



AUSTRALIAN MEDICAL  
ASSOCIATION

ABN 37 008 426 793

T | 61 2 6270 5400

F | 61 2 6270 5499

E | [info@ama.com.au](mailto:info@ama.com.au)

W | [www.ama.com.au](http://www.ama.com.au)

42 Macquarie St Barton ACT 2600

PO Box 6090 Kingston ACT 2604

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## **Productivity Commission Issues Paper – National Disability Insurance Scheme (NDIS) costs**

**Review of NDIS Costs**  
**Productivity Commission**  
**GPO Box 1428**  
**BARTON ACT 2600**

[www.pc.gov.au/inquiries/current/ndis-costs](http://www.pc.gov.au/inquiries/current/ndis-costs)

### **Introduction**

As the peak professional organisation representing medical practitioners in Australia, the Australian Medical Association (AMA) welcomes the opportunity to provide a brief submission to the Productivity Commission Issues Paper on National Disability Insurance Scheme Costs (NDIS).

The medical profession has a key role, and interest, in the success of the NDIS, in particular the ways in which the NDIS impacts on, and interacts with, mainstream services. The AMA is particularly interested in how planning, assessment and eligibility criteria will ensure Australians with disability, and in particular people with mental illness, will be managed within the NDIS.

### **Cost drivers – gaps between NDIS and PHN:**

The paucity and inconsistency of services that fit between General Practitioners and Emergency Departments is of particular concern, as this presents myriad challenges to both the NDIS and Primary Health Networks (PHNs). For this reason, the mechanisms through which Primary Health Networks can commission disability services should be considered in any assessment of the sustainability of the NDIS. The intersection between eligibility for NDIS support packages and PHN services is where gaps are most likely to occur, and costs shifted across the health sector.

The range of primary care and specialist medical treatments and psychosocial services available to people living with mental health problems is not confined only to those on NDIS support packages. As the Issue Paper notes, ILC services are there, in part, to assist people with disability, their families and carers, with referral to community and mainstream services. As funding for these services is provided by both the Commonwealth and State/Territory Governments, the costs of

NDIS support packages cannot be viewed without referencing the costs (and availability and accessibility) of community and mainstream services.

As an example, the AMA draws the Productivity Commission's attention to concerns about PHNs not being able to purchase psychosocial services. These are services that coordinate supports, such as employment, housing, independent living and community participation, for people with severe and persistent mental health issues who have complex needs. As mental health funding is transferring to the PHNs, it is reasonable to expect that, at a minimum, PHNs provide both clinical and psychosocial care, as needed. However, at the Senate Estimates hearing (Community Affairs Legislation Committee, 1 March 2017), the Department of Health acknowledged that PHNs have expressed concerns about gaps that may be created where NDIS support packages are not available to people with mental health problems, and that workforce shortages are also a problem:

**Ms Cole:** The issue around psychosocial support is not actually a PHN issue. We can talk to that issue now, if you wish. Some of the PHNs have obviously expressed the concern that the NDIS may result in some issues with or some gaps in the psychosocial area. That has been clear. Most of them—certainly the rural ones—have also indicated that workforce continues to be a major issue for them in addressing service problems, as you would expect—particularly psychologists. Some have identified some issues around the availability of psychiatry services and around things such as the need to develop appropriate low-intensity services. Essentially those are the kinds of themes that are coming out. I do not believe they are anything new to anyone who has been familiar with the sector for a while, but in a sense the NDIS issue of psychosocial provision of support is a slightly different issue from the PHNs themselves. Except where the PHN is actually a lead agency—for example, for partners in recovery—they do not have responsibility for those programs.

From this testimony it appears that PHNs do not have responsibility for the provision of psychosocial services. This is relevant to the financial sustainability of the NDIS in that it represents a cost-shift that is likely to be borne by the States and Territories. Further to this, evidence provided by Mr Cormack, Deputy Secretary, Strategic Policy and Innovation Group, stated that the Department of Health no longer has policy responsibility for those on NDIS support packages.

