

# National Disability Insurance Scheme

## Transition to full scheme - Regulation Impact Statement

May 2015

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## ABBREVIATIONS

ABI	Acquired Brain Injury
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AFDO	Australian Federation of Disability Organisations
AIHW	Australian Institute of Health and Welfare
ASD	Autism Spectrum Disorder
CAC Act	Commonwealth Authorities and Companies Act
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CSDA	Commonwealth/State Disability Agreement
DAAWS	Disabled Australian Apprentice Wage Support
DCAF	DisabilityCare Australia Fund
DCSI	Department of Communities and Social Inclusion
DES	Disability Employment Service
DS NMDS	Disability Services National Minimum Data Set
FaHCSIA	Department of Families, Housing, Community Services, and Indigenous Affairs
FTE	Full time equivalent
GDP	Gross Domestic Product
GP	General Practitioner
HACC	Home and Community Care
ICT	Information and communications technology
ISP	Individual Support Package
LACs	Local Area Coordinators
MS	Multiple Sclerosis
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDA	National Disability Agreement
NDCA	National Disability Carers Alliance
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NGO	Non-Government Organisation
NIIS	National Injury Insurance Scheme

NSW	New South Wales
NT	Northern Territory
PC	Productivity Commission
QA	Quality Assurance
QLD	Queensland
RIS	Regulation Impact Statement
RTO	Registered Training Organisation
SA	South Australia
SCRGSP	Steering Committee for the Review of Government Service Provision
TAS	Tasmania
TOR	Terms of Reference
TTY	Teletypewriter – a special type of phone.
VIC	Victoria
WA	Western Australia

## BACKGROUND

### Prevalence of disability

The Australian Bureau of Statistics (ABS) estimates that 4.2 million people in Australia in 2012 (or 18.5 per cent of the Australian population) had a disability (ABS 2013<sup>1,2</sup>).

Approximately 2.51 million were under the age of 65 (12.8 per cent of the under 65 population).

Of those aged under 65, 2.15 million had a specific core activity limitation and/or schooling or employment restriction:

- 302,200 (1.5 per cent of those under 65) had a profound<sup>3</sup> core activity limitation;
- 421,500 (2.1 per cent) had a severe core activity limitation;
- 1,112,400 (5.7 per cent) had a moderate or mild core activity limitation; and
- 342,850 (1.6 per cent) had schooling or employment restrictions only.

Indigenous people have significantly higher rates of profound or severe core activity limitation than non-Indigenous people. Disability data on 'core activity need for assistance' are available from the ABS 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS).

Nationally, 10.3 per cent of Indigenous people aged 18 years and over reported a profound or severe core activity restriction in 2008, around twice the rate for non-Indigenous people (4.7 per cent) (ABS 2009). The disparity between Indigenous and non-Indigenous people was consistent across age groups.<sup>4</sup>

### Users of disability services

According to the Australian Institute of Health and Welfare (AIHW), around 312,539 people received disability support services in 2012–13.<sup>5</sup> Intellectual disability is the most common disability among people who use disability services (32 per cent), followed closely by physical disability.<sup>6</sup>

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<sup>1</sup> ABS 2013, *Disability, Ageing and Carers Australia: Summary of Findings 2012*, Cat. no. 4430.0, Canberra.

<sup>2</sup> For the purposes of the survey, disability was defined as 'any limitation, restriction or impairment which restricts everyday activities and has lasted or is likely to last for at least six months'. Examples of disability 'range from loss of sight that is not corrected by glasses, to arthritis which causes difficulty dressing, to advanced dementia that requires constant help and supervision'.

<sup>3</sup> A profound limitation is where a person is unable, or always needs assistance, with communication, mobility and/or self-care tasks. A severe limitation is where a person sometimes needs assistance with these tasks, has difficulty understanding or being understood by family or friends, or can communicate more easily using sign language or other non-spoken forms of communication.

<sup>4</sup> Centre of Aboriginal Economic Policy Research and the Australian Institute of Health and Welfare, *Indigenous Australian and the National Disability Insurance Scheme: The extent and nature of disability, measurement issues and service delivery models*, October 2012, pages 8-10.

<sup>5</sup> AIHW, *Disability support services: services provided under the National Disability Agreement 2012–13*, p. 1.

<sup>6</sup> *ibid.*, p. 1.

The majority of service users needed assistance with independent living (64 per cent), activities of daily living (55 per cent) and with work, education and community living (61 per cent).<sup>7</sup> This was followed closely by community access, accommodation support and respite (each at about 10–20 per cent respectively). There is some overlap since some people may use more than one type of support. The table below<sup>8</sup> taken from the 2012-13 AIHW report<sup>8</sup>, provides a summary of the users of disability support services provided under the National Disability Agreement by service group in each state and territory.

**Table 1: Services users, service group by state and territory, 2012–13**

Service group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT(a)	Total
Accommodation support	10,153	14,821	6,761	4,252	5,267	1,326	475	553	43,592
Community support	37,307	44,629	19,014	14,165	13,593	4,929	4,092	1,862	139,142
Community access	15,703	16,773	9,380	4,752	6,042	1,567	700	521	55,403
Respite	10,580	16,042	5,041	3,549	1,876	471	327	250	38,072
<i>Total state/territory services</i>	<i>53,128</i>	<i>72,170</i>	<i>27,583</i>	<i>17,187</i>	<i>18,386</i>	<i>6,547</i>	<i>4,673</i>	<i>2,757</i>	<i>201,675</i>
Employment	43,777	31,486	26,667	10,536	12,846	3,061	1,801	579	129,698
<b>Total</b>	<b>91,802</b>	<b>98,948</b>	<b>51,289</b>	<b>24,857</b>	<b>29,055</b>	<b>9,166</b>	<b>6,187</b>	<b>3,244</b>	<b>312,539</b>

(a) From 2012–13, the Northern Territory DS NMDS data includes individuals using BCC services.

Notes 1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the 12-month period. 2. Service user data were not collected for all NDA service types. 3. Totals for Australia may not be the sum of service components because individuals may have used services in more than one state or territory during the 12-month period. 4. Total service users may not be the sum of service group components because individuals may have used more than one service group over the 12-month period.

The number of service users generally increased over the 5 years to 2012–13 (by 12% between 2008–09 and 2012–13), but there was a slight (2%) decrease between 2011–12 and 2012–13. The change in the number of service users was not evenly spread across jurisdictions or service groups and reflected both an actual decrease in service users in some jurisdictions and some changes in the way the data were collected or reported. For example, in 2012–13:

- improved client linkage and continuous data-quality initiatives in Victoria resulted in a decrease in the number of Victorian service users reported. In particular, the improvement in completeness of Victorian statistical linkage keys contributed to a reduction in double counting, and an activity previously classified under ‘community access’ was amalgamated under ‘community support’ in that jurisdiction from 2012–13 onwards;
- an audit review in South Australia identified anomalies in reporting by some service providers, which resulted in a number of clients no longer being reported; and

<sup>7</sup> *ibid.*, p. 2.

<sup>8</sup> AIHW, *Disability support services: services provided under the National Disability Agreement 2012-13*.

- the reason for the decrease in the number of open employment service users is not clear but may reflect a slight reduction in demand for this program compared with 2011–12.<sup>9</sup>

There were decreases in the use of some service types between 2011-12 and 2012-13, notably community access, which decreased by around 12%. In contrast, the use of accommodation support and respite both increased over that time (by 5% and 3% respectively). This compares with a decrease in accommodation support and an increase in community access in the 12 months prior to that.

Most users of disability support services are located in major cities and inner regional areas.

**Table 2: Users of disability support services provided under the National Disability Agreement, by geographic location, 2012-13**

	Major cities	Inner regional	Outer regional	Remote	Very remote	Not stated	Total
(%)	62.8 %	24.1 %	10.5 %	1.4 %	1.0 %	0.2 %	100 %

Source: Steering Committee for the Review of Government Service Provision 2014, *Report on Government Services 2014*, Productivity Commission, Canberra, Table 14A.4.

## Providers of disability services

Most providers of disability support services are not-for-profit organisations, many of whom were founded as charities or self-help groups of parents, families and friends of people with disability. Their primary objective is to support improvement in the lives of people with a disability, rather than to meet commercial objectives.<sup>10</sup> Government providers also play a significant role.

The majority of providers rely on payments from state/territory (state) governments as their major source of income to continue their day to day operations. The Australian Government also grant funds a range of organisations. As the main purchaser, governments determine the type, quantity and price of services provided to people with a disability, and government regulation provides for safety and quality standards. Services are provided according to the amount of funding provided instead of the actual price of support for an individual. Reporting to government has focused on outputs (the number of services provided) with a limited focus on the outcomes achieved. In addition to government funding, the sector has relied on ‘charitable’ structures and contributions from the Australian public.<sup>11</sup>

<sup>9</sup> AIHW, *Disability support services: services provided under the National Disability Agreement 2012-13*.

<sup>10</sup> PricewaterhouseCoopers (unpublished): Planning for a sustainable disability sector, pages 14, for the Department of Families, and Housing, Community Services and Indigenous Affairs.

<sup>11</sup> PricewaterhouseCoopers (unpublished): Planning for a sustainable disability sector, page 14, for the Department of Families, and Housing, Community Services and Indigenous Affairs.

In 2012–13 there were 2,151 disability support providers funded by state and Commonwealth governments throughout Australia, managing 15,659 service-type outlets.<sup>12</sup> Available supports included:

- accommodation support — large residential institutions (more than 20 people) offering 24-hour care, hostels, group homes, attendant/personal care, in-home accommodation support, alternative family placements, and other accommodation support
- community support — therapy for individuals, early childhood intervention, behaviour intervention, counselling, regional support and support teams, case management and coordination, and other community support
- community access — learning and life-skills development and recreation/holiday programs
- respite — in own home, centre based, host family respite and other flexible arrangements
- employment — open employment, supported employment or a combination of both
- advocacy, information/referral services, mutual support or self-help groups, and alternative formats of communication

The majority of service-type outlets (60.9 per cent) are located in major cities and a small number (3.2 per cent) in remote or very remote areas. The remainder of service-type outlets (36.6 per cent) are located in inner (26 per cent) and outer (10.6 per cent) regional areas.<sup>13</sup>

Current ABS surveys do not isolate people working in disability service provision. However, estimates of the disability-related workforce were prepared by PricewaterhouseCoopers (PwC) for the then Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) by cross-tabulating occupations and industry classes from the 2006 Census. Applying this methodology to the 2011 Census showed a 39 per cent increase in the estimated disability-related workforce between 2006 and 2011 (excluding management and administrative staff). Variations by occupation were: ‘allied health welfare professionals’ - 53 per cent; ‘support workers’ - 44 per cent; ‘Nursing’ - 17 per cent and ‘Community Care Workers’ - 14 per cent.

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<sup>12</sup> AIHW, *Disability support services: services provided under the National Disability Agreement 2012–13*, p. 11. Includes Commonwealth funded open employment outlets (1,958 outlets) as open employment is not funded through the NDIS.

<sup>13</sup> *ibid.*, p. 18. Note: Four service-type outlets listed their remoteness area as unknown.



**Table 3: Disability-related workforce, net growth, 2006 to 2011 by state and territory**

Occupation Group	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Allied Health Welfare Professionals	4 349	4 606	2 080	1 110	1 273	442	271	178	14 400
Nursing	1 108	813	554	310	668	67	51	51	3 622
Community Care Workers	4 436	2 759	2 159	2 101	998	347	206	217	16 223
Support Workers	17 682	13 750	10 846	4 824	5 093	2 345	727	490	55 763
<b>Total (Number)</b>	<b>27 700</b>	<b>21 930</b>	<b>15 966</b>	<b>8 465</b>	<b>8 114</b>	<b>3 190</b>	<b>1 262</b>	<b>945</b>	<b>87 579</b>
<b>Variation since 2006</b>	<b>9 026</b>	<b>5 415</b>	<b>4 400</b>	<b>2 567</b>	<b>1 937</b>	<b>796</b>	<b>293</b>	<b>334</b>	<b>24 774</b>
<b>% Variation</b>	<b>48%</b>	<b>33%</b>	<b>38%</b>	<b>44%</b>	<b>31%</b>	<b>33%</b>	<b>30%</b>	<b>55%</b>	<b>39%</b>

Source: Sphere (2014) 'National disability related workforce, methodology and modelling results', based on custom-ordered ABS 2006 and 2011 Census data of selected occupations and industries

The total projected workforce, based on a continuation of past net growth, is estimated to be around 116 200 by 2016 and 144 700 by 2021, compared with PwC estimates of the current workforce of 80,100 in 2013 and a required workforce under the NDIS of 165,500 in 2018.

## Role of governments

In Australia, the provision of disability services for personal care and support is currently the responsibility of state governments. State governments are responsible for assessing the needs of people with disability, and funding and coordinating the services provided to them.

The Australian Government provides income support (Disability Support Pension) and disability-specific payments such as the Mobility Allowance, Carer Allowance, Carer Payment and Child Disability Assistance Payment. It also provides funds for employment services and has a role in mental health and other programs such as autism.

## National Disability Agreement

The National Disability Agreement (NDA) defines the roles and responsibilities of the Australian and state governments in the provision of services and supports to people with disability and their carers.<sup>14</sup>

The **Australian Government** is responsible for:

- provision of employment services for people with disability (which includes regulation, service quality and assurance, assessment, policy development, service planning, and workforce and sector development) in a manner that most effectively meets the needs of people with disability consistent with local needs and priorities;

<sup>14</sup> See [http://www.federalfinancialrelations.gov.au/content/national\\_agreements.aspx](http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx), (accessed 9 February 2014).

- provision of income support targeted to the needs of people with disability, their families and carers;
- provision of funds to states to contribute to the achievement of the NDA objective and outcomes;
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with state governments; and
- ensuring that Commonwealth legislation and regulations are aligned with the national policy reform directions and the *United Nations Convention on the Rights of Persons with Disabilities*.

**State governments** are responsible for:

- the provision of specialist disability services, except disability employment services (which includes regulation, service quality and assurance, assessment, policy development, service planning, and workforce and sector development) in a manner which most effectively meets the needs of people with disability, their families and carers, consistent with local needs and priorities;
- ensuring that state legislation and regulations are aligned with the national policy and reform directions; and
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with the Australian Government.

