA's current consultation process on support coordination be used to clarify the role of support coordination and of the various types of providers engaged in similar roles, to avoid unnecessary overlaps and gaps in services
- the NDIA facilitate reallocating participants' plan budgets towards support coordination when it improves plan utilisation and participant outcomes.

AHPA supports the intentions of Draft Recommendation 3, given the potentially significant differences between those participants who can themselves, or in conjunction with their support network, exert greater influence over their plan design and the services that they access, and those participants that cannot. However, AHPA has concerns about the practicality of the proposal. We question whether the use of planners and Local Area Coordinators (LACs) to provide coaching to participants as a means of increasing their system literacy and ability to better exert choice and control to access services, is likely to be effective.

AHPA's view is that there are still significant issues in relation to the skills and expertise of the planner and LAC workforces, as well as significant time pressures on both, that are likely to limit any capacity to provide this type of support to participants without significant additional training and resourcing. This view has been put forward and acknowledged in prior inquiries, which have noted the continuing inconsistencies and quality issues in the planning process. In considering the role of planners and LACs in addressing underutilisation of plans, we note the potential conflict for planners and, to a lesser extent LACs, in increasing utilisation while also responding seeking to reduce expenditure. We note that regular examples have been reported to AHPA by practitioners and participants, where planners have argued against the use of the supports that participants have requested or where they have sought to advise on the use of cheaper assistive technology options than those prescribed by allied health professionals. In all cases, participants and providers have indicated that they felt this was done to reduce plan costs. This experience has been particularly prevalent in relation to the use of some professions such as music therapy and exercise physiology, as well as in relation to the prescription of assistive technology by audiologists, occupational therapists, and speech pathologists. It is difficult to see how planners, in pushing participants not to make use of appropriate services, based on what we understand to be intentions to save money, will be effective supporters of increased plan utilisation.

Despite these concerns, AHPA supports the importance of helping participants and their families to utilize their plans. We encourage the funding of coaching and argue that rather than increasing the resourcing provided to planners and LACs to undertake this function, the NDIA should instead seek to fund existing participant support and advocacy organisations to expand their work to support participants.

AHPA strongly supports the need to monitor and evaluate the introduction of plan flexibility and argues that this should be aligned with the proposed independent oversight of independent assessments. The introduction of plan flexibility, at the same time as independent assessments are being introduced with a new and less flexible process of going from draft to final budgets, introduces significant potential questions and uncertainties into the scheme. For participants this may add additional flexibility but may also result in underfunded supports being topped up from other parts of a budget with a commensurate reduction in other necessary supports. For providers, this may create additional uncertainty about future provision of services. We argue that as both the independent assessment and flexible budget initiatives are closely aligned and likely to rolled out at similar times, both reforms should be overseen in conjunction with one another. We further argue that this should also be an independent national monitoring and evaluation process with oversight by a participant and provider committee. Results from the monitoring and evaluation process should be reported on regularly to ensure that participants and the broader community have transparency in relation to the impact of these changes.

AHPA also supports work to better clarify the role of support coordination, particularly in relation to other NDIS-funded roles such as recovery coaches. We recognise the important role that service coordination can play, noting that prior to the NDIS case management played a major role in supporting people with disability to access a variety of funded and community-based services. AHPA

is of the view that increased consistency in relation to training and expertise, as well as greater clarity about scope, will have significant benefits to participants and improve the effectiveness of the scheme. However, AHPA cautions against the recommended reallocation of funding from supports to support coordination without a rigorous framework to ensure that this does in fact improve outcomes rather than the expenditure of plan budgets on coordination services rather than the services a participant may want and require. We argue that instead there should be additional work by the NDIA to undertake research work to quantify the extent to which a lack of access to support coordination is contributing to underutilisation, and for which cohorts. This would then allow the NDIA to better structure the planning process to identify where support coordination may be needed with a view to increasing funding of that in plans.

Draft Recommendation 4

To improve the effectiveness of plan reviews, the Queensland Government should propose that the NDIA publicly report on plan reviews, including their outcomes and performance against goals.

AHPA supports the proposal to increase NDIA reporting on plan reviews, noting that this will be particularly important in the context of introducing independent assessments and new planning polices with more rigid and standardised budgets. AHPA argues that reporting should clearly articulate the key drivers contributing to plan reviews, including whether particular participant cohorts or factors impacting participants are particularly prevalent.

