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Ms Esther Kerr-Smith

General Manager - Markets & Providers
National Disability Insurance Agency
Via email: market@ndis.gov.au

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Dear Ms Kerr-Smith

Thank you for the opportunity to comment on the *Personal Care and Community Participation 2016/17 Price Review.* Given the limited time available for consultations, Mental Health Australia has not been able to respond to the detailed questions the consultation paper asks. However, we are using this submission as an opportunity to raise a range of important pricing issues that the NDIA could consider in the future.

Introduction

Since rollout of the NDIS commenced in launch sites, mental health providers have raised concerns about the match between the hourly prices paid by the NDIA for psychosocial support work and the reality of delivering that work by suitably qualified personnel. Some providers have described their work in launch sites as 'loss-leading', undertaken under the assumption that it will be eventually become apparent to the NDIA that its pricing structures need revisiting, and acknowledging that this is one of a myriad of implementation challenges.

Less optimistically, some mental health providers envisage a 'race to the bottom', where a less skilled workforce becomes a competitive advantage and choice for participants is eroded over time, as providers become unable to support more highly trained workers under the terms set by the NDIA.

Mental Health Australia is eager to assist the NDIA to learn more about the key cost drivers within the business model for mental health providers.

With these different scenarios in mind, it is encouraging to note the NDIA's observation that "if price limits were set too low, providers would be unable to recover even efficient costs. This could result in a significant share of providers leaving the sector and/or a lack of new investment in disability services."

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*Mental Health Australia **recommends** that the NDIA gives further consideration to strategies that would identify the types of organisations most at risk, mitigates against these very real risks, and discusses these strategies with stakeholders as the market for disability services evolves.*

Most providers are unaware of the detailed work and assumptions in the NDIS Methodology for Reasonable Cost Model regarding overheads, supervision, etc. This makes it difficult for providers to give you detailed and thought out input to consultation processes.

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*Mental Health Australia **recommends** the NDIA engages in an ongoing dialogue with providers about the current assumptions in the model. This will support more detailed, and thorough consultation processes in the future, and build the NDIA's evidence base.*

Support Co-ordination

To put the concerns outlined above in perspective, it should be noted that the adoption of the revised Price Guide in August 2015, along with other changes in NDIA practice, may have changed the extent to which mental health providers are negatively affected by the NDIA's pricing determinations. Many activities for people with psychosocial disability undertaken on a flexible, client-directed basis could now be carried out through the support coordination role. New arrangements may also help support the significant amount of time spent by mental health providers that is not directly client-facing – that is, 'behind the scenes' work of various kinds that would be consistent with how support coordination often takes place for people with psychosocial disability. Alternatively, some of these activities may be carried out by LACs, under different funding arrangements, particularly at the earlier stages of client engagement. However, there is still limited information publicly available on the delineation between IFP and LAC functions from this perspective.

Mental Health Australia hopes the new flexibility and the addition of a three-tiered support coordination function will facilitate more alignment between participant goals and the outcomes achieved, but it remains to be seen whether this is borne out in practice. Early anecdotal evidence suggests significant variation between launch sites in how the support coordination function is being built into plans. It is therefore important that ongoing monitoring occurs, informed by the experiences of participants and providers directly affected.

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*Mental Health Australia **recommends** that the NDIA monitors the use of support coordination items (at each of the three levels) in plans relative to other support items, including but not limited to personal support and community participation, for participants with psychosocial disability.*

This evidence can then be used to evaluate whether plans being written over time are consistent with the NDIA's intention (as articulated in the revised Price Guide) that support coordination be a major contributor to participant wellbeing.

Pace of change

The mental health sector is currently undergoing multiple reform processes, in addition to the NDIS. These include:

- the Australian Government's response to the National Mental Health Commission's Review of Mental Health Programmes and Services, which will see major changes in the funding and structure of mental health services across Australia;
- the forthcoming 5th National Mental Health and Suicide Prevention Plan, which is likely to bring further change to the sector; and
- new mental health legislation in many states and territories.

Therefore, the mental health sector needs additional time to embrace and adopt the current reform agenda, before even more changes are imposed on the sector.

