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National Lead Clinicians Group
Enhancing clinical leadership and engagement in the Australian health system

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Contents

Executive summary	1
Recommendations for action.....	1
A quick overview of the National Disability Insurance Scheme (NDIS)	3
The National Disability Insurance Scheme (NDIS)	4
National Injury Insurance Scheme (NIIS)	6
Where does the NDIS intersect with the health and aged care sectors?.....	7
Implications of the NDIS for the health sector	9
Eligibility and access.....	9
People aged 65 and older	11
Coordination between the health sector and NDIS.....	11
Workforce	12
Permanent impairment and people with episodic or fluctuating illnesses.....	13
Mental health.....	14
Service provision boundary issues	16
The risk of inequity.....	16
Timely access.....	17
Stakeholder awareness and education.....	17
Other policy issues	17
Existing disability support services	17
NDIS funding and service mix	19
The cost of the NDIS.....	20
Inconsistency with the 2011 National Health Reform Agreement.....	20
Opportunities for system learning.....	20
Recommendations for action.....	21
1. Establish tripartite working group.....	21
2. National roll-out	22
3. Opportunities for system learnings	22
Attachment 1: NDIS roll-out by state and territory	23
New South Wales.....	23
Victoria	23

South Australia 23

Tasmania 23

Australian Capital Territory 24

Northern Territory 24

Queensland 24

Western Australia 24

Attachment 2: other NDIS inclusions and exclusions 25

 Early childhood..... 25

 School education..... 25

 Family support 26

 Higher and vocational education 27

 Housing and independent living 28

 Employment..... 28

Executive summary

- The National Disability Insurance Scheme (NDIS) is not a health scheme. The NDIS funds disability support and a range of related services designed to maximise the independence of a person with a disability. Health care is a specific exclusion.
- The NDIS is organisationally separate from both the health system and the aged care sector. At the national level, the NDIS is the responsibility of the Minister for Social Services (and not the Minister for Health) and is being administered by the National Disability Insurance Agency (NDIA), which is an independent statutory agency.
- While the NDIS is not a health scheme, and health care is a specific exclusion, it will intersect with the health system on a number of levels. To ensure the NDIS does not lead to fragmented care for participants, the Department of Health, the Department of Social Services and the NDIA will need to work closely to monitor and resolve any issues that arise during the implementation phase. This will require active, joint collaboration to develop appropriate policy responses.

Recommendations for action

1. Establish formal Department of Health, Department of Social Service and National Disability Insurance Agency tripartite working group with the following roles and responsibilities
 - **Education and information** for key targeted audiences regarding eligibility requirement and other key implications of the NDIS and the National Injury Insurance Scheme (NIIS)
 - **Workforce implications** monitored and addressed in a coordinated manner
 - **Patient inequity** issues monitored and coordinated policy responses undertaken
 - **Permanent and fluctuating impairment** required coordinated care and active policy responses
 - **Mental health** implications need to be better understood and coordinate actions to be taken to overcome barriers
 - **Service provision boundary disputes between health and disability sectors** require a resolution mechanism through negotiation rather than determined solely by the NDIA
 - **Timely access** issues monitored and a fast track system for hospital referrals to/from the NDIS developed

- **Inconsistency with the 2011 National Health Reform Agreement** monitored and addressed as appropriate
2. While it is the responsibility of the Department of Social Services and the NDIA to work toward a nationally consistent approach as the scheme moves to full roll-out, the Department of Health should monitor roll-out to ensure health services are not negatively impacted.
 3. Review the NDIS evaluation in order to inform the health system with applicable lessons. At the system level, the NDIS presents opportunities to learn more about individualised service planning and funding, and better ways to measure need and outcomes.

A quick overview of the National Disability Insurance Scheme (NDIS)

- The NDIS is not a health scheme. The NDIS funds disability support and a range of related services designed to maximise the independence of a person with a disability. Health care is a specific exclusion.
- Eligibility is limited to those aged under 65 years at the time of making application.
- The NDIS is being progressively implemented across Australia, with pilots already underway in four sites. The scheme should be fully implemented by 2019 in all states and territories except Western Australia (WA). WA has only signed up to a two year pilot at this stage.
- Over 80 per cent of those joining the NDIS so far have an intellectual or a neurological disability.
- The NDIS is, in effect, a voucher scheme. Each participant is allocated their own funding and can use this funding to pay for the services they receive (“consumer directed care”). Participants have a range of options for how their plan is managed.
- A National Injury Insurance Scheme (NIIS) is also in development. The NDIS covers people with disabilities that are non-traumatic in origin. The NIIS will cover people with catastrophic trauma-related injuries caused by motor vehicle accidents, workplace accidents, medical accidents and general accidents (occurring in the home or community).
- Health related services that can be funded under the NDIS include aids and equipment, prosthetics, artificial limbs, home modifications, personal care, domestic assistance and, in some circumstances, allied health therapies.
- However, the boundary between health and disability services as defined in the NDIS guidelines is somewhat arbitrary. As one example, therapy for maintenance purposes is eligible for NDIS funding while therapy for the purposes of functional improvement is not.
- Details of the NDIS are not well understood. The community perception is that the NDIS is a new funding scheme for people who have suffered traumatic injuries. This is not the case.
- There is also a perception that the NDIS will have major implications for the health system and for the health care that patients receive.
- Healthcare providers have an important role in explaining both the NDIS and the NIIS to patients and their families, in ensuring that referrals are appropriate and that family expectations are realistic.