Draft Recommendation 5

In order to improve the information available to the market to assist participants and providers in planning, the Queensland Government should propose that the NDIA:

- work with stakeholders to determine and address ongoing data gaps
- further increase the availability of basic data in the form of spreadsheets or similar. The NDIA should also make publicly available detailed unit record level data that has been de-identified so that participants cannot be identified.
- review its website and materials to better direct readers to related documents, websites, data, learning materials and research and evaluation materials held by other institutions within and outside the NDIS.

AHPA strongly supports the need to improve the information available to the market to assist participants and planners in relation to planning. AHPA has previously argued strongly, including as part of our previous submission to this inquiry, that a lack of data collection about the availability (or lack thereof) of appropriate allied health providers is significant impacting participants in Queensland. That lack of data collection, and the lack of data about demand for services, also limits the NDIA and Australian governments in undertaking proactive planning to address thin markets and service gaps. AHPA further argues that in addition to determining data gaps, work is also required to consolidate and link existing data sources to improve capacity to undertake workforce planning.

AHPA also argues for the need to improve access to information via the NDIS website and other sources of information such as the NDIS Commission website and the Department of Social Services' (DSS) Boosting the Local Care Workforce (BLCW) website. We note consistent feedback from practitioners, particularly those that are new to the scheme, expressing difficulty in navigating the different websites and understanding how various aspects fit together. AHPA also notes the ongoing frustration of the allied health sector in relation to the dissemination of communications materials about new updates and changes by the NDIA. Current processes frequently involve updates of different parts of the website without additional notifications that changes have been made or

where. As a result, peak associations and providers are often left undertaking frequent searches of the website waiting for information to be released. Given that this information may have significant impacts on business practices and planning, this creates significant uncertainty for providers as well as making it difficult for peak associations to support providers in understanding changes.

We note the later recommendations by the QPC in relation to provider guarantees as a potential means of addressing this issue.

Draft Recommendation 9

The Queensland Government should propose that the NDIA develop an application programming interface (API) that allows participants to share their NDIS information and receive provider proposals in a safe way, to facilitate digital marketplaces. NDIA and NDIS Quality and Safeguards Commission (QSC) policies should support the development of digital marketplaces such that digital intermediaries are able to use both provider and participant information.

This will:

- assist providers in identifying new market opportunities, such as opportunities to coordinate demand in markets where there are relatively few participants (through demand pooling), and achieve economies of scale
- allow participants to 'post' required supports for tender
- provide direct information for market stewardship on thin markets (where tenders are unmet)
- facilitate price monitoring.

Where the NDIA and QSC hold information on the quality of supports provided, that information should also be made available to enhance the value of digital marketplaces.

AHPA supports the proposal to build an API to allow to support digital marketplaces and increased sharing of information between providers and participants. We note consistent feedback from AHPA members about the significant variation in the quality of information available to them and the impact this has on initial engagement with participants in relation to assessment and service planning. AHPA also notes that it is currently undertaking work in conjunction with the Australian Digital Health Agency (ADHA), and provider and participant representatives, in Queensland to examine potential opportunities to use digital health infrastructure such as My Health Record to improve participant and provider information sharing.

While AHPA supports improved use of technology and sharing of appropriate information, we strongly caution against the proposal to have the NDIA and the NDIS Commission (referred to by the QPC as the QSC) make information about the quality of supports without first undertaking work with the sector to carefully define quality. AHPA is not aware of any current measures that could be used to define and rate the quality of supports. We note that the NDIS Commission already provides information about compliance and enforcement actions on its website.

AHPA argues that any consideration of defining and reporting on the quality of supports should involve additional consultation and that any framework for reporting should be developed through a process of co-design with strong representation from all provider groups, including allied health, and participants.

Draft Recommendation 10

The Queensland Government should propose that in markets where there are significant and persistent shortfalls in supply, the NDIA allow:

- extended service agreements to be offered by participants as an incentive to providers to enter the market and/or expand supply
- longer duration participant plans to support the use of extended service agreements.