**Australian and state governments are jointly responsible** for:

- development of national policy and reform directions to meet the agreed objectives and outcomes of the NDA;
- funding and pursuing research that provides an evidence base for national policy and reform directions;
- developing and implementing reforms to improve outcomes for Indigenous people with disability; and
- the provision of data, including a commitment to providing data for the Disability Services National Minimum Data Set and a commitment to the improvement of data.

## **National Disability Standards**

National Standards for Disability Services were first developed in 1993 and were revised in 2013 to reflect current language, philosophies and service models, particularly the move to individualised supports and person-centred service delivery.

There are six National Standards that apply to disability service providers:

- 1. Rights:** The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence.
- 2. Participation and Inclusion:** The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.

3. **Individual Outcomes:** Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.
4. **Feedback and Complaints:** Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.
5. **Service Access:** The service manages access, commencement and leaving a service in a transparent, fair, equal and responsive way.
6. **Service Management:** The service has effective and accountable service management and leadership to maximise outcomes for individuals.

### Funding for disability services

Total government expenditure on specialist disability services under the National Disability Agreement (NDA) in 2012-13 was \$7.2 billion (a real increase of 3.7 per cent on 2011-12). Of this, \$5.0 billion (69.4 per cent) was funded by the states. The Australian Government provided \$2.2 billion (including \$1.3 billion in transfer payments to the states).

Direct government expenditure on specialist disability services (after the costs of administration) under the NDA was \$6.7 billion in 2012-13. States spent \$3.3 billion on accommodation support, \$1.2 billion on community support, \$653 million on community access services and \$416 million on respite services. The Australian Government spent \$680 million on employment services, \$70 million on community support services and \$75 million on other support services.

**Table 4: Real Government direct service delivery expenditure under the National Disability Agreement, by service type, 2012-13 (\$m)**

Service Type	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Aus Govt
Accommodation Support	1173.0	649.8	606.2	424.9	287.0	95.5	58.0	47.5	..
Community Support	233.7	571.4	167.5	111.2	58.7	19.8	9.3	12.3	70.3
Community Access	300.4	45.6	145.7	87.3	38.7	24.2	8.5	3.1	1.0
Respite	148.9	97.0	80.7	36.4	34.3	7.4	7.6	3.3	8.8
Employment	..	..	..	..	..	..	..	..	680.3
Advocacy, information & print disability	11.1	8.3	13.0	5.5	1.6	2.6	1.4	0.3	18.4
Other support	33.5	43.7	31.4	22.2	35.9	0.4	1.3	3.0	75.1
<b>Total</b>	<b>1900.6</b>	<b>1415.8</b>	<b>1044.5</b>	<b>687.6</b>	<b>456.3</b>	<b>149.9</b>	<b>86.1</b>	<b>69.5</b>	<b>853.9</b>

Source: Steering Committee for the Review of Government Service Provision 2014, *Report on Government Services 2014*, Productivity Commission, Canberra, Table 14A.8.

## Quality Assurance and Safeguards Framework

Quality and safeguarding arrangements for providers of disability supports are currently managed by the 'terms and conditions' in contractual agreements between providers and the government agencies that provide funding. These agreements can also refer to additional requirements in state legislation that providers need to meet. For example, all jurisdictions have either included the National Standards for Disability Services<sup>15</sup> in their disability and other relevant legislation, or mapped these to existing standards to ensure each standard has the same meaning across Australia. To demonstrate they are meeting these standards, most state governments and the Commonwealth currently require providers to submit to an independent quality assessment or quality evaluation process within 12 months of their funding agreement commencing.

Most states require checks for those who are working with children and some have specific requirements for those who are working with vulnerable people. Employee recruitment requirements are also a part of many funding agreements between state governments and providers of supports.

All states require those working with children (including children with disability) to undergo risk-based assessments by a government screening agency. In addition, most current funding agreements include requirements that staff undergo police and referee checks at specified intervals. However, the information taken into account and ongoing monitoring arrangements differ substantially between jurisdictions. This is problematic given that workers may move interstate.

### Need for a nationally consistent Quality and Safeguarding Framework

In the context of managing the transition to an NDIS, governments need to reconsider protections for people with disability and arrangements to ensure supports are of a high quality.

1. *Greater choice and control.* Existing arrangements for quality and safeguarding are based on funding agreements between governments and providers of supports. These funding agreements set quality expectations for participants and providers and aim to protect people with disability from harm. The NDIS, in contrast, provides the funding to individual participants who then make choices about their supports. This creates the need for a new quality and safeguarding framework because it is the person with disability, not government, who is able to make judgements and decisions about the quality of providers. It also means a different mix of providers will enter the market, requiring a new approach to quality and safeguarding.
2. *Governments will no longer be purchasing specialist disability services.* In the NDIS, the primary funding relationships will be between the person with disability and the

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<sup>15</sup> The standards can be found at: [www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/new-national-standards-for-disability-services](http://www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/new-national-standards-for-disability-services).

provider of supports. This means the Commonwealth and states will not continue to have funding agreements with providers. The current quality assurance arrangements, and some of the current safeguards, will therefore no longer apply.

3. *An opportunity exists to streamline requirements, reduce red tape and promote the market for supports.* The development of a new quality and safeguarding framework is an opportunity to simplify the rules and make them the same across the states. This should facilitate the start-up of new national providers and offer greater choice to people with disability in the scheme.
4. *There is a greater need for National consistency.* The NDIS is a national scheme and as such needs a consistent quality and safeguarding framework for all jurisdictions that it operates across.

For these reasons, the Council of Australian Governments (COAG) Disability Reform Council (DRC) consulted with interested parties during February to early May 2015 on a new quality and safeguarding framework that is consistent with the overall approach of the NDIS.

Decisions on a new framework will be taken by Ministers and implemented as the NDIS transitions to full scheme.

## **PROBLEM**

Following general community concern, the issue of the long-term care and support of people with a severe or profound disability was referred to Productivity Commission (PC) in February 2010.

The PC's final report, Disability Care and Support, was released on 10 August 2011.

The PC found that the current disability support system was underfunded, unfair, fragmented and inefficient. It gave people with disability little choice over the supports provided and no certainty of ongoing access to appropriate supports. It increased the long term cost of support by failing to intervene early. It used out-dated service models and devalued the roles of families and carers.

The PC found that there is significant unmet need for disability services in Australia, and this has been the case for decades. It has led to rationing and the growth of waiting lists, which leads to greater unmet demand. It affects a wide range of everyday activities including self-care, mobility, communication, cognition, and transport. Two-thirds of people requiring assistance with core activities only receive informal support. People who only receive informal support make up the vast majority of those indicating that their core needs are fully met. If informal care cannot be sustained, there will be increased demands on an already rationed formal system.

The PC noted that the level of unmet demand was difficult to predict as many people do not apply for support due to excessive and uncertain waiting times or because the service required is simply not available. Waiting times for basic support are often several years with longer waiting periods for supported accommodation, and therapies (12 to 18 months)

which then impacts on therapeutic outcomes. As a result, the PC found that most people who require assistance with core activities had their needs met but with informal support alone.

The PC also observed variation in the amount of funding per service user and service coverage (the number of people using each type of support as a proportion of the potential population). The PC noted the trade-off between coverage and expenditure per service user - more support to fewer people or less support to more people – and noted that no jurisdiction had an absolute advantage in both coverage and funding per service user.

Further, the PC noted that the combined coverage for all support varied significantly between jurisdictions showing ‘that a considerable majority of the potential population do not receive any such services.’<sup>16</sup> In recent discussions with the states for transition to full scheme, Queensland appears to have the highest level of unmet need and the population with the highest proportion of new packages.

State and territory governments currently make varying contributions to disability services in their jurisdictions from their own funds (table 5). In theory, some of the differences could reflect differing levels of effectiveness of state and territories in achieving outcomes for people with a disability, or differing unit costs. Accordingly, a state might spend less per person because they can achieve the same or better outcomes as some other jurisdiction at a lower cost. Apart from the Northern Territory, where unit costs of delivering supports appear to be significantly higher than elsewhere given its significant indigenous population (AIHW 2002, p. 62), neither different efficiency or unit costs have a major role in explaining the overall variations in spending between jurisdictions. (The variations in coverage ratios discussed below are a far more significant factor.)<sup>17</sup>

**Table 5: Providing specialised supports for people with disability**

State-funded spending under the National Disability Agreement<sup>a</sup>

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
<b>Own state funded \$ per user<sup>a</sup></b>	32 610	18 437	32 416	27 273	13 896	22 648	15 784	26 526
<b>Coverage (2008-09)<sup>b</sup></b>	19.0	39.2	15.2	24.6	40.4	20.6	43.5	26.9
<b>Own \$ per potential population (2009-10)<sup>c</sup></b>	6 200	7 232	4 911	6 703	5 617	4 667	6 861	7 146
<b>Spending share less population share (2009-10)<sup>d</sup></b>	0.8	3.1	-3.3	-0.3	-0.5	0.2	-0.2	0.2
<b>Trend growth rate in real spending from 2004-05 to 2009-10 (%)<sup>e</sup></b>	6.4	0.9	11.7	6.8	3.3	2.5	1.3	7.0

<sup>a</sup> This uses the 2008-09 user population and 2009-10 own state *funding* of disability supports and services under the NDA (and so does not include the value of transfers from the Australian Government). It includes administrative costs and payroll taxes. Funding of non-NDA disability supports and services by state and territory governments (such as HACC services, community mental health and taxi vouchers) is not included. This is because consistent and accurate data on such funding by each state and territory are not readily available. Since jurisdictions may spend more or less than the average in this area, this would alter the above numbers — but in all likelihood not to a qualitatively different degree. <sup>b</sup> Coverage is the number of users in 2008-09

<sup>16</sup> Productivity Commission, pages 137-138.

<sup>17</sup> Productivity Commission, page 684.

as a percentage share of the number of people with severe or profound disability aged 0–64 years from the 2009 SDAC. **c** This is own-state spending in 2009-10 per person with a severe or profound disability aged 0–64 years in 2009. **d** Calculated as the difference between a jurisdiction's share of total state and territory expenditure (own-state only) and its share of the Australia-wide population of people with a severe or profound disability aged 0–64 years. Accordingly, a positive number means that a jurisdiction is spending more than its disability population share, and is relatively more generous than the average. **e** This is the trend growth rate estimated by fitting the log of real expenditure (2009-10 prices) using ordinary least squares from 2004-05 to 2009-10.

*Sources:* Calculations based on SCRGSP (2011) and analysis of unpublished ABS 2009 SDAC unit record data.

Several patterns are apparent in the data. Some jurisdictions serve a much higher share of the potential population of service users. For example, the share is high in Victoria while Queensland has a much lower share.

Typically, those jurisdictions that cover relatively small shares of the potential population spend relatively highly on those they do support. So Queensland spends around \$32 000 per service user, whereas Victoria spends around \$18 000 per user. The most likely reason for this pattern is that states like Victoria also provide supports for people who are not in crisis, and who need lesser amounts. This brings down their average spending.<sup>18</sup>

The PC also observed that the level of funding provided for disability support services also varies between regions within jurisdictions. The PC provided as an example HACC services in Victoria where, for historical reasons, funding per potential population varied between regions by as much as 35 per cent. It also noted that people in remote areas were also less likely to use government funded services since less service per potential population were available.<sup>19</sup>

Consequently, people in non-metropolitan regions either went without, or travelled long distances to receive support. Because of targeting, cost efficiency and population density, often people in non-metropolitan areas are also likely to be lacking other human and support infrastructure meaning that they go without any form of support.

In addition, even within jurisdictions, services were delivered by a multitude of programs that were separately funded and managed. Programs often lacked certainty over funding, were uncoordinated in regard to overlaps as well as gaps in services, and added to complexity and navigational issues for users since people needed to deal with a number of programs and agencies to receive the full suite of services.

The PC also found that underfunding is only part of the problem. The PC identified systemic failures that include:

- the fragmented structure of the disability system, and a lack of coordination, have made it extremely difficult for service users and their families to access services.
- a lack of portability of disability supports between states.
- out-dated service models which distort allocation decisions.
- a lack of person-centred planning and a general lack of consumer choice.

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<sup>18</sup> Productivity Commission, page 685.

<sup>19</sup> Productivity Commission, page 138.

- a lack of certainty around waiting times and the availability of supports mean that families can not plan for the future.
- more timely and forward looking service delivery could save the system money.
- the lack of essential frameworks that would allow the system to identify and solve its problems. These include a strong governance structure and data systems.

The incremental annual cost when fully operational in 2018-19 (the difference between what is currently spent on disability support and what would be spent under a national disability insurance scheme) was estimated at around \$6.5 billion.

### **THE PC'S PREFERRED APPROACH**

In response to the problems identified, the PC proposed a new approach to disability support arrangements. Under its preferred approach, Australians would contribute to, and be covered by a national disability insurance scheme (NDIS).

The NDIS would apply to all Australians with a disability. It would provide information and referrals, and provide 'funded support packages' for people with significant and permanent disability whose assistance needs could not be met without taxpayer funding.

The NDIS would provide 'reasonable and necessary' support across the full range of long-term disability support currently provided by specialist providers, as well as support the development 'by the market of innovative support measures'. Services such as health, public housing, public transport, mainstream education and employment services would remain outside of the NDIS with the NDIS providing referrals to these services.

Income support would not be provided by the NDIS (continued under the Disability Support Pension by the Australian Government).

Importantly, the PC recommended that the assessment of 'reasonable and necessary care and support needs' be across a 'broad range of life activities, and should take account of an individual's aspirations and the outcomes they want to achieve' (recommendation 7.1).

The PC estimated the gross cost of the NDIS at full operation in 2018-19 at \$13.6 billion or:

*around 4 per cent of existing tax revenue for all levels of government. (PC 2011, p. 781)*

The most significant component of this cost was for the provision of tier 3 individual supports (individually funded support packages).

*It is estimated that after the gradual introduction of the scheme over several years, the annual gross cost of tier 3 individual supports (which covers around 411 250 people) in 2018-19 would be between \$11.1 billion and \$14.1 billion (\$12.6 billion on average), with care and support being the largest component of costs. (PC 2011, p. 776)*

Other costs identified in running the NDIS when fully operational (in 2018-19) were estimated at around \$1.1 billion (9 per cent of outlays). These comprised:



- \$300 million for management and staff (finance, human resources, legal, program management, analysts, researchers, data minors, auditors, monitoring and compliance), assessors, call centres, office space and IT (including an electronic record for people with a disability)
- \$550 million for local area coordinators
- \$13 million for dispute resolution
- \$3 million for advertising campaigns
- \$200 million for capacity building including funding for tier 1 and tier 2, funding for disability support organisations, funding for assisting service providers in transitioning to the new system, an innovation fund, small payments to service providers for handling added referrals from people with disabilities stemming from the NDIS, and funding for an emergency response. (PC 2011, pp. 776-777)

Because of the complexities of implementation, the PC's vision was that the NDIS would be rolled out in a few regions in Australia in mid-2014 and would be progressively extended to be fully operational covering all Australia by 2018-19 (recommendation 19.1).