The National Disability Insurance Scheme (NDIS)

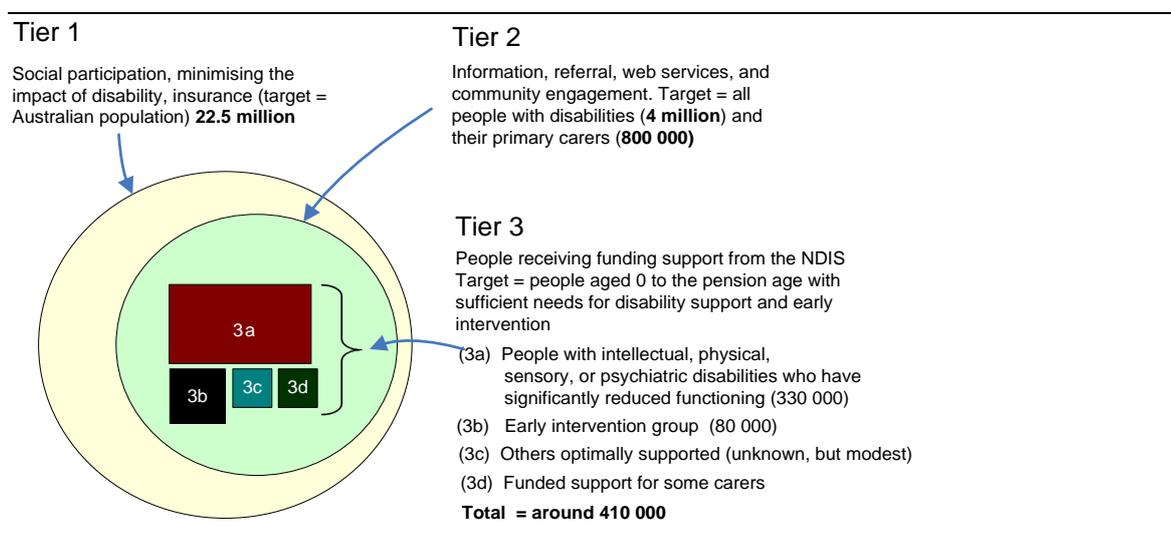
The NDIS is designed to provide long-term care and support to people who have lifelong disabilities (as defined in the NDIS Act 2013) and who are not covered by existing insurance arrangements.

The NDIS is not a health scheme. In fact, health care is a specific exclusion under the NDIS legislation. The NDIS funds disability support and a range of related services designed to maximise the independence of a person with a disability.

The NDIS has not been established as a national agreement. It has been established to date as a series of bilateral agreements between the Commonwealth and the states and territories.

The NDIS was recommended by the Productivity Commission (PC) in August 2011.¹ The PC recommended a three tiered system as shown in Figure 1. Tier 1 is community awareness and social participation and Tier 2 is for any person with a disability. What the PC envisaged as Tier 3 is what is now known in the community as the NDIS. However, all three tiers are part of the total scheme.

Figure 1 The three tiers of the National Disability Insurance Scheme as proposed by the PC



The NDIS is being progressively implemented across Australia, with pilots already underway in four sites. Attachment 1 sets out the implementation timetable by state and territory.

The NDIS is open to any individual with a disability who is under 65 years of age at the time they apply and who is either an Australia citizen, a permanent resident, or a New Zealand citizen who is a Protected Special Category Visa holder.

¹ Productivity Commission 2011, *Disability Care and Support*, Report no. 54, Canberra. Available at <http://www.pc.gov.au/projects/inquiry/disability-support/report>. Accessed 28 February 2014.

A person meets the disability requirements of the Act if:

- “(a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments, or to one or more impairments attributable to a psychiatric condition; and
- (b) the person’s impairment or impairments are, or are likely to be, permanent; and
- (c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities: communication, social interaction, learning, mobility, self-care, self-management; and
- (d) the impairment or impairments affect the person’s capacity for social and economic participation; and
- (e) the person is likely to require support under the NDIS for the person’s lifetime.”²

A diagnosis or impairment is not, per se, sufficient grounds for eligibility. For example, a person who is totally blind would only be eligible for Tier 3 of the scheme if their condition impacts on their ability to manage activities of daily living and to socially and economically participate in the community. The same applies to all other impairments.