AHPA supports Draft Recommendation 10, noting that this is likely to be only one of a range of market interventions needed to address persistent shortfalls in supply. In relation to allied health services in rural and remote regions of Queensland, we note extensive evidence showing that providers seeking to employ allied health providers have significantly greater difficulties recruiting for roles, even where these are full-time roles. This typically results in more time spent recruiting and a need to employ less-experienced practitioners requiring additional training and support.

AHPA has argued in previous submissions, including to this inquiry, that addressing shortfalls in supply of allied health services will require long-term approaches focused on both the education pipeline and the development of a coordinated, national workforce strategy for allied health. Such a strategy would mimic the medical workforce strategy and involve a range of coordinated initiatives.

Draft Recommendation 12

The Queensland Government should propose that the NDIS Quality and Safeguards Commission work closely with stakeholders such as the Aged Care Quality and Safety Commission and the Australian Commission on Safety and Quality in Health Care to streamline quality standards and introduce mutual recognition of professional qualifications across relevant sectors.

AHPA supports Draft Recommendation 12, noting that recognition of professional qualifications is not typically an issue for allied health sector. Instead allied health professionals are significantly impacted by existing regulatory requirements, such as Worker Screening and registration with the NDIS Commission, an impact that is likely to increase if additional requirements are introduced by the Aged Care Quality and Safety Commission (ACQSC) and the Australian Commission on Safety and Quality in Health Care (ACSQHC).

Draft Recommendation 13

The Queensland Government should fund a pilot for Allied Health Assistant roles to better understand the role in the context of disability services, particularly in relation to delegation and supervision, and risk management. Greater use of Allied Health Assistants can help alleviate some of the shortage of allied health professionals and provide a pathway for support workers or new workers to the industry seeking to increase their skill levels. The pilot should be led and coordinated by industry.

AHPA is cautiously supportive of additional work in relation to the use of allied health assistant roles in the context of disability services. We note that a range of pilots have already been funded through various Commonwealth grants, without resulting in clear solutions to allied health workforce shortages. While AHPA and its members recognise the potential role and value of allied health assistants, we argue that a range of barriers still exist that are likely to limit the effectiveness of further pilots. These include:

- the absence of a national, NDIA-endorsed policy on the delegation and supervision of allied health assistants, which impacts appropriate plan development and structuring of funding by the NDIA
- current insurance requirements do not work effectively within existing business models, such as where allied health assistants are not employed directly by the allied health professional
- lack of consistency in the education and experience of allied health assistants, which increases risk and uncertainty for allied health providers

AHPA argues that the development of a national supervision and delegation framework, is a necessary pre-condition for any further work. We further argue that participants in regions of workforce shortage, and the allied health sector, would welcome a coordinated workforce plan based on developing and funding models of care that include remote supervision of allied health assistants by allied health professionals, arrangements to support regular visits by the allied health professional, and long-term development of the local allied health workforce. It is highly likely that this plan would be most effective where it is coordinated across health, disability, and aged care.

Draft Recommendation 15

The Queensland Government should propose that the Australian Government introduce a Provider Guarantee as a counterpart to the Participant Service Guarantee.

As part of the Provider Guarantee, the NDIA and the NDIS Quality and Safeguards Commission should institute processes to regularly review their regulatory requirements to ensure that they produce net benefits. A timetable of reviews should be publicly released, with the review process being transparent and involving consultation with the sector.

AHPA supports the proposed introduction of a provider guarantee as one strategy to begin addressing the significant level of uncertainty about future viability that providers of all sizes and types continue to report. From the perspective of the allied health sector, that uncertainty is not driven by the exertion of choice and control by participants choosing to shift their services. Instead it is primarily driven by uncertainty about if and when significant policy changes will be introduced by the NDIA that may impact the viability of their businesses. We also note that an additional significant contributor to the level of uncertainty about the NDIS is the role of, and complex interaction between, different governments and different agencies all of whom may at different times implement policies and programs that impact providers in the sector.

Recent examples of such change include changes to how rural loading classification was determined for the delivery of telehealth services. Changes were made to the classification in the initial Price Guide for 2020/21 without consultation or advance warning with the result that a range of providers of telehealth services had all loading removed from the prices that they could charge. While AHPA does not seek to argue the appropriateness of that change here, it is a clear example of a change that was made with the potential to undermine an existing business model, without clear warning or opportunity to discuss. We commend the NDIA for their responsiveness in addressing this particular issue, but note that this is an issue that is likely to arise again under current processes.