Funding for innovation & co-ordination.

We welcome the NDIA's commitment to encouraging service provider innovation.

While individualised funding is at the very heart of the NDIS, the Productivity Commission recognised that individualised funding may mean there will be less research, less experimentation and less innovation than is desirable. They noted that therefore there are grounds for providing additional funding (perhaps as grants) to support research and experimentation – separate to ILC.[1]

While individualised funding is vital to deliver genuine consumer choice, and may improve outcomes, individualised funding does not necessarily mean unit-cost based, 'fee-for-service' model, and could include elements of fixed, or upfront, charges. This is similar to many utility bills, where there is a mix of fixed and variable charges, to reflect the mix in underlying cost drivers in the business.

There is a broad acknowledgement that in some contexts a unit-cost, fee-for-service model may not result in the best outcomes in human services, and some level of fixed charges would be beneficial, to complement existing payment arrangements. The Primary Health Care Advisory Group's recent report on *Better Outcomes for People with Chronic and Complex Health Conditions*, for example, argues that "the current fee-for-service payment model is in conflict with the proactive, coordinated and ongoing team based approaches that are needed to support the prevention and optimal management of chronic and complex conditions." In its response to that report, the Australian Government is proposing a mixed payment model, which will "encourage providers to be innovative and flexible in how they communicate and deliver care." This mixed-payment model is still individualised and patient-centred, with choice and control, but will ensure that the remuneration arrangements provide the right incentives to GPs.

Similarly, the Partners in Recovery programme (PIR) guidelines allow for an 'innovation fund,' which allows PIR providers to explore, fund and trial innovative models of delivering services. The Innovation Funds are designed to promote collaborative action and encourage innovative solutions that ensure recovery-oriented, effective and timely access to the services and supports required by people with severe and persistent mental health conditions. The projects funded are designed be locally focused and to:

- support collaboration between services;

[1] p521

- support the expansion of best practice recovery-oriented services;
- have a system improvement and recovery integration focus; and
- deliver positive outcomes for people with severe and persistent mental illness and their carers and families.

The PIR innovation fund has been used recently to fund projects like:[2]

- a trial of a family-inclusive recovery model for adults experiencing severe mental health difficulties and their families/carers;
- a trial of a holistic approach to addressing the physical health and wellbeing needs of adults with a disability;
- building the capacity of community pharmacists to support people with a mental illness living in the community and raise awareness of the role of community pharmacy among the mental health sector.

These sort of projects will play a vital role in the success of the NDIS. However, the transition of PIR into the NDIS threatens this element of PIR, as it seems clear that service providers will not have sufficient funds to undertake this type of work through the existing pricing structure. This requires investment in service provider capability, either through some sort of capitation payment for service providers undertaking innovative trials/pilots, similar to the Practice Incentive Program (PIP), or a recognition of the broader corporate overheads, such as strategic planning, research and development, and innovation.

Funding for core capacity requirements

Many aspects of service providers' costs are fixed, or related to the number of clients, rather than the number of client-hours. This includes, for example, ICT infrastructure. As the NDIA's discussion paper notes, funders "have [not] supplied the tools and/or additional funding to" measure or improve efficiency, and "donors have often seen operation reviews as not 'core' to the mission of the NFP." In practice, this has meant a significant under-investment in ICT (and related workforce skills) and other functions that are essential to the running of an organisation but not directly related to service provision. This was recognised through the introduction of the "establishment fee allowance" in 2015.

The Productivity Commission's report on the *Contribution of the Not-for-Profit Sector* noted that "[g]overnments could better tailor their support to promote development of relevant intermediary services and greater adoption of ICT to build sustainable capacity" and that "[g]overnments engaging in sector development activities should ensure that ICT issues are mainstreamed and that NFPs develop ICT strategies along with other business development planning." The importance of funding ICT for providers in human services has long been recognised in health, and is particularly warranted when the government is enforcing significant system changes on providers.

These arguments are especially relevant for the NDIS, given the focus on outcomes measurements, both in Individually Funded Packages, and in Information, Linkages and Capacity Building (ILC). In order for providers to be able to generate the data needed to

[2] http://www.northbrisbane.pirinitiative.com.au/innovation-fund/

track a wide range outcomes within and across provider settings, a significant investment in ICT capability will be required.

