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AMSANT Submission in response to NDIS Thin Markets Project Discussion Paper

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AMSANT is the peak body for the community controlled Aboriginal primary health care (PHC) sector in the Northern Territory (NT). AMSANT has been established for 20 years and has a major policy and advocacy role at the NT and national levels. We have 25 members providing Aboriginal comprehensive PHC across the NT from Darwin to the most remote regions.

The ACCHSs sector in the NT is comparatively more significant than in other jurisdictions, being the largest provider of Aboriginal PHC to Aboriginal people in the NT. Around two thirds of all Aboriginal PHC contacts in the Aboriginal primary health care system are provided by ACCHSs, with the remainder provided by the NTG Aboriginal primary health care system. Furthermore, ACCHSs have a wider scope of service provision than NTG services.

Nearly all of our members provide comprehensive primary health care inclusive of Social and Emotional Wellbeing (SEWB) and mental health services, and some provide early childhood programs (focusing on parenting and child development rather than just clinical service delivery), family support programs and youth work with a minority also now providing NDIS services and aged care services.

As a peak body AMSANT plays a role in advocacy and support of our member services to understand the NDIS and to assist ACCHSs to determine whether it is viable for them to become providers. However, this work is currently done without any direct funding and therefore our capacity to provide the level of support to member services that they need is restricted.

Funding for a dedicated position within AMSANT would allow us to provide the appropriate level of support to our members in considering whether and how to become a provider, as well as to develop sector-wide positions and solutions to issues such as thin markets and work collaboratively with the NDIA to achieve them. Funding for a position such as this has been provided to peaks in other jurisdictions.

This submission is focused on solutions to the market failures that health services in our sector face in providing services under the NDIS and has been structured in response to the 4 types of responses identified in the discussion paper.

By way of context we also highlight the following as key considerations for addressing market failures in the unique environment of the Northern Territory:

- A potential 48,000 people living with a disability are expected not to be eligible for support under the current Scheme
- 53.1% of current plans are for Aboriginal or Torres Strait Islander people
- Almost 30% of plans are for people with CALD backgrounds
- There is only a 56% utilisation rate in the NT for already existing plans
- 76% of participants require support coordination, compared with 25% nationally. For some services, 100% of their clients may require support coordination as well as broader advocacy
- Basic needs relating to the social determinants of health - housing, food security, safety etc. - are not being met in many places in the NT, particularly remote Aboriginal communities. For NDIS clients who experience poor living conditions, filling these basic needs will continue to be a higher priority than specific disability supports and poor living conditions will make effective delivery of disability support services more expensive and complex.

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Addressing thin market issues

It is AMSANT's experience that many aspects of Aboriginal health and the wider human service delivery sector are not suited to the introduction of greater competition and user choice under a market-based system such as the NDIS. There are many reasons for this, but they include the particular model of community controlled governance that has been developed across health and other areas which is an expression of self-determination exercised by Aboriginal communities.

In the ACCHS sector, this has led to a holistic and culturally responsive comprehensive primary health care service delivery model that could not be provided by a privatised or government system. Both the Commonwealth and Northern Territory governments recognise ACCHSs as the preferred model for delivering PHC to Aboriginal communities in the NT and support a process for progressive transition of health services to community control. This also acknowledges a further strength of community controlled services - that they generally provide better service outcomes through culturally responsive services that include a high proportion of Aboriginal staff.

A further significant factor against competitive, market-based systems is the remote locations within which our services operate, which lack sufficient economies of scale to support the viable provision of the full range of health and human services necessary for the NDIS, let alone multiple, competitive providers of services. In the NT limitations in service providers also extends to regional centres and even to Alice Springs and Darwin.

This issue sits within a broader policy issues of the personalised market driven mechanism of NDIS requiring patients and families to have high health literacy and capacity to navigate a complex system and undertake negotiations with a large bureaucracy to obtain the best outcome

from the scheme. As noted in a recent review, this type of scheme can widen existing inequalities if these structural issues are not addressed[1]. There is strong evidence that this is happening in the NT.

Certain health-related human services delivered by ACCHSs as part of comprehensive PHC are currently subject to competition and contestability, leading to numerous instances of such services being delivered by external NGO, private sector and government agencies resulting in less efficient, less effective and less cost-effective outcomes. Member services report they often play a significant role advocating for participants to be provided quality and culturally safe services within the community in instances where they are not the coordinator of supports provider.