#### **HOW THE PC MODEL WOULD OPERATE**

The PC envisaged an insurance based system comprising three tiers:

**Tier 1** – All Australians would be eligible to be covered by the NDIS in the event of a disability. All taxpayers would share the cost of disability support services provided by the NDIS through taxation;

**Tier 2** – All Australians with a disability and their carers/families would be provided information and referral services including information about the most effective care and support options, linkage and referral to cost-effective services; and

**Tier 3** – All Australian people with a permanent disability or long term limitations (intellectual, physical, sensory, psychiatric who have significantly reduced functioning); who require and would benefit from early intervention; and people with significantly reduced functioning in self-care, communication, mobility or self-management who require significant ongoing support.

Assessment of people with disability would identify the support required to address an individual's 'reasonable and necessary' care and support needs across a broad range of life activities. Insurance principles would be used to estimate the cost of reasonable and necessary support and services, taking into consideration the aspirations of the individual and his/her carers/family.

Based on the assessed level of disability, as well as individual aspirational goals, an 'individual support package' would be determined for the person with disability.

The 'individual support package' could provide a range of supports including aids and appliances, home and vehicle modifications, personal care, community access (including learning and life skills development), respite care, specialist accommodation support, domestic assistance, transport assistance, supported employments services and specialist

transition to work programs, therapies, local area coordination and development, crisis and emergency support, and assistance dogs.

In contrast to the current arrangements, a key change envisaged by the PC is that people with disability would have options for exercising greater choice and control over what supports they receive and who supplies them.

Supports would include specialist disability services (such as supported accommodation, respite care, early childhood intervention, learning and life-skills development), as well as other services available to the general community (such as domestic assistance, home maintenance and gardening services). Assistance for a person with an individualised support package would include referrals to mainstream services (such as health - clinical support, education) but not include funding for these. The change in focus would increase competition, promote innovation among service providers and improve quality.

Individuals could choose to have funds allocated to them under an individualised plan managed solely or in part by a government agency or by a specialist provider of funds management services. Or they could choose to self-manage all or part of their funding package.

The PC proposed the NDIS be administered by a National Disability Insurance Agency (NDIA), an independent Commonwealth statutory body at arm's length from governments overseen by an expert board with members chosen for their commercial and strategic skills by state and Australian governments. The Board would be advised by an advisory council comprising representatives from people with disabilities, carers, suppliers of equipment and services, and state service providers.

The NDIA would establish service charters that specify the conduct of the NDIA itself, and specialist service providers and disability support organisations.

The NDIA would support the decisions made by people with disability. It would: administer a quality framework that would provide for complete, nationally consistent standards with application to all funded specialist service providers and disability support organisations; encourage best practice; provide consumers with information about the quality and performance of providers; and administer an innovation fund that providers would use to develop and trial novel approaches to disability services.

The NDIA would administer robust data reporting by providers and participants, and systems to guide financial management, inform decisions, monitor and evaluate outcomes and enable performance monitoring. It would enable independent research by making the data publically available (subject to confidentiality, privacy and ethical considerations).

The NDIA would be independently reviewed with any changes subject to independent assessment of the impacts and implemented through explicit changes to legislation.

The PC made additional recommendations regarding the delivery of disability support to Indigenous people. These included early intervention and prevention (without duplicating relevant programs), the maintenance of block funding where services would not otherwise

exist, fostering smaller community-based operations, employing Indigenous staff, encouraging innovation and flexibility including with access to support services, while being mindful of other measures addressing Indigenous disadvantage throughout Australia.

The PC noted that the proposed NDIS would be ‘too large and complex to implement fully at a single start date. It would need to be rolled out in a carefully staged way.’<sup>20</sup>

## **GOVERNMENTS’ RESPONSE**

In response to the PC Report, at its 19 August 2011 meeting, COAG agreed on the need for major reform of disability services in Australia through an NDIS.

Subsequently, COAG agreed that reform should take a social insurance approach that would share the costs of disability services and supports across the community. In addition, the reform should adopt insurance principles that estimate the cost of reasonable and necessary supports, promote an efficient allocation of resources based on managing the long-term costs of supporting people with disabilities and their carers while maximising the economic and social benefits.

The NDIS would be ‘person-centred’, giving people greater choice and control over what supports and services they receive and who delivers them. As a result, service providers would need to be innovative and respond to the needs and preferences of individual clients. Services would be better coordinated and responsive to local needs, with improved linkages between disability services and mainstream and community services, including health, aged care, employment, education, housing and transport services. Support would be available to assist people with disability to make choices and navigate the range of services. An NDIS would also recognise the essential support provided by families and carers and support them in their roles.

On 7 December 2012, the Commonwealth and states reaffirmed their commitment to an NDIS by signing an Intergovernmental Agreement for the NDIS Launch.

Between December 2012 and May 2014, the Commonwealth signed bilateral agreements with New South Wales (NSW), Victoria (VIC), South Australia (SA), Western Australia (WA), Tasmania (TAS), the Australian Capital Territory (ACT) and the Northern Territory (NT) to establish trial sites for the NDIS. The bilateral agreement between the Commonwealth and Queensland for transition to full scheme did not include a trial before commencing transition.

Jurisdictions agreed that the lessons learned in the trial sites would inform governments about when and how to proceed to a full NDIS. Jurisdictions also agreed that participants in the trial sites would receive ongoing support until a decision is taken to move to a full NDIS and that the funding and governance arrangements agreed for the trial sites did not create a precedent for the full NDIS.

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<sup>20</sup> Productivity Commission, page 929.

On 1 July 2013, trials began in TAS for young people aged 15-24, in SA for children aged 13 and under (on 1 July 2014), and in the Barwon area of VIC and the Hunter area in NSW for people up to age 65. From 1 July 2014, trials commenced across the ACT, the Barkly region of the NT, and in the Perth Hills area of WA.

## POLICY OBJECTIVES

The needs of people with disability are diverse, and that changing from current systems will involve complex transitions for people with disability, providers and the disability-related workforce, governments' objectives. Commonwealth and State and Territory governments are working together through the Disability Reform Council to build an NDIS which delivers the following outcomes to eligible people with disabilities:

- People with disability will be supported to participate in and contribute to social and economic life to the extent of their abilities;
- People with disability and their carers will have certainty that people with disability will receive the individualised care and support they need over their lifetime;
- People with disability will be able to exercise more choice and control in their lives, through a person-centred, self-directed approach to service delivery with individualised funding;
- People with disability, their families and carers, service providers, the public and governments will have greater transparency and certainty of funding for disability care and support;
- Disability care and support will be more accessible;
- Disability care and support will meet nationally consistent standards;
- Disability care and support will be sustainably resourced; and
- Disability care and support will contribute to governments' commitments to closing the gap on Indigenous disadvantage<sup>21</sup>.

The objectives for the NDIS are set out in the *National Disability Insurance Scheme Act 2013* (NDIS Act). The objects of the NDIA Act are to:

- in conjunction with other laws, give effect to Australia's obligations under the Convention on the Rights of Persons with Disabilities done at New York on 13 December 2006 ([2008] ATS 12);
- provide for the National Disability Insurance Scheme in Australia;
- support the independence and social and economic participation of people with disability;
- provide reasonable and necessary supports, including early intervention supports, for participants in the National Disability Insurance Scheme launch;
- enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;

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<sup>21</sup> COAG High-level principles for a National Disability Insurance Scheme

- facilitate the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability;
- promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the mainstream community;
- raise community awareness of the issues that affect the social and economic participation of people with disability, and facilitate greater community inclusion of people with disability; and
- in conjunction with other laws, give effect to certain obligations that Australia has as a party to:
  - the International Covenant on Civil and Political Rights done at New York on 16 December 1966 ([1980] ATS 23);
  - the International Covenant on Economic, Social and Cultural Rights done at New York on 16 December 1966 ([1976] ATS 5);
  - the Convention on the Rights of the Child done at New York on 20 November 1989 ([1991] ATS 4);
  - the Convention on the Elimination of All Forms of Discrimination Against Women done at New York on 18 December 1979 ([1983] ATS 9); and
  - the International Convention on the Elimination of All Forms of Racial Discrimination done at New York on 21 December 1965 ([1975] ATS 40).

These objects are to be achieved by:

- providing the foundation for governments to work together to develop and implement the National Disability Insurance Scheme launch; and
- adopting an insurance-based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability.

In giving effect to the objects of the NDIS Act, regard is to be had to:

- the progressive implementation of the National Disability Insurance Scheme;
- the need to ensure the financial sustainability of the National Disability Insurance Scheme;
- the broad context of disability reform provided for in:
  - the National Disability Strategy 2010-2020 as endorsed by COAG on 13 February 2011;
  - the *Carer Recognition Act 2010*; and
- the provision of services by other agencies, Departments or organisations and the need for interaction between the provision of mainstream services and the provision of supports under the National Disability Insurance Scheme.

In addition to the objects and principles outlined in the NDIS Act, the transition will have the following further specific aims:

- build upon the evidence from trial sites;

- ensure the transition is rolled out in a way that does not inflate the cost of the full scheme;
- develop an environment where people with disability can exercise choice and control over the services they choose by supporting a diverse and innovative workforce and market to grow and better meet the needs of its client base; and
- ensure that carers and the families of people with disability are active partners with the scheme, and are fully involved in decisions that affect them.

## **STATUS OF THE RIS**

The NDIS is a joint venture of Commonwealth, State and Territory governments. The NDIS is being implemented progressively in three stages: trial, transition and full scheme. The timeframes for trials (if applicable), transition and full scheme are outlined in the Heads of Agreement (HoA) between the Commonwealth and individual states (except WA) which were agreed between December 2012 and May 2013.

On 7 December 2012, the COAG released the NDIS Consultation Regulation Impact Statement (RIS) for public consultation closing on 1 February 2013. The purpose of the COAG Consultation RIS was to elicit feedback on the options and impacts, including costs and benefits of the proposed approaches to the design of the NDIS. The RIS also canvassed approaches to determine a desired balance of regulation between the current arrangements and market based approaches. Feedback from the COAG NDIS RIS informed policy decisions for the NDIS trials and the NDIS scheme design, which was reflected in the NDIS Act and Intergovernmental Agreements for the trials.

At its meeting of 19 September 2014, the DRC asked Commonwealth and State officials to work together, and with the NDIA, to consider feasible options for transition. Ministers noted that it is early days for the three trials that commenced in WA, ACT and NT on 1 July 2014 and the lessons from these trials will also need to be taken into account as the full scheme rolls out. Officials were asked to report on progress to the next meeting of the DRC. A RIS was not prepared for the DRC as the decision to transition to full scheme had been agreed in the Heads of Agreements already signed between the Commonwealth and State governments.

At its meeting of 12 December 2014, the DRC's communiqué noted that:

- the DRC is committed to a full roll-out of the NDIS and is considering approaches to full scheme roll-out;
- all governments agreed that a key consideration will be ensuring that transition results in a sustainable scheme with high-quality supports for people with disability;
- all governments will ensure that the transition to full scheme is achieved, consistent with the timeframes and funding arrangements set out in the Heads of Agreements already signed between the Commonwealth and State governments; and

- the DRC asked officials to continue work to consider the feasibility of options for transition.

At its meeting of 16 February 2015, the DRC’s communiqué noted that:

- all governments reaffirmed their commitment to ensure the transition to the full scheme roll out of the NDIS is achieved, consistent with the timeframes and funding arrangements set out in the Heads of Agreements already signed between the Commonwealth and State and Territory governments;
- work has undertaken by the Commonwealth and State and Territory governments, in consultation with the NDIA, to develop approaches to transition taking into account local circumstances of each jurisdiction and promoting the best possible outcomes for people with disability. All governments are identifying practical actions required to support participants, providers and the market as well as to develop the workforce during the transition to full scheme;
- negotiations are underway on the approach to transition in each jurisdiction and the phasing in of clients, with agreements expected to be finalised bilaterally between relevant governments; and
- work is underway to develop the form and content of operational plans by June 2015. These plans will detail key implementation arrangements for each jurisdiction, and will focus on the preparations required by all parties to ensure the NDIS is successfully implemented consistent with transition agreements.

At its meeting of 17 April 2015, COAG reaffirmed its commitment to ensure the NDIS is rolled out effectively and sustainably around Australia, and noted progress with NDIS trials and that this is informing full scheme rollout. COAG also noted that jurisdictions are endeavouring to finalise transition agreements by end August 2015 to support national rollout of the scheme, noting Western Australia’s agreement will be made later to take account of its comparative trials of different approaches to implementing the NDIS.

## CONSULTATION

During the design and development phase of the NDIS a range of mechanisms were established to capture the views of stakeholders to inform its design. The COAG Engagement Strategy developed in 2012, provided a consistent approach for all jurisdictions when undertaking engagement activities for the NDIS. As part of this strategy significant engagement was undertaken via the NDIS Advisory Group and Expert Groups, ‘Your Say’ website and The National Disability and Carer Alliance Engagement Project. COAG also released a Consultation Regulation Impact Statement (RIS) in December 2012 as a basis for further consultation with stakeholders and the public on the regulatory impacts of the NDIS.<sup>22</sup>

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<sup>22</sup> A list of those who made submissions on the Consultation RIS is included in attachment A.