For at least the last 13 years, the Australian Government has continually provided financial support to the medical sector (in particular GPs) to adjust to new payment processes and ICT requirements on a 'per patient' basis. Currently, this is around $6.50 per patient per year.[3] There have also been additional incentives to encourage doctors to adopt electronic Medicare claiming[4] and support to software vendors to update their programmes to adjust to changes in payment procedures for Medicare.

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*Mental Health Australia **recommends** that the NDIA investigates how its pricing models can incorporate the costs of innovation, co-ordination with other service providers, ICT investments and other inputs that are not explicitly supported through an hourly unit price, but which nonetheless affect long-term viability in the NDIS marketplace.*

Funding for translators and interpreters

Under the existing arrangements for the Translating and Interpreting Service (TIS National), most NDIS providers are likely to be responsible for paying for translation and interpreting services, where required. This means that NDIS prices need to factor this price into their overhead calculations. Indeed, the Department of Social Services notes that "[o]rganisations that require language services (such as interpreting) and receive substantial government funding should incorporate the cost of these services into their application for funding."[5]

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*Mental Health Australia **recommends** that the NDIA considers the best way of ensuring participants from linguistically diverse backgrounds are able to access TIS services as required.*

Efficiency of the not-for-profit sector

The discussion paper notes that "[w]here funding has been provided by governments, management has had little incentive to improve efficiency, because providers have typically been required to return any surplus in funding to government." While it is true that surplus funding generally had to be returned to governments, Mental Health Australia is concerned about the NDIA's assertion that the NGO sector has had little incentive to improve its efficiency, both historically and in the recent past.

Most non-government service providers in mental health have had to compete through rigorous competitive RFT processes, where governments make decisions based on price. Ongoing funding indexation, usually based around a composite measure of minimum wages

[3] The current PIP Digital Health incentive is $6.50 per patient per year. Previous incentives include the PIP Information Management/Information Technology incentive, which started prior to 2003 and the PIP eHealth incentive.
[4] Transition Support Package for Electronic Claiming for Medicare
[5] https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/settle-in-australia/help-with-english/free-interpreting-service

and CPI, has consistently been lower than the real cost drivers of delivering mental health services, if it has been applied at all. This has required NGOs to identify efficiencies every year, simply to maintain existing services. In addition, the 2014-15 budget paused indexation for 3 years, which equates to a real cut of around 6 per cent, forcing the NGO sector to find further efficiencies. These pressures have remained even while governments have broadly agreed that greater investment is required in the non-government mental health sector if we are to see improvements in mental health outcomes at national and state/territory level.

Alongside such pressures are other factors influencing costs to providers. The Productivity Commission's report observed that "efficiency and effectiveness of delivery of services… is adversely affected by inadequate contracting processes [by government]. These include overly prescriptive requirements, increased micro management…. and inappropriately short-term contracts."

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*Mental Health Australia **recommends** that the NDIA closely considers the recommendations of the Productivity Commission's report on the contribution of the non-profit sector to ensures that it does not repeat the well-documented mistakes of other government agencies in its commissioning task.*

This will in turn maximise the value of the investment the NDIA is making to bring deliver greater choice and control to people with disability.

Training, supervision and support

Government, and the NDIA, recognise the importance of training, encouraging innovative and efficient use of the workforce, and the development of a skilled workforce. However, Mental Health Australia considers that the current price schedules are not sufficient to provide quality training, supervision and support to the frontline staff. Indeed, the NDIA's Methodology for Reasonable Cost Model does not appear to explicitly include training and development.