It is our position that we must favour regulation and alternative commissioning models in order to address market failures. Attempts to facilitate and deepen these markets should note the reality that for many Aboriginal communities, more substantial government involvement may always be required in the commissioning and regulation of disability services, and the alternative of further developing the capacity of ACCOs, development of new ACCOs and the building and strengthening of their workforce will produce a more efficient and effective service delivery system for these communities.

Alternative Commissioning: Funds pooling and centralised, needs-based planning

In relation to delivery of PHC in the NT, the ACCHSs sector has been advocating since the 1990s for a funding model based on both pooled grant funding as well as access to Medicare and the PBS. The need for this reform was made evident by lower rates of access to Medicare and the PBS and the reality that funding levels were not being allocated based on need, with little or no coordination between levels of governments, leading to large inequality between regions of the NT in access to health services.

A planned, collaborative approach to the application of funding resources, overseen by the NT Aboriginal Health Forum (NTAHF)[2], has delivered significant improvements in health outcomes for Aboriginal people over the last twenty years with reductions in inequitable funding along with an overall increase in funding. We would like to see a similar, centralised, needs-based planning approach taken to the delivery of NDIS services to Aboriginal people in the NT.

[1] Malbon, E., Carey, G., and Meltzer, A., (2019) Personalisation schemes in social care: are they growing social and health inequalities? *BMC Public Health*, 19:805

[2] The NTAHF comprises: Commonwealth Department of Health, Commonwealth Department of Prime Minister and Cabinet, NT Department of Health, AMSANT and the NT Primary Health Network.

We reiterate the Productivity Commission's sentiment in their position paper on NDIS costs that:

> *"... there will be a need for strong market stewardship and collaboration between the Australian and State and Territory Governments... Addressing thin markets requires a whole of government approach and community involvement."*[3]

The NDIS' individualised plan funding model is unlikely to create an adequate market for the required professions in remote areas as it is reliant on professions moving to the newly created market. Additionally, there are critical shortages of staff accommodation in many areas. However, accommodation shortages could be addressed if unspent NDIS funds were able to be allocated via a central planning mechanism.

Similarly, some Aboriginal communities will require new and repaired infrastructure in order to meet the expected demand for services under the NDIS, however this need cannot be easily met when funds are locked into individual patient plans for service delivery. Even the most considered care plan with sufficient funds allocated is of little use when there is inadequate infrastructure to facilitate service provision.

Beyond workforce and infrastructure concerns, there remains the significant question of whether a market-based approach can meet the needs of some of the most vulnerable people in our community. As an example, 23% of children in the Northern Territory have been assessed as vulnerable on two or more domains of the Australian Early Development Census (AEDC), twice as many as the national average[4].

Improving outcomes for these children requires a comprehensive and holistic approach, and should build on the core services model already developed and agreed on by NTAHF[5]. This would see NDIS funded services delivered in conjunction with nurse home visiting and parenting support programs and in many communities could utilise the existing infrastructure of child health and development centres where Families as First Teachers (FaFT) programs are delivered.

It is our position that the effective coordination of services and allocation of funds based on greatest need for Aboriginal children, and Aboriginal people more generally, will not be achieved through the NDIS' current model. Instead we recommend the establishment of a jurisdictional disability planning forum which would allow for centralised funds pooling, planning and needs-based allocation of NDIS funds for Aboriginal people with a disability.

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[3] Productivity Commission, Review of NDIS Costs Position Paper, pp 231-232
[4] AEDC Data Explorer, accessed via: https://www.aedc.gov.au/data/data-explorer
[5] NTAHF 2017, Progress and Possibilities, accessed via: http://www.amsant.org.au/wp-content/uploads/2017/08/What-Are-the-Key-Core-Services-Needed-to-Improve-Aboriginal-Childhood-Outcomes-in-the-NT-Report-FINAL.pdf

Regulation: Price setting

In the NT vast distances, expensive transport, staff housing shortages and language and cultural requirements created significant overhead costs for remote service providers. Current pricing levels under the NDIS for remote services and transport do not reflect the true costs of providing services which often result in cost shifting for organisations from core funds. This is leading to clients missing out on services required. The Independent Pricing Review noted:

> *"Remote loadings are not sufficient for some remote areas where there are high costs-to-serve due to factors including extra travel time, lack of infrastructure and facilities, and the cost of deploying/housing a workforce. In some cases, such as for communities in the Northern Territory, air travel and overnight accommodation is necessary to reach participants, and this cannot be claimed from the NDIA."*

We note that the NDIA has recently increased the amount of claimable travel for remote areas to 60 minutes. While this is a significant improvement on the originally claimable 20 minutes, it still does not cover the cost of travel to many remote areas of the NT where air travel for a number of hours may be required.