## CURRENT ENGAGEMENT ACTIVITY

Current engagement activity includes:

- **Information, Linkages and Capacity Building (ILC) (Tier 2) framework consultation:** The purpose of this engagement is to inform stakeholders about the ILC Framework, to seek stakeholders' views on the policy and to inform them of the implementation process, including the potential for future opportunities to provide input. Engagement commenced in 2015 with all jurisdictions undertaking targeted consultation on the ILC framework with key stakeholders.
- **Review of the NDIS Act 2013:** the Commonwealth will invite written feedback from key jurisdictional stakeholders prior to the commencement of an independent review of the *NDIS Act 2013* on 1 July 2015.
- **Quality and Safeguards Framework Consultation:** COAG has agreed to the development of a national approach to quality and safeguarding for the NDIS. A consultation paper titled, '*Proposal for a NDIS Quality and Safeguarding Framework*' will be released for public consultation and stakeholders will be invited to provide feedback to the government. The period of consultation was from 9 February to early May 2015 and people with disability, families, carers and service providers will have the opportunity to make submissions or participate in a forum discussion on Department's online engagement platform. The consultation will also involve a series of public meetings and targeted workshops.
- **Transition of Commonwealth Programmes to the NDIS Communication Strategy 2014-2016):** The Strategy aims to develop a transparent, practical coordinated and integrated approach to communication with all programme service providers as they transition to the NDIS. Initial communication commenced in November 2014 and will continue as the NDIS rolls out. Communication tools include a new NDIS programme transition page on the DSS website, letters for programme owners to use for trial site providers with key messages, an NDIS Transition Mailbox and Frequently Asked Questions.
- **NDIA Engagement** – The NDIA hosted community and provider forums and information sessions in some trial sites during February and March 2015. These forums allowed the community and providers to hear detailed information about the NDIS, meet members of the local NDIA team, learn about becoming involved with the NDIS, and ask questions. Community capacity building activities will also be undertaken by Local Area Coordinators in trial sites and include active engagement with the local community to improve the community's general awareness and understanding about people with disability, the role of NDIA and the sorts of activities and supports that people with disability need.
- **NDIS Independent Advisory Council** – Provides independent advice to the NDIA Board about the way in which the NDIA performs its functions in relation to the



NDIS, including how the NDIA enables people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports.

Additional Engagement and communication mechanisms to cover the transition from trials to full roll-out of the NDIS may include:

- Release of COAG communiqués on progress towards transitioning from trials to full scheme;
- Engaging Disability and Mental Health Peaks funded by the Commonwealth to provide advice around the NDIS; and
- Fact sheets that could be made available on the NDIA website describing the broader process with the transition from trials to full roll-out of the NDIS.

## **STAKEHOLDERS' RESPONSES TO THE CONSULTATION RIS**

### ***Eligibility assessments***

Comments on the role of the NDIA focussed on the eligibility assessment process, and review mechanisms for appealing assessment decisions.

Some respondents expressed concerns that decisions made by the NDIA would be subject to internal review before access to an external review body was provided. Others questioned whether Administrative Affairs Tribunal members would have the skills needed to be able to review decisions made by the NDIA. Potential participants and disability support organisations questioned how assessment processes under the NDIS would align with existing assessment processes, and whether those currently assessed for care would need to be re-assessed before entering the NDIS. Several respondents advocated the use of specialist tools to assess functional capacity (The Neuromuscular Alliance of Tasmania, the Australian Blindness Forum and the Royal Blind Society of South Australia).

Some respondents questioned whether applicants would be given reasons for a rejection of their application by the NDIA, noting that such information was important in helping the applicant determine the merit of lodging an appeal. Some respondents sought government support for applicants to lodge appeals (for example, Disability Advocacy Network Australia).

Carers Australia asked how the NDIA would take into account the need of carers (noting their concerns will differ from the interests of participants).

The Youth Disability Advocacy Service noted the disruption and stress that requests for reassessment can cause for people with disability and requested reassessments should be infrequent, limited to changes in circumstances, or be triggered by the applicant.

### ***Age thresholds***

Several providers and disability support organisations opposed the introduction of an age threshold. Alzheimer's Australia said that eligibility should be based on clinical need, rather than on the age of a person when they apply for assistance. The Royal Blind Society of South

Australia commented that vision rehabilitation is a specialist disability service and not an age issue.

Others suggested that if an age threshold was warranted, it should apply to the date a person was diagnosed and not the date on which they lodged an application for assessment with the NDIA. Alternatively, the NDIA should have the discretion to consider applications where the disability is shown not to be age-related.

### ***Controls on participants' use of funds***

People with disability and their support groups sought no restrictions on the use of funding where a support plan had been agreed and funding was administered by the individual or their nominee.

Support providers raised three issues. The first related to ensuring ongoing public support for the NDIS by limiting funding to goods and services that were directly related to a person's disability support needs. Providers also suggested that some parts of individual support packages be directed to the purchase of particular treatments that are known to lower support needs (and costs) over the longer term, even if appearing to the participant not to reflect 'value-for-money' in the short term. Thirdly, providers asked for a requirement on participants to give reasonable notice periods before terminating a support or service agreement, particularly where the cost of providing supports included a large fixed component.

People with disability and their support groups and some providers supported the ability for individuals to pool part of their NDIS payments to purchase supports and services, especially in regional areas, where the alternative was the provision of supports via block payments. Where the use of block payments was considered to be the most efficient approach, people with disability sought a greater role in determining who the recipients of block funding should be and in participating directly in any assessment of the outcomes of block funding.

### ***Quality assurance and safeguards frameworks***

All respondents supported a need for safeguards. However there were differing views on the type of safeguards that should be put in place.

Some favoured fewer safeguards, with an emphasis on providing information to individuals, their families and carers that would help them make informed decisions. This group also favoured a reliance on mainstream regulation, with changes where needed, rather than disability-sector specific regulation. Examples of the types of controls included: police checks for plan managers and support staff working with children and young people; requirements to publish qualifications and professional accreditations of support staff; and access to independent complaints mechanisms, advocates, community visitors and ombudsmen. One respondent stressed the importance of allowing people with disability 'to take risks, to make mistakes, and to learn from doing so, just as other members of the community do'. For this group, regulations, however well intentioned, should not be used to restrict choice.

These stakeholders also questioned the value of quality assurance schemes. The Australian Federation of Disability Organisations observed that auditing ‘generally occurs after abuse or neglect had occurred, and in many cases months after. If accountability mechanisms are to be effective, they need to ‘shine the light’ when abuse or neglect occurs.’ Others agreed. The National Council on Intellectual Disability noted: ‘Quality assurance does not address abuse and neglect. Nor do national disability standards. Segregation of people with disability invites neglect and abuse.’

Many existing providers and some disability support organisations, however, supported the retention of existing quality assurance, accreditation and registration requirements, and the introduction of minimum service standards to ensure the integrity of the system in the transition to a national disability insurance scheme.

The Bedford Group supported a tiered approach to regulation, with minimal regulation for low risk activities, registration requirements for modest risk, and a more stringent regulatory regime for higher risk situations. Assistive Technology Suppliers Australia noted: *‘Assistive technology operates in a well regulated competitive commercial market-based environment (TGA, Australian Standards and mainstream consumer legislation)’*. The Australian Rehabilitation and Assistive Technology Association supported supplier regulations to *‘guard against fraud and inexperience’*.

The Young People in Nursing Homes National Alliance wanted approval, registration, regulation and monitoring of all providers, the establishment and monitoring of compliance with standards for corporate governance and service delivery, the development and oversight of all competencies and skill sets required to deliver supports and services and means for participants to provide feedback.

The Australian Advisory Board on Autism Spectrum Disorders suggested that regulatory standards should include ‘regular auditing of case files, mandatory attendance by professional staff at approved professional development and mandatory regular supervision of professional staff by experienced clinicians’.

Lifestyle Solutions supported mandatory provider registration, quality assurance standards and mandatory internal and independent monitoring and complaint processes.

Some respondents acknowledged the costs of higher levels of regulation but felt such costs were justified. Carers Australia said:

*Registration requirements for high risk services will limit participant choice by limiting entry, but seems a sensible safeguard against ‘over-crowding’ that accompanies an injection of significant government funding.*

While providers who operate across jurisdictions supported measures to harmonise existing quality assurance arrangements under a national framework, others suggested mutual recognition of existing State-based requirements would be a practical and low cost step.

Other providers were concerned about the lack of harmonisation of regulatory requirements across the aged care, healthcare and disability care sectors. For example, the

Royal Blind Society of South Australia noted that it will have to be registered under the NDIS and under the aged care system, meet two assessment systems, comply with two reporting systems, and implement two invoicing systems and two quality assurance systems.

Representatives from the community mental health sector noted that different standards, the National Standards for Mental Health Services currently apply to them and did not expect this to change in the transition to a national disability insurance scheme.

On behalf of COAG, DSS has been consulting with stakeholders on a quality assurance and safeguards framework for the NDIS. Consultation closed in early May 2015.

On 11 February 2015, the Senate of the Parliament of Australia referred the matter of violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability to the Senate Community Affairs References Committee for inquiry and report. The reporting date is 24 June 2015.

### ***Complaints mechanisms, dispute resolution and mediation services***

Respondents were generally supportive of the complaints mechanisms and dispute resolution and mediation services that were currently in place and were concerned that these were not lost in the transition to a national disability insurance scheme. Others sought strengthened arrangements for people with disability to register complaints, free of the fear that doing so could lead to the loss or diminution of current services.

### ***Pricing of supports and services***

Participants and providers were equally concerned about the use of price benchmarking by the NDIA, especially when there were currently no readily observable prices for many supports and services (Bedford Group, Attendant Care Industry Association, Vision Australia, National Disability Services, and Neuromuscular Alliance of Tasmania). Benchmarking was also criticised on the grounds it would reduce choice and/or quality.

Some respondents asked for price-banding as an alternative to price setting, or for the NDIA to negotiate prices for particular supports and services directly with providers (Motor Neurone Disease Australia/Multiple Sclerosis Australia, Novita, and Young People in Nursing Homes National Alliance).

The Cerebral Palsy League of Queensland called for price controls of some services during the transition stage to ensure price spikes did not occur.

People with disability and disability support organisations called for greater transparency over pricing. Many acknowledged that they did not know the current cost of their care. They sought information on how prices for services were determined and suggested that if a website of service providers was established, that it include pricing information.

Providers commented on the difficulties and costs of moving to a fee-for-service model, including the need to develop more complex business planning and accounting systems.

Some asked how the transition from block funding to fee-for-service would be managed, if block funding would cease when current contracts expired, or if there would be scope to renegotiate block funding, on a reduced scale, as individualised funding was rolled out.

Several respondents supported a continuation of block funding (Royal Blind Society of South Australia, Guide Dogs NSW/ACT). Carers Australia suggested that the common criticisms of block funding reflect funding limitations and not just the features of block funding per se. The Young People in Nursing Homes National Alliance noted that in some cases, block funding could be a more efficient form of providing some types of services. The Endeavour Foundation suggested a blended-funding approach whereby block funding was maintained for overheads and other major fixed costs, with funding under ISPs limited to the provision of labour.

### ***Competition issues***

Existing providers from the government and non-government sectors were concerned that the introduction of fee-for-service funding could encourage providers to engage in anti-competitive conduct to establish or improve their market share. While there are generic laws against anti-competitive conduct (primarily the Competition and Consumer Act 2010), the difficulty some providers foresaw was the ability of these laws to be applied promptly to prevent this conduct from occurring. Some providers questioned if additional resourcing was to be provided to the Australian Competition and Consumer Commission to handle disputes and complaints from the disability care sector.

A particular concern for government providers was that if not-for-profits are unable to compete and leave the disability sector, the burden of being a provider of last resort on those who remain may rise.

### ***Costs on existing providers***

While several respondents expected the introduction of an NDIS to increase their operating costs, few service providers gave details.

Where provided, estimates of start-up costs varied between 2 and 6 per cent of total current revenue (including government grants, donations and other income), with changes to information technology, accounting and administration systems the largest component (around one third) of the total. Other significant start-up costs included staff retraining costs, changes to working capital (to meet increased cash flow costs), business planning, and program redesign costs.

The cost of installing new information technology systems ranged from around \$200,000 for smaller organisations to \$1.5 to \$2 million for larger providers. Staff retraining needs varied from training in recording service delivery, itemised billing and invoicing, to managing OH&S risks in unfamiliar workplaces. There was also significant variation in the cost of training and the numbers of staff that required retraining across providers. Larger providers suggested the cost of staff training could be around \$500 per current employee.

Higher ongoing costs were expected in the areas of service delivery record-keeping, billing, invoicing and reporting requirements, staff training, other workforce costs (supervising and managing an increasingly casualised workforce), information technology (more regular software updates and higher software licensing fees), and advertising/marketing costs. These costs were not quantified.

### ***Costs on participants***

Respondents identified three types of costs on participants.

The first were the costs to lodge applications for assistance, to undergo needs assessments, to develop their personal plans of life goals and aspirations and to develop, with the NDIA, plans for managing the provision of their supports. Most respondents saw that participants currently incur costs in preparing for and undertaking needs assessments and that these costs were likely to continue under the NDIS. However, they also felt that the NDIA should rely on existing information where available to avoid the costs of participants having to re-obtain medical assessments and other information that the NDIA would require to complete a needs assessment.

The second group of costs would be incurred by participants who required assistance from third parties to engage in each of these steps. The issue here was not whether participants could receive help from third parties at these stages, but who should pay for this third party support. Some respondents clearly felt that participants should be free to appoint third parties but the costs of the third party should be borne by the scheme.

The final group of costs were those borne by potential participants who would receive less government support under the NDIS than they would under current arrangements. Respondents felt that it was legitimate to add these costs to the overall cost of the scheme if potential participants were not given the option to remain on their current, more generous arrangements.

### ***Managing the transition***

A significant concern to a number of stakeholders was maintaining continuity of care in the transition to the full scheme. For example, if standards for personal care workers were strengthened, would those currently providing care be able to continue to do so while upgrading their qualifications?

The Neuromuscular Alliance of Tasmania was concerned about what may happen if current providers were unable to adapt to the proposed changes and chose to exit the market before new providers could be established.

The Commonwealth and states are aware of these concerns and are developing workforce strategies for the transition to full scheme to ensure continuity of care for existing recipients of supports.

A related concern of many providers and disability support organisations was the impact the rollout of the NDIS would have on private philanthropy and volunteering rates (Bedford

Group, Neuromuscular Alliance Tasmania, and Australian Blindness Forum). However, as the Productivity Commission observed, any reduction in private philanthropy was likely to be more than offset by the increase in government funding for the sector. It would also allow private philanthropy to be diverted from areas of core needs to the provision of ancillary services.

## **TRIAL EXPERIENCE**

### **PARTICIPANTS**

Some early indications from participants in the trial sites have confirmed that the changes for participants, their families and carers have been overwhelmingly positive.