The National Centre for Vocational Educational Research (NCVER) identified that training hours in the community services sector are approximately 32hrs per employee per year.[6] However, the University of Western Australia has identified that the NGO sector is not investing sufficiently in training and developing its staff, due to a lack of time and money. The study also finds that NGOs that systemically develop their people do better and deliver positive economic returns.[7] International research also indicates that high performing firms spent, on average, 6 per cent of their payroll on employee development.[8]

In addition, many professions, including social workers and mental health nurses, have specific continuing professional development/education (CPD) requirements. Mental health

6 www.sapo.org.au/binary/binary761/Employer.pdf

[7] https://drive.google.com/file/d/0B1--xR9XdxCEZ0lRaGZ1S1BHT2c/view

8 http://www.skilledup.com/insights/how-top-companies-make-the-roi-case-for-employee-training

nurses need to undertake at least 67 hours per year,[9] and social workers at least 50 hours per year,[10] of CPD.

To ensure that NDIS providers can invest in training, and ensure their staff meet their professional CPD requirements, changes may be needed to both the staff utilisation rate (and back-filling positions), to ensure that staff have the time to attend training, as well as in the corporate overhead rates.

Ensuring pricing adequately enables professional supervision to be maintained is equally important. Professional supervision is different from typical supervisory functions in business management structures. For example, according to the Australian Association of Social Workers (AASW), the functions of social work supervision include education (using self-reflection and critical analysis to develop practice knowledge and skills), support (acknowledging the potential personal impact of social work on the worker) and accountability (i.e. reviewing practice against standards and client outcomes).[11] Both the AASW Supervision Standards 2014 and AASW Practice Standards for Mental Health Social Workers[12] impress the importance of professional supervision, with the former recommending that, at a minimum, new social workers are involved in supervision for 60 minutes fortnightly and those with two years or more experience 60 minutes monthly.

Provision of sufficient funding for training and continued professional development through supervision is especially important during the transition, to ensure that all frontline staff understand the impact of the NDIS on their practice, their organisation and people who use their services.

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*Mental Health Australia **recommends** that the NDIA conducts a price review on training, supervision and support.*

Continuity of relationships

Mental Health Australia would like to endorse the submission of Anglicare Tasmania, in particular regarding the importance of continuity of relationships with client-facing personnel. The development of trusted relationships and consistency in support for people with psychosocial disabilities is important and beneficial for better health outcomes.

However, this may not be possible under the existing pricing structure, which pays based on the activity being undertaken, rather than the skills of the staff member. Thus, it is financially difficult for the same person to be undertaking the assistance with daily life (at around $40-$45/hr), as who is undertaking individual skills development and training, life transition planning, or support connection ($54-$55/hr).

[9] http://www.acmhn.org/images/stories/Credentialing/GuidelinesReCredentialingAugust2014.pdf
[10] http://www.aasw.asn.au/practitioner-resources/cpd-requirements-for-amhsw
[11] https://www.aasw.asn.au/document/item/6027
[12] https://www.aasw.asn.au/document/item/6739

*Mental Health Australia **recommends** that mechanisms be developed so that it is financially viable for participants to choose to have all of their support from the same person.*

Comorbidity/physical health

Three out of every five people (60%) living with a mental illness have a co-existing physical illness. This is approximately five times the rate of the general population. Compared to the general population, people living with a mental illness are:

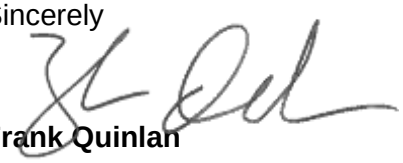
- Three times more likely to have cardiovascular disease;
- Three times more likely to have respiratory disease;
- Two times more likely to have diabetes;
- Two times more likely to have osteoporosis;
- 50% more likely to be overweight/obese
- 70% more likely to smoke; and
- Six times more likely to have dental problems.

This means it is vital for people with psychosocial disabilities in the NDIS to have holistic care, which treats any co-existing physical illness. Currently, many mental health services can also deal with some substance abuse issues, and other physical health conditions, which are outside of the NDIS. The flexibility of block-funding allows this. We are concerned, however, that the move to the NDIS may lead to greater fragmentation of care, as providers will no longer be able to provide these services.

*Mental Health Australia **recommends** that the NDIA conducts a review on how NDIS pricing structures impact on care needs outside of the NDIS.*

The contact for this submission is Daniel Casey, Manager, Policy and Projects (02 6285 0845 or Daniel.casey@mhaustralia.org).

Sincerely



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