We note further examples of potentially major changes currently being contemplated including the introduction of independent assessments, which may have a significant impact on providers currently providing assessment services for participants, as well as on how providers will be able to support plan reviews. A further example is the proposed introduction of evidence requirements for funded autism spectrum disorder interventions, based on an evidence review conducted for the

NDIA by the Autism Cooperative Research Centre (CRC). We note that this was a review of existing evidence rather than targeted research demonstrating if an intervention is ineffective. Yet it is likely that providers of services that are not well-established in existing research may be unable to continue providing services even if the provider and participant are of the view that the intervention is effective.

In arguing for a provider guarantee, AHPA would like to see greater commitment to early communication and consultation about planned policy changes, including greater transparency about how decision-making processes work, as well as an improved commitment to managing change within the sector, including supporting peak bodies to advise and support members about implementing changes. AHPA argues that the provider guarantee would need to include not only the NDIA but also the NDIS Commission, DSS and all Australian governments involved in making high level decisions about the Scheme.

AHPA strongly supports the importance of regularly reviewing the impact of NDIS Commission and jurisdiction-based regulatory requirements and their impact on providers and participants. AHPA has argued previously that the regulatory requirements imposed by the NDIS Commission on registered providers contain significant inequities for both participants and providers. While we support the intention of the NDIS Commission and the registration process, we have argued at length that imposing different regulatory requirements depending on if someone is an Agency-managed participant in the NDIS, a self- or plan-managed participant, or outside the scheme makes little sense if outcomes for people with disability are the focus. AHPA and its members have argued strongly that as health professionals, allied health providers are subject to a range of regulatory mechanisms designed to safeguard consumers of their services. Any additional regulatory requirements are likely to impact the available workforce for consumers and regular reviews should seek to determine the extent to which there are genuine safety improvements for participants that justify increased provider burdens.

We also note the significant inequity for providers in rural and remote settings, areas with the greatest workforce challenges, who are required to pay significant additional costs in relation to third party audits relating to travel and accommodation costs for providers. There is some evidence to suggest that even without those additional costs, regional providers are typically paying higher audit prices.

Additional options for addressing workforce shortages

AHPA directs the QPC to its previous submission to the inquiry in which we have outlined a range of factors that we have found to contribute to workforce shortages. This includes the need to develop a national allied health workforce strategy, in conjunction with the health and aged care sectors, which provides targeted funding aimed at attracting practitioners to areas of workforce shortage, and supports programs to assist those practitioners to access mentoring and supervision. This will need to be independent of the price structure of the NDIS, which is not well designed to address workforce gaps. For example, feedback from providers in areas of workforce shortage suggests that incomes for early career professionals are at a level that means the income derived from charging for the services of those professionals is insufficient to cover the cost of training and supervision. Moreover we note that it is unrealistic to expect providers to negotiate the cost of training and supervision into service agreements with participants. Participants rightly expect to be charged according to the level of experience and expertise of the practitioner providing services. Recent discussions with DSS suggest that the Australian government continues to consider workforce development in relation to the allied health sector the responsibility of the open market despite ongoing evidence of the failure of this approach.

Draft Recommendation 15

The Queensland Government should propose that the NDIA increase the independence of the NDIA's Pricing Reference Group. A Pricing Commissioner should be appointed who would report directly to the NDIA Board. The role of the Pricing Commissioner should be to:

- chair the Pricing Reference Group
- provide advice on pricing methodologies and parameters
- ensure that the NDIS Quality and Safeguards Commission has significant input into the annual pricing review process and is able to review proposed changes prior to changes being made.

The Pricing Commissioner should be supported by a secretariat independent of the NDIA.
The Disability Reform Ministers' Meeting should issue an annual risk appetite statement providing advice to the Commissioner and the NDIA Board on the appropriate balancing of competing participant outcome, market development and financial sustainability objectives in regulating prices.
To improve transparency of decision-making, Board decisions and supporting information should be made public.

These arrangements should be reviewed as part of the Australian Productivity Commission's scheduled 2023 review of NDIS costs.