Participants have benefitted from higher levels of support, improvements in the quality of support, greater flexibility and improved choice of support. Services can now be obtained at times that better suit the needs of participants, their families and carers, and can be tailored to the needs of the individual. For example, participants have sought care outside of normal work hours (before and/or after school or work, on weekends and public holidays). They have been able to receive supports at home or tailored supports on a one-to-one basis. Participants have been able to use their support funding to participate in a wider range of activities. Participant satisfaction with the NDIA remains high. On a scale of very poor (-2) to very good (+2), with neutral being 0, participant satisfaction as of 31 March 2015 was reported by the Scheme Actuary at 1.64.

Benefits for families and carers have included reduced stress and financial pressures, increased access to respite care and domestic assistance, and increased opportunities to return to work.

However, there have also been costs for participants, families and carers, in learning about the NDIS, in preparing for and participating in the development of individualised plans, and in managing support needs. Some have also taken part in reviews of their individualised plans. The 'red tape' costs to participants, family and carers of participating in the NDIS are discussed in more detail below.

Some participants have also found that access to some services and supports is still limited, possibly because the NDIS is in trial<sup>23</sup>. (Although it may also partly be a consequence of how supports have been priced by the NDIA, with providers unwilling to offer services where they feel the prices set by the NDIA will not cover their costs.) There have been some participants who have experienced gaps in provision, because providers have been unable to find additional staff to meet the increased demand, while other participants have used the services of several providers, to manage risks around continuity of care. Until the NDIS is fully implemented, participants cannot leave a trial site and expect to receive the same level of supports.

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<sup>23</sup> NDIS Report *Roadmap to a Sustainable Workforce*

Issues such as a lack of demand for particular supports and services may be addressed in some regions as more participants are transferred into the NDIS and demand for those services grows. However in outer regional, rural and remote areas, participants may continue to experience lack of choice of supplier of certain supports and services.

Governments are concerned about the roll out of services and supports to these areas and the NDIA will continue to work with providers to ensure that supports agreed in a participant's plan are available at reasonable cost to the NDIS. The NDIA is also considering creating and maintaining a pool of more expensive specialised aids and equipment to manage the cost of such supports to the NDIS.

## **PROVIDERS**

### ***Adjustment costs for existing providers***

Before the trials commenced, PwC was commissioned by the then FaHCSIA to estimate the costs that existing providers may face in transitioning to operating on a fee-for-service basis. While some providers of disability supports already operate on such a basis, many providers are dependent on block or activity-based funding.

At the time, PwC found a wide variation in providers' expectations, driven in part by their size of operations, and in part by their experience in delivering services on a fee-for-service basis. Some of the costs providers expected to incur included investments in information and communications technology systems to better monitor front line service delivery, and in financial and accounting systems to better track unit costs. Most expected to invest in personalised planning and tracking systems, and in training for front line staff in recording and reporting service delivery and outcomes. Some providers expected to increase training for managers in human resources management and marketing. All expected the costs of service delivery to rise because of increased opening hours, greater tailoring of supports to individuals' needs and the need to recruit staff with different skills and experiences.

Of the 13 providers surveyed seven were assessed as having a low level of preparedness for transition to the NDIS. All four of the small providers interviewed were rated at being at a low level of preparedness. For medium and large providers, size was less of an indicator of preparedness. Indicative estimates of the likely costs of transition are summarised in Table 6 below.

Providers were also asked to comment on how their costs may change under an NDIS. Most expected to have to increase their spending on finance and administration and on marketing. While unable to cost the latter, large providers (those with more than 1000 clients) expected to have to hire an additional 4-5 full time equivalent (FTE) staff, while mid-sized providers (201-1000 clients) expected to hire an additional 2-3 FTE staff. Some small providers suggested their administrative costs may double (an increase of between 0.5 and 1.5 FTE staff).



**Table 6: Indicative estimates of transition costs (costs over 3 year period) – by provider size**

Scale of Provider size	Range of expected transition costs (High range transition costs indicates low preparedness)	
	Low range	High range
large (> 1000 clients)	\$2,000,000	\$4,000,000
Medium (201-1000 clients)	\$800,000	\$1,500,000
Small (51-200 clients)	\$150,000	\$200,000
Micro (<50 clients)	\$55,000	\$80,000

Source: PwC estimates based on data provided in consultations with disability support providers

While providers in the trial sites have not quantified the costs that have been incurred in transitioning to the NDIS, most have confirmed that they have increased spending in the areas identified above. All providers have increased spending on back office staff. Larger providers have made changes to financial reporting systems to capture billing on a fee-for-service basis while continuing to account for services delivered under block funding and activity-based funding. Workers have also been trained in invoicing clients for services delivered under the NDIS and have begun invoicing participants, other plan managers and the NDIA.

Providers have hired additional workers and extended their operating hours in order to cater for more individualised demand. Managers are spending more time on planning and co-ordinating the provision of services to participants and less time directly supervising and supporting staff. Many managers feel that being unable to supervise support workers directly may increase the risk of workplace injuries and, consequently, workers' compensation costs.

Early findings from the trial sites suggest that most providers have been able to adjust, in the short term, to the challenges of moving to a more participant-driven system of disability supports. Providers have extended opening hours, demand for some services has increased, and new programmes have been added. Some providers have recruited additional staff (although on an increasingly casualised basis) while others have been able to move staff from areas of lower demand to areas of higher demand without having to increase their workforce.

Where demand has declined, services have been changed to better target individuals' needs. Others have used funding from other sources, including reserves, to maintain services until more participants join the NDIS and a clearer picture of demand emerges.

One of the difficulties providers have faced is in planning services when demand from participants is uncertain. The changes to service delivery, while benefitting participants, have also increased costs for providers and presented challenges for mentoring, supervising and supporting staff in the workplace. Some providers are concerned that a reduced ability to supervise staff and to monitor workplace risks will increase the likelihood of workplace accidents or injuries and increase workers' compensation costs.

Most support workers have reported an increase in paperwork associated with delivering services to participants. They have also noted a reduction in supervision and on-the-job support from managers. Many of those on casual arrangements have noted that the hours offered are limited, and can involve significant travel times.

Some providers have acknowledged that the jobs they can offer are generally less attractive to staff, and this could increase recruitment and retraining costs in the future, but this is seen as a cost of moving to a system of individualised demand.

Managers have also reported spending increasing amounts of time on administration, particularly the co-ordination of participants' supports.

It is difficult to determine how providers have adapted to invoicing participants on a fee-for-service basis. As of 31 March 2015, 13 610 participants had approved plans in place and \$754.0 million of support had been committed to them. But actual payments to service providers were only \$228.4 million, of which \$72.6 million related to supports provided in 2013-14. Unless the underspend relates entirely to government-provided supports on an 'in kind' basis, the figures suggest that either the support hasn't been provided or providers are yet to invoice the NDIA for supports provided.

### **Workforce**

As noted above, there are no direct measures of the current size of the disability-related workforce. In 2011, PricewaterhouseCoopers (PwC) predicted that the disability sector workforce will likely need to double in size between 2011 and 2019–20 as a result of full implementation of the NDIS. PwC estimated the current workforce at around 70 000 full-time equivalent (FTE) positions and expected the full NDIS to require 160 000 FTE positions.<sup>24</sup> PwC noted that growth would need to occur in all jurisdictions.

A more recent study by Sphere, comparing 2006 and 2011 Census data, using the methodology developed by PwC, suggests that the disability-related workforce (excluding management and administrative staff) grew by around 39 per cent to 87 500 workers in 2011. If past net growth were to continue, the total projected workforce would reach around 116 200 workers by 2016 and 144 700 workers by 2021.

Early findings from the trial sites support the view that the workforce will be able to expand as the NDIS is rolled out. Most providers have been able to recruit additional workers to meet the changes in demand for their services, although there are some exceptions. Providers have also been able to recruit staff for support and back office roles. The composition of the disability-related workforce in the trial sites is also changing, with recruits coming from new sources to better match participants' interests. Casual employment is increasing, with some exceptions.

However, the scale of the trial sites is still quite limited – as of 31 March 2015, only 16 433 participants had been assessed as eligible for the NDIS and only 13 610 participants had

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<sup>24</sup> PwC, *Planning for a sustainable disability workforce report*, 2012, additional material.

approved plans in place and the findings from the trial sites may not be typical of the experiences of participants and providers as the NDIS expands.

It is therefore possible that some labour shortages may occur, for example, in rural or remote areas where the potential workforce is smaller, or in areas of specialised care, such as allied health services, where those with specific skills can move easily between the aged care, disability care and community care sectors.

As part of negotiations for the transition to the full NDIS, governments are developing an integrated workforce, market and sector strategy to monitor workforce developments and identify interventions to increase the size and diversity of the workforce, support more diverse needs, and attract and retain appropriate professional skills.

### **Sector**

The Sector Development Fund (SDF) has been established to assist the disability sector (including people with disability, their families, carers and service providers) to transition to the new arrangements for disability support under the NDIS. SDF funding has been provided to each jurisdiction and has also been used to develop a number of resources for providers including:

- a Best Practice Human Resources guide for disability service providers, with the aim of strengthening recruitment and retention in the disability workforce;
- an approach for disability service providers to attract new workers into the workforce and provide pre-employment training;
- a working model for disability service providers to assist in establishing separate processes and structures for independent financial intermediary services and facilitation services of a disability support organisation;
- a guide to costing and pricing in preparation for roll out of the NDIS, including a workbook and costing tool that allows organisations to input their own information and model the impact of moving to a new costing and pricing approach;
- a training package for Not for Profit organisations to assist in improving governance and business processes in advance of the NDIS;
- a toolkit to help organisations to fully understand their current capacity for change, and any areas they should focus on to succeed under the NDIS;
- a learning program to assist service providers identify the organisational changes necessary to ensure they have the capacity to meet their current challenge; and
- a practical guide to change management and strategies for adjusting to the new environment for delivering individual supports under the NDIS.

## IMPACT ANALYSIS

The transition to the full scheme NDIS will require a significant increase in funding for disability support. While this cost will become clearer as more information is collected from the trial sites and bilateral agreements on transition to full scheme are agreed, the best current estimate of the total cost of the full scheme cost is around \$22.6 billion, of which the Commonwealth's contribution is around \$11.5 billion.

It will also have significant impacts on the lives of people with disability, their families and carers, on providers of disability supports and services and on the disability-related workforce.

### MEASURE OF THE REGULATORY BURDEN ON PARTICIPANTS IN THE NDIS

As part of its deregulation agenda, the Commonwealth Government has adopted a methodology to estimate the regulatory burden (Regulatory Burden Measure (RBM)) on businesses, individuals and community organisations of their interactions with government. Under the RBM, costs are estimated over a ten-year period and presented on an annualised equivalent basis.

Where there is a change in regulation, the change in regulatory burden is estimated and counted towards the Commonwealth Government's regulatory target. As the decision to introduce an NDIS was taken by the former Government, the regulatory burden associated with the NDIS forms part of the burden of existing regulation. This cost, on individuals, is estimated below. Where decisions on transition to the full NDIS may affect the regulatory burden, the impacts are also noted.

Under the NDIS, one-off costs to participants will include applying for access to the NDIS and participating in the development of individualised support plans. Ongoing costs will include participating in plan reviews. There will also be ongoing costs for participants who choose to manage part or all of their support funding. These participants will have to submit a 'My Plan Purchases' form to generate NDIS payments.<sup>25</sup> Other costs to participants will include appointing a nominee for an NDIS participant and appointing a representative for a child participant in the NDIS.

It should be noted that these arrangements also exist in some form in the current disability system. For many other participants, particularly people new to the disability service system, there will be a reduction of costs because they will no longer have to fill in applications for multiple programmes provided at the state and Commonwealth level.

Applying for access is expected to take, on average, one hour of a participant's time as existing recipients of supports will be identified from information already held by governments which should reduce the cost of applying for access for these individuals. The development of a participant's plan is expected to take up to four hours. The time spent reviewing a plan is expected to take between one and four hours.

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<sup>25</sup> More information about the pathway for a person with disability is in Attachment B.

Appointing a plan nominee or representative of child participant in the NDIS is expected to take, on average around one hour. It has been assumed that 18 per cent of participants will appoint a nominee and 6 per cent will appoint a representative. It has also been assumed that half of all participants will require assistance from a family member or carer during the planning and review processes. Acquiring funding is expected to take participants between 1 and 4 hours a month, but only 1 per cent of participants are expected to manage their own funding.

Based on an expected enrolment of 460 000 participants over the first ten years of the NDIS, the total regulatory burden on participants is estimated to be \$55.8 million on an annualised equivalent basis. The Commonwealth's share is estimated to be \$29.02 million on an annualised equivalent basis<sup>26</sup>.

If the Commonwealth and State governments were to continue current funding arrangements, but increase funding for disability supports to meet unmet demand, the regulatory burden on new recipients of supports would be similar to arrangements under the NDIS, but the large number of existing recipients of supports would not have to have their support needs assessed by the NDIA.

New and existing recipients would also be subject to different ongoing needs re-assessments and review processes than the annual review requirements currently set out in the NDIS legislation. The costs of reviewing participants' plans under the full NDIS are likely to change over time as the Agency becomes more familiar with individuals' needs. In some cases, plans may need to be revised more frequently than annually (for example for early interventions) while those with more stable needs may need less frequent reviews. The time participants spend preparing for plan reviews is also likely to fall as they become more familiar with review arrangements.

Finally, some recipients of supports may face higher costs where funding of disability supports remains on a programmatic basis, with different application and eligibility criteria. For example, the Commonwealth Department of Social Services identified a regulatory burden of around \$13.2 million on an annualised basis for 9 activities that will be transferred to the NDIS. Many of these programmes offer supplementary supports to people with specific needs. Each has its own application and assessment process.

### **MEASURE OF THE REGULATORY BURDEN ON PROVIDERS IN THE NDIS**

As noted above, the Australian Government's Regulatory Burden Measure (RBM) estimates the costs to businesses, individuals and community organisations of their interactions with government. These costs are estimated over a ten-year period and presented on an annualised equivalent basis.

Where there is a change in regulation, the change in regulatory burden is estimated and counted towards the Commonwealth Government's regulatory target. As the decision to

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<sup>26</sup> The Commonwealth's share is based on its share of funding for the full Scheme.

introduce an NDIS was taken by the former Government, the regulatory burden associated with the NDIS forms part of the burden of existing regulation. This cost, on providers (businesses and community organisations), is estimated below. Where decisions on transition to the full NDIS may affect the regulatory burden, the impacts are also noted.