**Mr Cormack:** First of all, the policy responsibility for the NDIS does not rest with this department. It rests with another department ... We work very closely with DSS. Obviously, as the rollout progresses we feed into our DSS colleagues any issues that are emerging, any concerns that are being raised by the sector groups. I am sure you have had those put to you. Our job is to assist government and to assist the lead agency, which is DSS, to implement the transition through to the NDIS. We have responsibility for two programs and will continue to have responsibility for those right up until the end of June 2019. Over that time the clients in those programs will transition across. As we identify issues with transition at the level of the PHNs—some of the PHNs, but not all, are involved in a service provider capacity there—we provide that information to DSS to assist with the progressive implementation of the NDIS and, yes, of course we provide information to our minister to ensure that he is aware of this very important piece of program implementation. His responsibilities as a minister are with some of those specific programs that are transitioning. This is part of the process of providing ongoing policy advice to government, and we continue to do that right up until the present time.

I just want to go back to one really important conflated point: under the current arrangements a number of pre-existing Medicare Locals that have now been swept up into PHNs had direct service delivery responsibilities for certain psychosocial services that are now on the pathway to transition into the NDIS, but not all PHNs fit that category. Certainly, for any PHN that has inherited a service profile that is funded under Partners in Recovery or Day to Day Living, there is an expectation that they will continue to offer that right up until the point where it is fully transitioned into the NDIS. In that sense it is our expectation and, indeed, our commitment under the continuity of service arrangements that those

services will continue. However, if there is a PHN that has no history in that space of providing or commissioning out of those two programs, we need to be mindful about a broader national rollout of an NDIS and not commission services that are already going to be funded and provided for under an expanded NDIS rollout from 2019-20. That is the point that we are trying to make. Not all PHNs are the same.

It is therefore paramount that any response to emerging cost pressures in the NDIS – and indeed any review of drivers of NDIS costs – be undertaken in parallel to a similar analysis of the services delivered by PHNs. This is especially important when considering the psychosocial services people with disability need to help them manage and function in their daily lives.

### **Scheme Boundaries**

The Productivity Commission Issues Paper noted that “poorly defined boundaries between the NDIS and mainstream services can raise the risk of gaps in services, duplication of services and cost shifting ... particular concerns have been raised about the interface between the NDIS and mental health services.” This problem of defined boundaries and likelihood of gaps in services has the potential to both erode the ability of the NDIS to meet the needs of all Australians with a disability, but also to increase the burden on other parts of the health care system.

The AMA has been advised of situations where NDIS restrictions may result in some vulnerable people ending up in more costly and less appropriate health care. For instance, as we understand it, eligible recipients of NDIS packages cannot purchase interpreter services. People from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander (ATSI) people may be adversely impacted by this, as they often rely on interpreter services to access and understand the Australian health system. The logical outcome of an exclusion of interpreter services in NDIS packages is that costs and health care provisions are shifted to another jurisdiction or service.

Another aspect that relates to eligibility and services not funded through the NDIS is that three important mental health programs – Partners in Recovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PhaMs) – are being rolled into the NDIS. Our concern here is that those people assessed as ineligible for NDIS support packages may not be eligible for other forms of mental health care by the Commonwealth. This could see greater pressure on GPs, psychiatrists and State hospitals from those who fall ‘between the new cracks’ and are left with few alternative options for medical and psychological care.

The AMA supports investment in community mental health services which provide GPs with enhanced referral pathways, and service options, especially for those with low to moderate mental health problems or who need support in managing their day-to-day activities.

The Productivity Commission Issues Paper does not quantify how many Australians with mental health conditions will now no longer be eligible for the NDIS, although there has been a figure of 200,000 mentioned by mental health advocates. An evaluation is needed so that both the health sector and governments know the exact number of people not deemed eligible for an NDIS support package but who nevertheless have ongoing or episodic mental health conditions. Where these people go, who will treat them, where they will be treated, and what medical and psychosocial supports will be provided, currently remains unknown. What can be predicted is that those with mental illness who are excluded from NDIS support packages may take up time and energy of clinicians and other health providers in more costly health care settings.