AHPA is cautiously supportive of the proposal for a more independent Pricing Reference Group, provided it does not reduce the degree of engagement and consultation with the allied health provider sector. The sector has welcomed work by the NDIA pricing team in recent years, which has resulted in a far higher level of transparency about the pricing process, alongside far better opportunities to participate in consultation processes. This has resulted in a higher degree of confidence in the price review process among practitioners and the professions. Yet we acknowledge that there is still capacity for further improvement, particularly in relation to final decision-making and the reasoning behind Board decisions. By better clarifying the price review process, including the intended outcomes or areas of inquiry, and the type of information sought, providers are likely to better accept decisions such as the lack of indexation for therapy line items in the last price review despite indexation of other pricing. Without an indication in consultation papers that indexation was subject to review or that evidence was required to justify indexation of therapy services alongside other line items, the sector did not respond specifically and may have been adversely impacted as a result. AHPA argues that the focus of any changes should build on the success of recent initiatives and focus on further improving sector understanding and contribution to the price review process.

We argue that a key support for improved contribution by the sector would be increasing access to de-identified scheme pricing data. The sector is largely limited to anecdotal feedback and individual examples when seeking to build the case for any adjustments to pricing rates or structures. Greater access to data, as is currently available for schemes such as Medicare, would represent a positive step forward.

AHPA welcomes the proposal to increase transparency in relation to Board decisions about pricing. Previous experiences in relation to both internal and independent price review processes have been largely opaque in relation to the basis for final decisions. Recent experience suggests that at times the Board may reject recommendations from the price review team, based on consultation with the sector, without providing guidance about how these decisions were reached. Without understanding the rationale for why those recommendations were not accepted, it is difficult for the sector to

provide effective support for future price reviews and to more effectively address pricing issues flagged by members.

As a final note, AHPA argues that pricing is not simply a matter of determining the correct hourly rate (or indeed removing caps on pricing). Instead we note that pricing issues continue to arise as a result of differing understanding among participants and providers of which services can be charged for and which must be borne by providers. Additional work to further define what can, and what cannot, be charged for would improve consistency and address some aspects of concern about current pricing rates. In particular, improvements here may reduce perceptions among providers that there are significant costs associated with operating in the scheme that cannot be recouped from participant fees.

Draft Recommendation 20

The Queensland Government should propose that the NDIA provide administrative payments data to an accredited provider/s for the establishment of a price comparator website for use by all providers, participants and other interested stakeholders.

AHPA does not support the establishment of a price comparator website for use by providers, participants and other stakeholders, as outlined in Draft Recommendation 20, without further consultation to determine how to create meaningful and accurate comparisons between services. We argue that without significant work to improve the capacity of participants to compare the relative quality of two different services, this will serve only to drive participants to the lowest cost service. It is also likely to increase tension between participants and providers when negotiating service agreements without a clear rationale for how this will improve the scheme.

Given the potentially significant variation in the particular skills, expertise and specialisation of allied health services, the different costs associated with providing different services in different geographic locations including different wages in different jurisdictions, and the potential for providers to charge differently in relation to non-face-to-face time and other costs, it will be extremely difficult to make meaningful comparisons.

Draft Recommendation 27

The Queensland Government should propose that the NDIS Thin Markets Project prioritise the development of a thin market framework that:

- establishes arrangements for identifying thin markets and developing timely responses
- responds to the underlying causes of thin markets on a case-by-case basis
- considers options for improved market coordination, including mechanisms to facilitate coordinated purchasing among participants
- considers alternative commissioning models for purchasing supports where other market-oriented options are not viable
- ensures thin market responses are adequately and consistently evaluated and reported.

AHPA supports Draft Recommendation 27, arguing that the development of a thin market framework is a necessary foundation for both short- and longer-term supply issues impacting participants in Queensland and other parts of Australia. We support the proposals in this recommendation as appropriate means of addressing short-term access issues. In addition to the elements of the framework outlined in this recommendation, we argue that the market should have greater access to information about potential thin markets, and about any interventions that are

being made in those markets through improved reporting, real-time reporting. We argue that this would provide an improved means of identifying areas of need and allowing the market to respond to these—for example, a provider in a different region may be able to provide appropriate remote, telehealth based services if aware of demand—and as a way of ensuring that any providers that may consider offering services in an area of market shortage are aware of any market interventions that are in place and can evaluate how these might impact them.