In the case of providers, one-off costs include learning about the NDIS and applying for registration as a provider of supports or as a provider of fund management services. Providers have to comply with registration conditions which are set out in the Act.<sup>27</sup>

Generic conditions of registration that all providers must meet include:

- *holding an ABN and an account with a financial institution;*
- *declaring agreement to be bound by the Agency's terms of business;*
- *declaring compliance with all employment and workplace health and safety laws that apply to the applicant; and*
- *declaring compliance with all other relevant laws that may apply to the applicant and their staff.*

Before registering providers of supports, the Agency must also have regard to<sup>28</sup>:

- *the qualifications and approvals relevant to the provision of those kinds of supports held by the applicant and the applicant's staff;*
- *the applicant's capacity to provide those kinds of supports;*
- *the applicant's experience in providing those kinds of supports; and*
- *if the applicant proposes to provide supports to a particular participant – whether that participant has stated that he or she considers the applicant to be suitable to provide those supports. (NDIS Rules for registered providers of supports, paragraph 3.11)*

Approvals include:

*Any approvals, licences, registrations, authorisations or certifications (however described) that an applicant or its staff are required to hold under an applicable law of the Commonwealth, a State or a Territory. (Ibid. paragraph 6.5)*

On average the registration process is estimated to take one day to complete the application and submit relevant copies of qualifications, registrations, and insurance details. Assuming the ratio of providers to participants in the trial sites carries into the full NDIS, up to 30 000 providers are expected to register with the NDIS over the ten-year costing period of the RBM. If that were to occur, the regulatory burden associated with registration processes is estimated at around \$1.97 million on an annualised equivalent basis.

A breakdown of service providers currently registered with the Agency, by provider characteristics and market profile is provided in Table 7 below.

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<sup>27</sup> Providers also have to comply with existing State quality assurance and safeguards requirements until a quality assurance and safeguards framework is developed. COAG is currently consulting with stakeholders on key elements of a future framework, elements of which may be implemented during the transition to full scheme

<sup>28</sup> The Agency's Terms of Business for Registered Support Providers are summarised in Attachment C.

**Table 7: Service provider characteristics and market profile**

Footprint	Allied Health	Disability Support	Disability Equipment	Plan Management	Total
National	70	70	67	32	90
State	1,082	1,055	1,081	198	1,559
Provider Type					
Non-Government Organisation	356	367	207	153	404
Small/Medium Enterprise	744	702	879	63	1,167
Other Private	16	16	28	2	35
Public	36	40	34	12	43
<b>Total</b>	<b>1,152</b>	<b>1,125</b>	<b>1,148</b>	<b>230</b>	<b>1,649</b>

Type	Providers Registered
New NDIS	1,364
Previously DSS	285

Source: NDIA Quarterly Report to COAG Disability Reform Council (31 December 2014)

On-going costs for providers include developing service agreements with participants, submitting invoices for payments with evidence that services have been provided, and maintaining service records and financial records for up to five years, for auditing purposes. Costs such as developing service agreements with participants and submitting invoices for payment would not ordinarily be considered regulatory burden as they would be incurred by an efficient firm operating in the normal course of business.

However, many existing providers consider that moving from current government funding arrangements to a fee-for-service arrangement is a significant change from business as usual. These providers consider the costs of upgrading information technology and financial reporting systems, and the cost of field staff time and back office staff time spent administering new record keeping systems, to be part of the regulatory burden associated with the transition to the full NDIS. Assuming each existing provider required at least one additional full time equivalent position to handle the additional administration, the change in regulatory burden associated with the introduction of the NDIS would be around \$217 million on an annualised basis.

The costs of claiming payments from the NDIA are estimated at \$17.5 million on an annualised equivalent basis.

Workers and/or their employees will also incur costs obtaining police checks and Working with Vulnerable People checks. While the fees associated with obtaining these checks do not form part of the regulatory burden as measured by the Government's framework, the time spent completing and submitting application forms is. These costs, for the additional 80,000 employees expected to be required under a full NDIS are estimated to be around \$375,000 on an annualised equivalent basis.

In total, the regulatory burden on businesses and community organisations is estimated to be around \$236.8 million on an annualised equivalent basis.

If the Commonwealth and state governments were to continue current funding arrangements, but increase funding for disability supports to meet unmet demand, the regulatory burden on new providers of supports and on new workers would be similar to the costs of transitioning to the full NDIS, as all states require providers to be registered in order to receive payments, and require support workers to obtain police checks and working with vulnerable people checks before being able to offer supports to people with disability.

Existing providers would also incur costs where states choose to convert existing block and activity-based grant funding to individualised funding packages. These costs may be similar to the costs of transitioning to an NDIS where states choose to transition existing funding to individualised funding under the control of a third party over a short period of time, but may be lower if states were to maintain existing levels of block and activity-based funding for supports indefinitely.

A slower transition to individualised funding packages would also delay the entry of new providers into the market, imposing a lower regulatory burden, as measured by the Commonwealth RBM, but would also reduce the benefits to people with disability, their families and carers, that greater competition will bring.

### **Regulatory Burden Measure**

The regulatory burden on businesses, individuals and community organisations of the NDIS is estimated to be \$292.6 million on an annualised equivalent basis. If transition to the full NDIS did not commence until one year later, the regulatory burden is estimated to be \$277.8 million on an annualised equivalent basis.

**Table 8: Regulatory burden estimate table<sup>29</sup>**

Average annual regulatory costs (business as usual)				
(\$ million)	Business	Community organisations	Individuals	Total
<b>Total, by sector</b>	\$15.96	\$107.18	\$29.02	\$152.16

## **OPTIONS**

Most States are committed to transitioning to the full scheme by 1 July 2018 (NSW and SA) or 1 July 2019 (VIC, QLD, TAS, ACT and NT)<sup>30</sup>. However, there is still uncertainty around the processes for phasing participants into the NDIS in some states, and the associated timing of

<sup>29</sup> The impact on providers of supports has been split across businesses and community organisations on the basis of the share of for-profit and not-for-profit disability service support agencies funded by Commonwealth and State governments in 2012-13. See AIHW, Disability Support Services, Appendix 2012-13, Table B.3.

<sup>30</sup> Western Australia has not agreed to an NDIS and there are currently no negotiations about transition.



financial contributions from the Commonwealth and these states to the NDIA.<sup>31</sup> States are also focussed on when they can access the DisabilityCare Australia Fund (CAF). There is also uncertainty around market design issues, including concerns about service delivery in rural and remote areas, the impacts of the NDIA's pricing of supports on quality and service viability, and how the Commonwealth transitions its programmes into the NDIS.

Options for alternative approaches to pricing of supports and the transitioning of Commonwealth programmes are discussed below.

## **PRICING**

One of the areas of most contention for providers in the trial sites has been the setting of prices for the most commonly used supports by the NDIA. The NDIA initially set prices for these supports in each trial area after researching what was being paid for supports by similar schemes. Since then, it has regularly reviewed its price lists to capture movements in underlying costs. The price lists are used to determine the overall level of funding for supports in a participant's plan.

Providers are currently required to agree to charge no more than the reference or benchmark price for common supports as a condition of registration. Providers have expressed a range of concerns about how these prices have been determined, especially when few providers were offering the types of services and supports participants and their families are now demanding (such as greater one-on-one care outside the provider's current facilities). They are concerned that the NDIA will continue to set reference prices for these supports, and require registered providers to accept them in the transition to full scheme and beyond, rather than allowing prices to be set by negotiation between participants and providers, as envisioned by the PC.

The PC envisaged that in the longer term, prices would be more flexible and negotiated directly between the service provider and consumer. In this setting, flexible shifts will attract a price premium meaning that people will have to pay more for flexibility and staff will be rewarded financially for working less desirable shifts.<sup>32</sup>

The NDIA adopted the approach of setting prices for the most commonly used supports in order to help estimate and approve the cost of individualised plans. The price list is not a comprehensive list of all supports that may be provided under the NDIS, but includes prices for the most commonly used supports.

As noted above, in setting prices for supports, the NDIA sought to use prices set in other schemes to 'ensure that the NDIA did not become a competitor to other purchasers in that market and to avoid inadvertently disturbing those markets'.<sup>33</sup>

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<sup>31</sup> All ACT eligible residents will have their eligibility determined in the trial period and therefore discussions are focussed on issues such as access to the Disability Care Australia Fund (DCAF), arrangements for over 65s, cross-billing arrangements, market design and financial contributions.

<sup>32</sup> Productivity Commission, page 716

<sup>33</sup> NDIA, <http://www.ndis.gov.au/providerspricing-and-payment/pricing-faqs>, (accessed 3 February 2015).

The NDIA has also sought to help providers adjust to the NDIS. The NDIA and NDS agreed to a six-week joint project to examine provider concerns and recommend solutions. The working group comprised staff from NDS and the NDIA, assisted by experts in pricing, accounting and economics from Seward Dawson Charter Accountants and Curtin University's Not-for-profit Initiative.<sup>34</sup>

The joint working group found that predicting the detail of the future market of disability support is difficult; it did not know how it will take shape as people with disability make choices about delivery of their supports. However, it expected that into the long term, there should be a place for enterprises of different types, shapes and sizes.

Until further into the roll-out, it proposed that NDIA prices adequately address current costs with a temporary 'transition price' that reduces gradually as the market adapts and that this needed to be clearly communicated.

The joint working group explored two ways to deal with this transition period.

1. Agree or propose a range for the future efficient price, based on estimations of how the market could look, then add a transition levy with an ongoing data collection to help support future direction of the efficient price; or
2. Publish transitional prices, then decrease them incrementally to get to a competitive market price by 1 July 2016. (This price may be adjusted in accordance with further data collection.)

The second approach recognised that the working group has not agreed the future efficient price, given the variability of current cost information and an unknown future market. NDS did not support the first approach as the assumptions that underpin the future price have not been agreed.<sup>35</sup>

The long term efficient price was developed using a ground up pricing model, and aims to 'define the direct cost elements at a rate that is sufficient to cover the efficient costs of a reasonable quality support provider at a point in time'.<sup>36</sup>

The joint pricing working group also recommended that a transition price for personal and community care be set, to minimise short term financial costs on providers and ensure continuity of care for participants during the trials. This would also allow the NDS to monitor the impacts of the transition price on providers during the transition period and the NDIA to improve the data used to set the long term efficient price.

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<sup>34</sup> NDIA NDS *Final Report of Pricing Joint Working Group*, page 6

<sup>35</sup> NDIA NDS *Final Report of Pricing Joint Working Group*, page 16

<sup>36</sup> NDIA, *NDIA report on the methodology of the efficient price*, 18 July 2014.

The NDIA management agreed to move to the long term efficient price for personal and community care in three steps over two years (1 July 2014 to 1 July 2016).

Despite the involvement of the NDS in the setting of the long term efficient price, the introduction of transitional pricing by the NDIA to cushion the impact of adopting the long term efficient price, and actions by the NDIA and NDS to monitor the impacts of the transitional prices on providers, many providers consider the long term efficient price to be inadequate.

Such disputes are common in markets that are subject to price regulation.

Part of the problem is that many providers do not know what the actual costs of providing individualised services are because they have not had to measure these costs before. Many have built their businesses around current government programmes and their cost structures reflect the requirements of those programmes, rather than the direct costs of providing specific services. They may know the costs of joint services, but are unable to separate the costs when one service can be invoiced to a participant in the NDIA and the other cannot.

As mentioned before, the number of participants enrolled in the NDIS is still small, and the number of participants with approved support plans in place is lower still. Accordingly, many providers find it difficult to predict where there may be demand for their services as more participants enter the NDIS and where demand for services will fall. Providers cannot easily adjust their fixed costs and overheads in the short term, and may be reluctant to do so until they know they will have a future in the industry.

While potential providers can look at the prices set by the NDIA for different supports and determine if they want to enter the market, existing providers can feel they have little choice but to continue to offer services and accept the prices offered by the NDIA until they can lower their operating costs or until they exhaust whatever reserves they may have.

For these reasons, existing providers are likely to have ongoing concerns about the NDIA's decision to set and enforce reference prices for the most commonly used supports.

One way of addressing this would be for the NDIA to continue to make its decisions about the setting of reference prices transparent, continue to work with the NDS to collect information on the costs of providing supports, and continue to monitor the impacts of reference prices on existing providers. At the same time governments would continue to monitor these impacts and work with the NDIA to develop criteria for assessing when reference prices no longer need to apply in particular markets and market segments.

A key recommendation in the report was that access to improved cost data is essential to better inform the efficient price. NDS would continue to monitor the impact of prices on providers during the transition period. The NDIA would continue to publish prices used to

cost participant packages and identify ways to improve flexibility for participants by encouraging vibrant and responsive markets for disability supports.<sup>37</sup>

### ***Options Considered***

One option would be to continue to use the interim transitional pricing strategy which commenced from 1 July 2014 until the transition to the full NDIS begins in July 2016, in line with the recommendation of the joint working group. Under this option an efficient price has been determined for providing weekday support for people with disability of \$36.70 an hour (in 2014 dollars). This efficient price is indexed at 1 July each year for inflation and adjusted on 1 December each year for the Equal Remuneration Order<sup>38</sup>. Hourly rates for shift and weekends are also increased consistent with the day time rates. However, to help Providers adjust to the future introduction of an efficient price, and to ensure a strong supply of supports into the future, the NDIA implemented a 'transitional price' to be effective from 1 July 2014 of \$38.78 an hour. Over the transition period the difference between the efficient price and the transition price will reduce as the efficient price increases. The transition price will cease on 30 June 2016.

Another option would be to begin negotiations with providers prior to the transition to the full scheme in July 2016. NDS has said that providers expect to be able to negotiate on the price, quantity and quality of assistance with daily activities and access to community activities from July 2014 – particularly if the NDIA support prices continue to be set below the cost of delivery.<sup>39</sup> One difficulty with this approach is that it transfers any pricing conflict between the NDIA and provider to the relationship between participant and provider. However, conflict could be minimised if deregulation is undertaken in the context of fair price-setting by the NDIA.