## **Market readiness**

A particular challenge to the success of the NDIS is workforce and workforce distribution. The Productivity Commission identified the difficulties in recruiting qualified staff, the unequal workforce distribution and demand for carers as key issues. It is worth noting that at the March 2017 Senate Estimates hearing, the Department of Health said that, in relation to on-going funding to the Mental Health Nurse Incentive Program (MHNIP), it is “the whole picture” of a region that DoH looks at. Said one DoH official:

“If you look at, for example eastern Melbourne, it is very significant. There is a congregation of psychiatry and psychology services in that region.”

The worry here is pressure points in mental health care will increase, and possibly worsen. Waiting times and bottlenecks are created because the supports for people with low to moderate mental health conditions, or people needing support in their day to day living, are no longer being provided for. This will directly increase the burden on psychiatry and public hospitals to meet a growing and unnecessary demand for care.

## **Eligibility for the NDIS**

Autism Spectrum Disorder (ASD) is an example of where the criteria for NDIS participant supports is not clear or effective. In late 2016, the AMA released a position statement on Autism Spectrum Disorder (ASD). The AMA Position Statement made specific recommendations, including:

That the Government make a strong, ongoing commitment, that people who are affected by ASD will have ongoing access to support through the NDIS.

The Productivity Commission is no doubt aware of widely held concerns about early intervention approaches and whether the NDIS is part of the health care system that is providing early intervention therapies to give children with ASD the best outcomes possible. In regard to ASD and indeed other mental health and intellectual disabilities, the AMA does not believe the criteria for participant supports is clear and effective. There is insufficient guidance for families of children with ASD. Improvements need to be made in recognising that in some conditions, such as ASD, there is no specific medical (or biomedical test) that can be used for diagnosis. A definitive diagnosis is made via screening tools and observation. Current research suggests that ASD can be reliably diagnosed at two years; a recent international review found that diagnosis often occurs at three years of age. An analysis of Medicare data found that the most frequent age for diagnosis was 5.9 years. In a survey of parents and carers of children with Autism, 34 per cent reported waiting over a year for a diagnosis, and close to 20 per cent reported waiting for more than two years.

The data suggests that children in Australia are not being identified as early as they should be. Early identification and diagnosis of ASD can make a significant difference in outcomes. During the process of diagnosis areas of deficits are likely to be identified. Following diagnosis, children can be referred on to a range of early intervention services which can be tailored to their needs. The fundamental goal of early intervention is to reduce the impact of the disability, which also tends to lower the costs for families and the wider community associated with the disability. It is likely that because of unclear criteria and guidelines, some Australian children are experiencing significant delays in diagnosis, and access to appropriate early intervention, which reduces the effectiveness of some interventions.

NDIS eligibility guidelines must be broad enough to capture early diagnosis, as the ASD example illustrates.

### **Assessment tools**

The AMA has received anecdotal evidence that raise concerns about the way in which NDIA assessment tools are being used to assess Aboriginal and Torres Strait Islander people. These reports suggest that the information collected may not be *valid, reliable, accurate* or *efficient* - the criteria for assessment tools.

For example, we were told that in one Aboriginal community, NDIA assessors did not leave their vehicle, instead they yelled questions of Aboriginal people regarding their disabilities. According to what the AMA was told, there was no verification of the person's identity other than to ask their name and conduct a conversation from a driveway. Another reported case was that Aboriginal people with disability were asked to leave their homes and find their way to a waiting vehicle for an assessment; this included an Aboriginal person in a wheelchair. Although these cases may be isolated, it raises the need to have culturally appropriate and accurate assessment tools that collect sufficient reliable information to assess support needs. The criteria for assessment – that is be conducted “in the least costly manner” – may lead to the most vulnerable and hard to reach people not being properly assessed by the NDIA.

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### **Contact**

Simon Tatz  
Director, Public Health  
Australian Medical Association (AMA)  
Ph: (02) 6270 5449  
statz@ama.com.au