In addition to the proposals in Draft Recommendation 27, AHPA argues strongly for the need to consider longer-term interventions to address supply issues where these may be required. AHPA holds the strong view, based on extensive discussion with members, that a more active form of market stewardship is required by the NDIA, DSS and individual governments, to ensure short- and long-term supply of services in all areas. The current dependence on providers opting to move into areas of market shortage appears to be failing and will require other interventions, ideally as part of a more coordinated workforce strategy.

AHPA argues that this is particularly important in more remote areas—while thin markets do exist in larger population centres, these are generally more likely to be addressed through a combination of short-term market interventions and improved information for providers about market gaps. However, in rural and remote regions, workforce issues are typically prevalent not just in relation to disability services but also in relation to health services more broadly. The extensive work undertaken by the National Rural Health Commissioner in relation to allied health identified a broad range of issues and some potential solutions. These included arguing for better data gathering, improved capacity to coordinate purchasing of services across funding schemes and, importantly, recognised the importance of improving education pathways for rural areas. Improved coordination with the education sector provides a major opportunity to train practitioners, at least partly, in the regions they are most needed. This approach has been shown to be more effective than other programs to encourage qualified practitioners to move into rural locations.

The development of a coordinated workforce strategy for allied health, along similar foundations as the one being developed for the medical workforce[i], is considered an essential foundation for meeting the needs of people with disability and other cohorts.

Draft Recommendation 30

To improve the evidence base of what works for the delivery of the NDIS and disability supports to Aboriginal and Torres Strait Islander people, the Queensland Government should:

- evaluate and report on initiatives for which the Queensland Government is responsible
- propose that the NDIA evaluate and publicly report on initiatives undertaken to improve delivery of the NDIS to Aboriginal and Torres Strait Islander people with a disability, their families, carers and communities.

AHPA supports the proposal in Draft Recommendation 30 to evaluate and report on both Queensland Government and NDIA-led initiatives with a focus on understanding how best to increase access to NDIS supports and services for Aboriginal and Torres Strait Islander people.

As part of the process of evaluating and reporting on current initiatives, AHPA calls for the need to focus on the effectiveness of workforce initiatives aimed at increasing the number of Aboriginal and Torres Strait islander health professionals, including Aboriginal health workers and allied health assistants, as well as allied health professionals providing services to their communities, regardless of whether these are funded under the NDIS or through other initiatives. Engagement with

Aboriginal and Torres Strait Islander groups including our colleagues at Indigenous Allied Health Australia (IAHA), suggests that increasing access to Aboriginal health professionals is a highly effective means of improving the experience of aboriginal people with disability.

Draft Recommendation 35

The Queensland Government should evaluate the effectiveness and efficiency of its interventions to promote access to the NDIS. That evaluation should consider all impacts, including but not limited to the effects on participants, providers, adjacent markets, other Queensland Government services, the Australian Government and NDIA, and adjacent markets (such as allied health).

As part of developing a robust and complete approach, the Queensland Government should consider evaluating and quantifying the impact of NDIS transitions on mainstream government services in Queensland, for example the impact of NDIS access on hospital resources.

AHPA supports the proposal to evaluate the impact of the introduction of the NDIS and related transitional arrangements associated with the introduction of the NDIS on other services, including hospital-based services and the adjacent allied health market. AHPA has received anecdotal feedback from a range of sources about the impact of the NDIS on the broader market including:

- an increasing number of hospital services becoming registered NDIS providers resulting in reduced access to services for those outside the NDIS
- reduced access to allied health services funded under other schemes such as Medicare and DVA where fees are well below market rates and those available under the NDIS, due to high demand for NDIS services
- reduced access to disability services for people with disability not deemed eligible for the NDIS.

AHPA notes that it does not have access to data to confirm the feedback it has received but considers it important for the Queensland Government to undertake work to measure the impact of the NDIS on service access as a foundation for potential policy and program responses.

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[i] https://www1.health.gov.au/internet/main/publishing.nsf/Content/Health%20Workforce-nat-med-strategy