On balance it would be preferable to use an interim transitional pricing strategy beginning from 1 July 2014 and allow the efficient price to increase incrementally to reach the transitional price, in order to get to a competitive market price when the full NDIS begins in July 2016. This approach would:

- minimise the likelihood of market failure in the trial sites;
- improve sector sustainability and ensure that significant transitional issues are dealt with at an appropriate pace with the right resources;
- maximise the visibility of the NDIA's long-term definition of an efficient cost frontier to both trial and non-trial suppliers;
- establish a more transparent approach to the long-term pricing strategy; and

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<sup>37</sup> NDIA NDS *Final Report of Pricing Joint Working Group*, page 17

<sup>38</sup> Pay rates for some employees in the social and community services industry are gradually increasing under the Equal Remuneration Order made by the Fair Work Commission. The increase will apply in full by 2020 and applies to the social and community services stream under the Social and Community Services Award.

<sup>39</sup> NDIA NDS *Final Report of Pricing Joint Working Group*, page 20

- make allowance for other transitions, such as the equal remuneration order and transition from old awards.

## **TRANSITIONING GOVERNMENT PROGRAMMES**

In planning for the transition to the full NDIS, governments have to determine:

- if, when and how current funding arrangements terminate, including how supports are managed for current recipients who are assessed as ineligible to become participants in the NDIS;
- how and when existing funding for disability support is transferred to the NDIS, including whether support is provided on an ‘in-kind’ basis or is ‘cashed out’; and
- how participants are transitioned into the NDIS (including by need, region, programme, age cohort or mix of approaches).

Most governments are considering a mix of approaches to transitioning participants into the NDIS. These include enrolling participants by region, by age-cohort and by type of need. Governments are also considering how to maintain existing supports for those who do not transition to the NDIS. States are also considering how to maintain services in outer regional, rural and remote areas. Options being canvassed include hybrid block/fee-for-service funding and continued government provision of services/provider of last resort contracts where market conditions are unlikely to support competition.

Total estimated NDIS costs in 2019-20, once every jurisdiction has reached full scheme, are estimated to be around \$21.9 billion (as at 7 February 2015). The Commonwealth is expected to fund \$11.7 billion (53 per cent) of scheme costs, of which \$8.5 billion is new Commonwealth investment. It is anticipated that around 40 per cent of new Commonwealth investment will come from the DisabilityCare Australia Fund. States and territories are expected to fund \$10.2 billion (47 per cent) of scheme costs.

### ***Commonwealth programmes***

The Commonwealth Government’s contribution to the NDIS has been, in part, funded from 17 existing Commonwealth Government (Commonwealth) programmes. These programmes will transition either in full or in part to the NDIS in recognition of the fact that the targeted client groups and types of supports provided by these programmes are the same as the support people would receive in the NDIS. This approach reduces the call on the budget and ensures that the Commonwealth does not pay twice to provide the same supports. To administer this approach, the Commonwealth has developed transition strategies for each Commonwealth programme that will:

- improve the alignment between current service offers and programme eligibility rules with the NDIS model;
- reprioritise assistance towards reasonable and necessary supports for people with substantially reduced functional capacity;
- minimise the Commonwealth’s financial exposure; and

- address continuity of support issues for current programme clients who are ineligible for the NDIS, particularly clients aged 65 years and over, under the commitment by governments to ensure that existing service users are not disadvantaged in the transition to the NDIS.

The majority of transitioning Commonwealth programmes are expected to cease at the end of 2018-19, with all funding redirected to the NDIS from 1 July 2019. The Continence Aids Payment Scheme (CAPS) and the Hearing Services Program (HSP) will continue alongside the NDIS to support clients ineligible to become NDIS participants, including a substantial proportion of clients aged 65 and over.

Funding for the remaining programmes will be individualised where it is possible to do so. Funds will then be cashed out as individuals become participants in the NDIS, consistent with the principles agreed by all governments. Where funds cannot be individualised, block or activity-based funding will continue but be progressively reduced in line with the NDIS roll-out.

The transition of these programmes is not regulatory in nature and is therefore not expected to result in a change in the regulatory burden.

### ***Options Considered***

NDIS trial experience indicates that in some cases, Commonwealth programme clients are not being found eligible for the NDIS and that some supports are not easily delivered under the NDIS model. This has the potential to create service gaps as people transition to the NDIS and may result in the Commonwealth paying twice to fund both the NDIS and clients that continue to access Commonwealth programmes outside the NDIS. The Commonwealth has considered three options to manage these risks over transition to full scheme.

The first option is to work with clients, providers and the NDIA to ensure that the current funding arrangements are implemented in full with appropriate mitigation strategies, including:

- redesigning the current service and funding models of existing Commonwealth programmes within the current funding arrangements to minimise the Commonwealth's future continuity of support commitments;
- providing assistance to existing clients and providers transition to a flexible, individualised and fully contestable operating model under the NDIS; and
- working with the NDIA to review and improve NDIS access processes and operational guidelines with regard to the legislative intent of the NDIS and to ensure that, where possible, reasonable and necessary supports and services are available under the NDIS.

This option is not preferred as these strategies alone are unlikely to adequately:

- address potential service gaps of a material nature;

- address all concerns of providers; and
- meet the commitment by governments that all existing service users are not disadvantaged in the transition to the NDIS.

The second, and preferred option, would include the work in the first option and in addition, where and to the extent that trial experience suggests a significant risk of a service gap, involve the Commonwealth adjusting Commonwealth programme funding contributions to the NDIS on a programme-by-programme basis to better reflect the transition of clients and supports from existing programmes to the NDIS, while continuing to monitor the evidence from the scheme and make further refinements to programme contributions if and when required.

This is the preferred option because it would provide more scope to address potential service gaps, provide continuity of support for existing service users, and ensure that the Commonwealth does not pay twice to provide the same supports.

An alternative approach is similar to the option above, but rather than adjusting funding contributions on a programme-by-programme basis would involve the Commonwealth uniformly adjusting Commonwealth programme funding contributions to the NDIS. This option is not preferred as it would not take into account the differences between programmes and would involve reductions to programme contributions where no service gaps exist, and may result in the Commonwealth paying twice to provide the same supports.

## **CONCLUSION**

The impacts of the NDIS on participants will be significant. By establishing common needs assessment and individualised planning processes, participants with similar needs will receive similar levels of support. Participants are able to exercise greater choice and control over how agreed support is provided; taking control of the provision of some supports directly where they choose to and allowing others to manage the provision of supports where they don't. Where they do not wish to be engaged in the day-to-day management of their support plans, they can rely on the NDIA to manage their support plans on their behalf.

Governments have also committed to continue to support those who are currently eligible for disability support but may not be assessed as eligible to participate in the NDIS. While this may increase the costs of providing disability support, jurisdictions have determined that the benefits to existing recipients of support outweigh the costs to the broader community of maintaining these arrangements.

Carers and families will benefit from the introduction of an NDIS because they will have a clearer understanding of the level and type of support that will be funded by governments, and will have greater certainty that support funding will be maintained over the participant's lifetime. Carers and families will also have greater confidence that support will be provided when it is needed and that the level of support provided will be adjusted as the participant's needs change. This will enable carers to better plan for the future.

Existing providers of disability supports will face significant challenges in adapting from programmatic funding to a fee-for-service business model. Impacts on providers will differ depending on the nature of the services and supports they provide, when current funding arrangements will cease, and how the transition to payment on a fee-for-service basis is made.

Some providers are preparing for these changes and are putting in place systems to cost, track and measure service delivery on an individualised basis. Others are waiting to see more details from the operation of the NDIS in the trial sites before making significant changes to their current business plans and programs. Many of the impacts on providers are a consequence of giving individuals greater choice and control over the use of their support funding. The regulatory burden on providers is currently limited to registering as a provider of supports or as a provider of support management services. However there may be changes to regulatory burden as a consequence of changes to quality assurance and safeguards, which is the subject of a separate (COAG) Regulation Impact Statement.

The disability-related workforce is also preparing for the transition to the full NDIS. Providers in many of the trial sites have been able to recruit additional workers as needed, but the workforce is becoming increasingly casualised, which could impact on staff recruitment and training costs.

One of the areas of most contention for providers in the trial sites has been the setting of prices for the most commonly used supports by the NDIA. Providers have expressed a range of concerns about how these prices have been determined and that the NDIA will continue to set reference prices for these supports, and require registered providers to accept them in the transition to full scheme and beyond.

Part of the problem is that many providers do not know what the actual costs of providing individualised services are because they have not had to measure these costs before. Many have built their businesses around current government programmes and their cost structures reflect the requirements of those programmes, rather than the direct costs of providing specific services.

One option to assist providers to adjust to the efficient price of their services is to continue to use the interim transitional pricing strategy which commenced from 1 July 2014 until the transition to the full NDIS begins in July 2016. Over the transition period the difference between the efficient price and the transition price will reduce as the efficient price increases. The transition price is due to cease on 30 June 2016.

Another option would be to begin negotiations with providers prior to the transition to the full scheme in July 2016. NDS has said that providers expected to be able to negotiate on the price, quantity and quality of assistance with daily activities and access to community activities from July 2014; however, this approach transfers any pricing conflict to the relationship between participant and provider and would result in the NDIA becoming a competitor to other purchasers in similar markets.



On balance it would be preferable to use an interim transitional pricing strategy beginning from 1 July 2014 and allow the efficient price to increase incrementally to reach the transitional price, in order to get to a competitive market price when the full NDIS begins in July 2016. This approach would minimise the likelihood of market failure, improve sector sustainability, establish a more transparent approach to pricing, and make allowance for other transitions.

The NDIA is also preparing for transition by investing in new ICT systems, recruiting additional staff and streamlining current application and planning processes. The NDIA will also have to determine how, and over what time frame, it intends to allow market prices for supports to evolve. In the meantime, ongoing engagement with providers when developing reference prices and maximum prices, particularly for key supports, should help providers during the transition to a fee-for-service based system of disability care.

At full NDIS, the annual cost of the NDIS is expected to be around \$21.9 billion, of which the Commonwealth's contribution is around \$11.7 billion.

The regulatory burden on businesses, individuals and community organisations of the NDIS is estimated to be \$292.6 million on an annualised equivalent basis. The Commonwealth's share of this burden, on the basis of current funding arrangements for the full NDIS, is \$152.16 million on an annualised equivalent basis. However, as the decision to introduce an NDIS was taken by the former Government, the regulatory burden associated with the NDIS forms part of the burden of existing regulation and therefore does not count for the purposes of the Government's \$1 billion net annual target.

## **IMPLEMENTATION AND REVIEW**

### **NDIS Implementation**

As noted above, current trials of the NDIS and the WA My Way scheme in WA will be used to inform decisions on possible transition to the NDIS in WA. In addition, arrangements for transition to the full NDIS in the ACT have been agreed, with all eligible participants to enter the NDIS during the trial period.

### **New South Wales**

The NSW Government intends to complete the transition to the NDIS by July 2018. Approximately 140 000 people in New South Wales will be supported by the NDIS.

In addition to establishing one of the trial sites for the NDIS, in the Hunter region of New South Wales, the NSW Government has introduced legislation to facilitate the transfer of all NSW Government disability services, staff, buildings, equipment and other assets to the non-government sector. From 1 July 2018, the NSW Government will no longer provide specialist disability services.

NSW will also have an early transition to the NDIS for 2 000 young people (aged 0 – 18) in the Penrith/Blue Mountains area.

The NSW Government's preferred approach is to adopt a geographic roll-out combined with a programmatic transfer of some cohorts.

## **Victoria**

The VIC Government intends to transition to the full NDIS over three years. From July 2016, the NDIS will progressively roll out in Victoria and by July 2019, all eligible residents will be covered. At that point, approximately 100 000 Victorians will benefit from the NDIS.

The VIC Government's preferred approach is to adopt a geographic roll-out combined with a programmatic transfer or priority of some cohorts.

## **Queensland**

The QLD Government intends to transition to the full NDIS over three years. From July 2016, a geographic roll out will occur in Queensland. At full scheme, around 97,000 Queenslanders are expected to benefit from the NDIS.

QLD has limited available funds in the first two years of the transition which results in a large number of participants back ended in the final year of the transition roll-out.

## **South Australia**

A backlog of access requests because of higher than expected numbers in the trial is expected to delay the phasing of participants into the NDIS in SA. However, the SA Government is committed to a two-year transition period, from July 2016 by July 2018. At that point, approximately 33 000 participants will benefit from the NDIS.

SA also has limited new funds in the transition and this would result in back-ended roll-out with large numbers of participants coming into the scheme in the final quarter of transition.

## **Tasmania**

The TAS Government is considering three approaches to transferring participants into the NDIS: age cohort, service type and a combination of the two, with facilitated access through TAS Gateway services. Through trial TAS already has a whole of state service footprint for a particular age cohort, with facilitated access through the TAS Gateway services. The TAS Government intends to complete transition over three years, from July 2016 by July 2019, at which point around 11 000 participants will benefit from the NDIS.

## **Northern Territory**

The NT Government is intending to transition around 7 000 participants into the NDIS over three years, from July 2016 by July 2019. The preferred approach of the NT Government is to adopt a geographic approach; however, the options are less progressed than other jurisdictions<sup>40</sup>.

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<sup>40</sup> Note the trial agreement to provide \$30 million Commonwealth funding over three years from 2019-20 to assist NT full - scheme.

## Review of the National Disability Insurance Scheme Act 2013

Section 208 of the Act established that an independent review of the operation of the Act (the Review), must commence on the second anniversary of the commencement of Chapter 3 of the Act. Thereby, the Review must commence by 1 July 2015.

The Review forms part of a suite of reviews looking into the operation of the NDIS. These reviews include the Productivity Commission Review of scheme costs, the review of the Intergovernmental Agreement<sup>41</sup>, the NDIS Evaluation of Trial and the review of Lessons Learned from Trial.

The Review of the Act will focus on whether the Act is appropriately supporting the objectives and principles of the NDIS, and the policy design of the NDIS as agreed by Governments, or as identified by findings and/or early lessons from other reviews commissioned by Governments and intended to inform the Review of the Act. The Review will include reviewing the Rules established under the Act.

The Review will consider:

1. The operation of the Act in furthering its Objectives and Principles;
2. If the Act can be simplified;
3. If the Act can be amended to increase the efficiency of the scheme's administration, including providing greater clarity around access requirements;
4. If the Act can be amended to ensure that the NDIA has the required capacity to control costs;
5. Whether parts of the Act could be refined, removed or replaced for the purposes of more effective regulation (including de-regulation where appropriate);
6. If the Act can be amended to ensure it interacts appropriately with other legislation, including State and Territory legislation;
7. Any interim or final recommendations for legislative change from other reviews; and
8. Any other matter relevant to the general operation of the Act.

Terms of Reference for the Review were agreed by Disability Reform Council (DRC) on 12 December 2014.