We have received anecdotal reports that in order to make up the remaining deficit in travel funding, some providers have been advised by the NDIA to claim additional treatment time from patient's plans. This not only reduces the total time available for treatment, but skews the data, giving the impression that patients are receiving more hours of service than they really are. It is worsening inequity and is fundamentally unjust.

Market deepening: Training and workforce development

It should be noted here, that for reasons stated above, AMSANT's preference is for a non-market-based system in the NT for providing NDIS services to Aboriginal communities, which would be based on developing the ACCO sector to provide services in conjunction with a jurisdictional disability planning forum which would allow for centralised funds pooling, planning and needs-based allocation of NDIS funds for Aboriginal people with a disability. Training and workforce development is a critical need in developing the capacity of such a system to service populations in thin market areas.

It is AMSANT's view that increasing the size of the Aboriginal and Torres Strait Islander health workforce is fundamental to closing the gap in Indigenous life expectancy. Evidence shows that Aboriginal health professionals can better ensure culturally appropriate and improved health care to other Aboriginal Australians.

There is a real need for the development of an Aboriginal workforce strategy to address existing workforce shortages and high turnover in remote areas, and address the need for culturally responsive service delivery. Such a strategy should be developed through a process which engages in a direct and meaningful way with Aboriginal organisations, and ACCHSs in particular, with consideration given for the unique situation in each jurisdiction.

It is absolutely essential that measures facilitate Aboriginal health services to 'grow our own' as a priority. If careful consideration and consultation is allowed to take place there is a real opportunity for the NDIS to expand employment in Aboriginal communities through the training of local Community Based Workers, Support Coordinators, and Interpreters to gain disability support qualifications, and potentially through options such as the introduction of Aboriginal Cultural Support as a funded Support Category in the NDIS.

AMSANT recognises the urgency to meet our Allied Health workforce shortfalls with the recent development of the Aboriginal Allied Health Academy in three secondary schools within Darwin in partnership with the Indigenous Allied Health Association. Such innovative models require immediate priority and investment to meet long-term workforce needs.

Additionally AMSANT is working in partnership with National Disability Services (NDS) in the consultation and development of a Human Services Industry Plan for the Northern Territory which will support identifying regional needs and the long-term investment in workforce capacity required to meet the needs under the NDIS.

Market facilitation: Communication, information linkages, place-based collaboration & partnerships.

The ACCHSs sector already provides comprehensive PHC to two thirds of Aboriginal people in the NT. In many areas, particularly in small remote communities, they are the main service provider with strong existing relationships in community and are already supporting people in their community with a disability.

We must ensure that the NDIS' competitive market based model does not undermine these vital services by bringing in external NGOs and the private sector who may be motivated primarily by financial concerns, rather than improved health and wellbeing outcomes, and do not have relationships with the community or local health service.

Recently we have been pleased to see the extension of the Remote Community Connectors Program which was originally established in WA. We are hopeful that this program will provide an opportunity for increased local employment through Aboriginal Community Controlled Organisations to promote understanding and awareness of the NDIS.

It is also vital that there be a linking up of information between NDIS and PHC service providers to ensure continuity of care. One of AMSANT's member services has reported cases where they have been working for a number of years to provide support and care to a client before realising that this person has already been signed up to the NDIS and have an existing care plan from a provider in another region. To address this issue we would recommend that every NDIS plan be on the shared electronic health record.

Similarly, it is important that a joint planning approach is taken to the delivery of services to remote areas. To facilitate this we recommend the development of a shared electronic calendar for remote travel and service delivery, which would allow providers to link-up their travel plans, reducing the cost of transport, but just as important is reducing the impact on the community and resident service providers of increasing uncoordinated provider visits.