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<sup>41</sup> At its meeting of 16 February 2015, DRC agreed to the Terms of Reference for the Review of the Intergovernmental Agreement, which will be undertaken in a parallel timeframe with the Review of the Act.

## **ATTACHMENT A – SUBMISSIONS ON THE COAG CONSULTATION RIS**

Activ Foundation Inc.

Ai Media

Alzheimer's Australia Victoria

Assistive Technology Suppliers Australasia Inc.

Attendant Care Industry Association

Australian Advisory Board on Autism Spectrum Disorders

Australian Blindness Forum

Australian Federation of Disability Organisations

Australian Rehabilitation and Assistive Technology Association Inc.

Autism Queensland Inc.

Autism Spectrum Australia

Bedford Group

Blind Citizens Australia

Brain Injury Australia

Carers Australia

Carers Queensland Inc.

Cerebral Palsy Alliance

Cerebral Palsy League of Queensland

Deafness Forum of Australia

Disability Advocacy Network Australia

Endeavour Foundation

Guide Dogs NSW/ACT

Inclusion Works Association Inc.

Lifestyle Solutions (Australia) Ltd

Macular Disease Foundation Australia

Mai-Wel Ltd.

Mental Health Council of Australia

Mental Illness Fellowship Victoria

Motor Neurone Disease Australia/Multiple Sclerosis Australia

National Council on Intellectual Disability

National Disability Services  
Neurological Alliance Australia  
Neuro-Muscular Alliance Tasmania  
Novita Children's Services  
Psychiatric Disability Services of Victoria  
Queenslanders with Disabilities Network  
Royal Society for the Blind of SA  
Samantha Jenkinson  
South Australian Government  
Suncorp Group  
UnitingCare Community Options  
Vision 2020 Australia  
Vision Australia  
WA's Individualised Services  
Young People in Nursing Homes National Alliance  
Youth Disability Advocacy Service

## ATTACHMENT B – PARTICIPANT PATHWAY IN THE NDIS

The NDIS process starts with a person with disability contacting the NDIA to find out if they are eligible for NDIS support. Some people may not need the individualised support available through the NDIS and can be assisted by being linked into a specific service or to a broad community support.

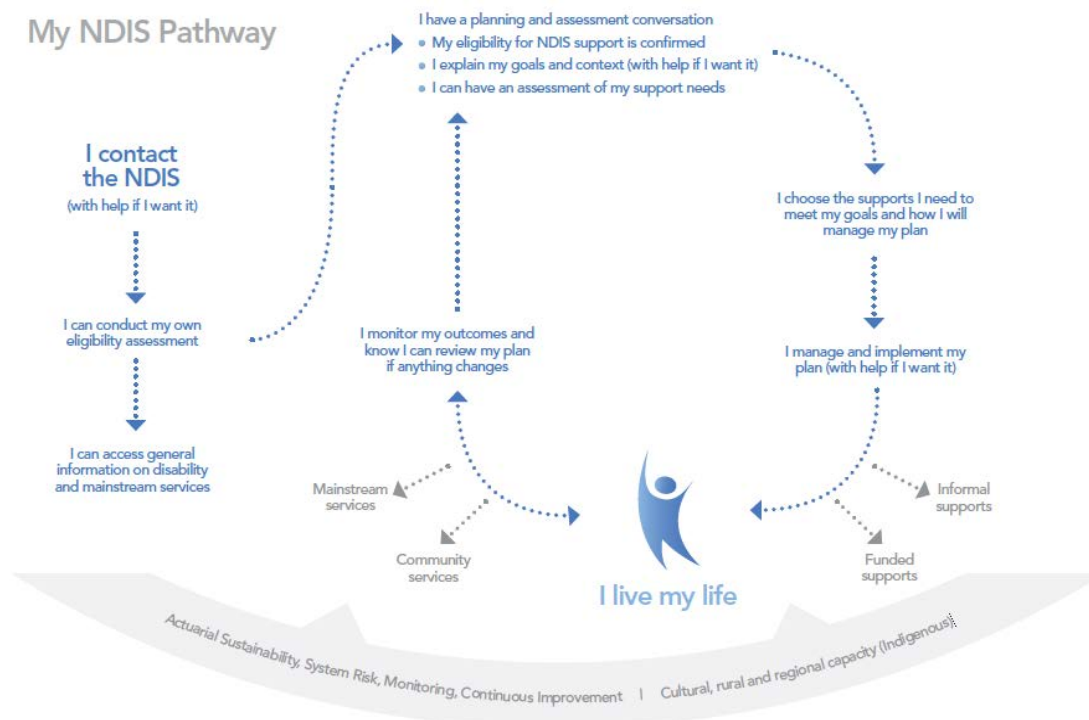
Eligible people meet with a planner to talk about their goals and aspirations, the reasonable and necessary supports needed to meet their goals, what safeguards might be required to maximise choice and control, and how they want to implement and manage their support package. This leads to the development of an individualised support plan.

People with disability then indicate how they would like their plan to be managed – whether they wish to manage it themselves or nominate another person, the NDIA or a combination of these options. Putting individual support plans into action involves people with disability choosing who will provide their supports. This involves control over how, when and where to receive supports and arranging these details directly with the chosen provider. Local Area Coordinators from the NDIA can help put plans into action.

Agreed review dates will mean people with disability can talk about their plans and make changes as necessary. Regardless of scheduled reviews, a person can seek a review at any time to discuss changes to their goals and plan, including what supports they need, how supports are provided, and who provides these supports.

The participant pathway is shown in Figure 2 below.

**Figure 2: Participant pathway**



## **ATTACHMENT C – NDIA TERMS OF BUSINESS FOR REGISTERED SUPPORT PROVIDERS**

The following section reproduces the Terms of Business for Registered Support Providers, published on the NDIA website and accessed on 17 October 2014 at:

[www.ndis.gov.au/document/288](http://www.ndis.gov.au/document/288).

The *National Disability Insurance Scheme Act 2013* provides for the making of Rules and requirements for registered providers of support.

The Rule – *National Disability Insurance Scheme (Registered Providers of Support) Rules* – states that registered providers must agree to the National Disability Insurance Agency Terms of Business. This document sets out those terms and should be read in conjunction with the Rule.

### ***Service Delivery***

Supports are to be delivered in accordance with the Objectives and Principles of the *National Disability Insurance Scheme Act 2013*, all relevant National Disability Insurance Scheme Rules and Guidelines, the provider's own Code of Conduct, Code of Ethics or Service Charter and any legislative or other requirements of the Commonwealth, State or Territory authority that is relevant to the type of support delivered.

*Competence:* Providers are expected to maintain a high level of competence in providing supports to National Disability Insurance Scheme participants and regularly update their knowledge and skills. A verified complaint about the incompetence of a provider may result in revocation of the provider's registration.

*Service agreements:* It is expected that providers will work with a participant to establish written or verbal agreement about the nature, quality and price of supports to be provided. All supports delivered will be in accordance with that agreement. Such agreements will accord with the National Disability Insurance Scheme Model Agreement and incorporate input from participants including internal management of complaints and cessation of supports. Service agreements need to be consistent with the National Disability Insurance Scheme's pricing arrangements and guidelines.

*Withdrawal or termination of services:* If a provider intends to withdraw or terminate the provision of services to a National Disability Insurance Scheme participant, adequate notice must be given to enable the participant, their nominee or the Agency to find a suitable alternative. The time frame for notice will vary according to the nature and frequency of the support and will be included in the agreement with the participant. The Agency is to be advised of an impending termination of services, if there is any risk to continuity of supports to a participant.

### ***Business Practices***

Providers are to comply with all applicable Commonwealth, state and territory laws in relation to conducting a business and governance arrangements.

Providers must not accept any offer of money, gifts, services or benefits that would cause them to act in a manner contrary to the interests of the participant.

*Conflict of Interest:* A conflict of interest, or potential conflict of interest (a situation where a provider could be influenced, or seen to be influenced by a financial or personal interest in carrying out their duties) is to be managed by bringing it to the attention of the agency and participant and providing assurance as to how it will be managed by the provider. A provider must have no financial or other personal interest that could directly or indirectly influence or compromise the choice of provider or provision of supports to a participant.

A plan management provider must disclose any financial interests in providing advice or management supports to a participant.

*Subcontracting:* Where a registered provider subcontracts the provision of supports, the subcontracted provider must comply with these terms and any employment or any workplace health and safety law that applies to the contractor in that provision or management. The provider must have mechanisms in place to ensure the subcontractor is compliant with workplace health and safety and employment laws.

Where a registered provider engages an individual as an independent contractor for the provision of supports or the management of supports, it will pay the independent contractor at least the amount payable as if the individual were employed in accordance with the *Fair Work Act 2009*.

Where a registered provider engages an entity as a contractor for the provision of supports or the management of supports, it will pay the entity an amount that accords with the applicable industrial instrument in relation to the work performed in fulfilment of that contract by each partner or member of the entity, including the *Fair Work Act 2009* where that is applicable.

The participant must be informed of, and understand, the subcontracting arrangements.

*Anti-discrimination:* When providing supports, a provider must provide supports consistent with the Objectives and Principles of the *National Disability Insurance Scheme Act 2013* and comply with anti-discrimination legislation and not discriminate on grounds of gender, marital status, pregnancy, age, ethnic or national origin, disability, sexual preference, religious or political belief.

*Insurances:* A provider must maintain an adequate level of relevant insurances including professional indemnity, public liability and workers compensation insurance when employing workers.

*Records management:* A provider is to keep proper and accessible records of the supports delivered to National Disability Insurance Scheme participants including financial records that are fit for audit. Adequate records must be maintained as evidence of the provision and payment for a support. Financial records are to be retained for at least 5 years. All other records are to be retained for a length of time in accordance with the relevant state or territory laws.



*Pricing and Payment conditions:* Providers can charge for supports delivered in accordance with the National Disability Insurance Scheme pricing arrangements and guidelines, after the support has been provided. Prepayment is not generally permitted for supports.

A claim for payment is to be submitted within a reasonable time (30 days) after the date of providing the support.

For a self-managing participant, a provider must clearly set out for the participant the costs to be paid, timing of delivery and the payment method. No charges are to be added to the price of the support, including credit card surcharges, or requested from the participant.

No fee additional to the agreed price for the support is to be levied upon a participant for reasonable and necessary supports set out in a participant's plan.

*Serious incident reporting:* Providers are required to report serious incidents to the National Disability Insurance Scheme State Manager and to the relevant statutory authority in the local jurisdiction. A serious incident is:

- the death of, or serious injury to, a participant;
- allegations of, or actual sexual or physical assault of a participant;
- significant damage to property or serious injury to another person by a participant; and
- an event that has the potential to subject a participant or National Disability Insurance Scheme to high levels of adverse public scrutiny.

### ***Interactions with National Disability Insurance Agency***

*Provision of information:* Providers must supply any information requested by the National Disability Insurance Agency in relation to the provision of supports within a reasonable time frame or as specified in the request.

Providers may be reviewed by the National Disability Insurance Agency in relation to supports funded for a National Disability Insurance Scheme participant. Providers must cooperate fully with National Disability Insurance Agency officers who are undertaking review activities.

Where a decision by the National Disability Insurance Agency is the subject of a merits review or complaint, or a request for information is made under the *Freedom of Information Act 1982*, the provider is required to cooperate in providing any documents or other information requested.

*Provider information updates* will be provided via the National Disability Insurance Scheme website and/or provider portal. Providers will be responsible for updating their knowledge and information about any changes to the National Disability Insurance Scheme's requirements published on the website or portal. The NDIS will provide alerts when new information is available.

*False declarations:* A provider must not make false or misleading declarations in their dealings with the National Disability Insurance Agency or during the delivery of their

supports. A declaration may be misleading if information is omitted or presented in a manner that enables a misleading view of a situation to be formed.

Providers must not collude with other parties with the intention of providing false or misleading information. Providers must take all measures to maintain the integrity of the supports they provide and their records.

*Notification:* It is the responsibility of the provider to maintain accurate contact details with the National Disability Insurance Agency. A registered provider must advise the National Disability Insurance Agency of any changes to the information contained within the application for registration as soon as is practicable. Paragraph 4.1 of the *National Disability Insurance Scheme Rule — Registered Providers* contains further detail about the requirement for providers to notify the National Disability Insurance Agency about changes in their compliance with the criteria for registration.

### ***Identification as an NDIS Provider and Use of the NDIS Logo***

Registered providers may identify their National Disability Insurance Scheme registration by stating “<Organization/person’s name> is registered to provide supports for National Disability Insurance Scheme participants.”

The National Disability Insurance Scheme logo is not to be used by a provider in any publicity material.

*Public comments:* As members of the community, all providers have the right to take part in public debate on issues of public concern. However, providers must be careful that public comments made as a private individual cannot be construed as an official comment on behalf of the National Disability Insurance Agency or the Government.

The provider must not represent themselves as spokespersons for the National Disability Insurance Scheme.

If elected or nominated as a spokesperson for a professional or community association, providers are entitled to make public comments about relevant issues. In making such statements, providers must clearly acknowledge that comments are made on behalf of that association and cannot be attributed to the National Disability Insurance Scheme.

### ***Confidentiality***

Providers must treat all information obtained as a National Disability Insurance Scheme provider as confidential.

All information related to participants must be stored in a secure manner. Providers must have a secure storage system for their records.

Participant information may be disclosed if the law requires the disclosure or when there is reason to believe that the use or disclosure is reasonably necessary for:

- reducing or preventing a serious or imminent threat to an individual's life, health or safety, or preventing a serious threat to public health or safety;
- preventing, detecting, investigating, prosecuting or punishing of criminal offences and other breaches of the law that attract a penalty;
- preventing, detecting, investigating or remedying of seriously improper conduct or proscribed conduct; and
- the preparation or conduct of proceedings before any court or tribunal.

With the exception of an imminent threat to life, health or safety, all requests for disclosure must be referred to the National Disability Insurance Scheme Privacy Contact Officer for consideration prior to release.

### ***Complaints***

Providers are to have clear and accessible complaints handling and dispute resolution processes. Records related to complaints are to be maintained for at least 5 years or as required by any other law.

All complaints to the National Disability Insurance Agency about a provider will be resolved in accordance with the Complaints Procedure of the National Disability Insurance Agency, or the State authority, whichever applies.

### ***References***

*National Disability Insurance Scheme Act 2013*

*Freedom of Information Act 1982*