Once accepted into the scheme, the person is termed a ‘participant’.

The NDIS was conceptualised by the Productivity Commission as an insurance scheme rather than a care scheme. The focus of the NDIS is on individualised funding and service planning and each participant is linked up with a ‘planner’ who works with them to develop an individualised plan that meets their needs. There is a stated commitment to ‘consumer directed care’—giving participants maximum choice both in the services they receive and in the service provider who will deliver those services (public, NGO and private sectors).

The NDIS is, in effect, a voucher scheme with participant benefits averaging approximately \$40,000 per annum (with an expected range of \$4,000-\$150,000 per annum once the scheme is fully established).³ Each participant is allocated their own funding and uses it to pay for the services they receive. Participants have a range of options for how their plan is managed, including managing it themselves, nominating another person to manage their plan (called a plan nominee), choosing to use a registered plan management provider, asking the National Disability Insurance Agency (NDIA) to manage their plan, or a combination of these options.

² National Disability Insurance Scheme (Becoming a Participant) Rules 2013. <http://www.ndis.gov.au/document/299> Accessed 28 February 2014.

³ NDIS, Quarterly Report to COAG Disability Reform Council, 31 December 2013. <http://www.ndis.gov.au/document/754> Accessed 5 March 2014

The profile of participants accepted into the NDIS in the first six months of the pilot sites can be summarised as follows⁴:

- In terms of primary disability, two thirds have an intellectual/learning disability, 20% a neurological disability, 7% a sensory disability, 4% a physical disability and 2% a psychiatric disability.
- 41% are aged under 15, 43% between 16 and 44 years and 16% over 45 years. This age profile reflects the eligibility criteria for the pilot sites to date.
- Most (71%) participants have chosen to have their support package managed by an NDIS agency, with only 2% choosing to self-manage their package.

National Injury Insurance Scheme (NIIS)

In parallel with the NDIS, a NIIS is also under development. The NDIS covers people with disabilities that are non-traumatic in origin. The parallel NIIS is designed to cover people with catastrophic trauma-related injuries caused by four types of accidents: motor vehicle accidents, workplace accidents, medical accidents and general accidents (occurring in the home or community).

The aim is that the NIIS will be a federated model of separate, state-based no-fault schemes that provide lifetime care and support for people who have sustained a catastrophic injury. The intention is that the NIIS will build on existing state and territory accident compensation schemes (for example, motor vehicle and workplace accidents).

Both the NDIS and the NIIS have their origins in recommendations by the Productivity Commission (PC) in August 2011. The PC recommended that the NIIS be separate for a number of reasons including:

- reducing the cost of the NDIS through a fully funded insurance accident scheme;
- making use of existing expertise and institutions of accident compensation schemes;
- using incentives to deter risky behaviour and reduce local risks that can contribute to accidents; and
- covering a broader range of health costs associated with catastrophic injuries, such as acute care and rehabilitation services.

The Australian Government continues to work with states and territories on the development of a NIIS.⁵ At the 21 March 2014 meeting of the Council of Australian Governments (COAG) Disability

⁴ NDIS, Quarterly Report to COAG Disability Reform Council, 31 December 2013.
<http://www.ndis.gov.au/document/754> Accessed 6 March 2014

Reform Council, it requested the Council on Federal Financial Relations prioritise the work on NIIS and report back by 1 December 2014 about minimum benchmarks for workplace accidents and medical treatment injury, and scoping work and options for general accidents.⁶

Where does the NDIS intersect with the health and aged care sectors?

The NDIS is organisationally separate from both the health system and the aged care sector. At the national level, the NDIS is the responsibility of the Minister for Social Services (and not the Minister for Health) and is being administered by the National Disability Insurance Agency (NDIA), which is an independent statutory agency.

The NDIS funds disability support services for people who are under 65 years at the time of making an application to join the scheme.

The NDIS is not intended to replace other mainstream systems and the designers of the scheme have stressed that the financial sustainability of the NDIS depends on other systems continuing their efforts to support people with a disability. For this reason, the NDIS Act specifically excludes the use of NDIS funding to pay for health care. The Act also specifies other inclusions and exclusions as set out in Attachment 2 of this paper.

Funding inclusions relevant to health care include:

- aids and equipment such as wheelchairs, hearing aids and adjustable beds;
- items such as prosthetics and artificial limbs;
- home modifications, personal care and domestic assistance that assist participants to live independently in the community or move back into their own home after being in hospital; and
- allied health and other therapy where this is required as a result of the participant's impairment, including physiotherapy, speech therapy or occupational therapy. However, the health system is responsible for therapy if it is part of the treatment or rehabilitation that a patient requires.⁷

Funding exclusions

The health system (public and/or private) remains responsible for clinical and medical treatment including:

⁵ Australian Government, The Treasury, *National Injury Insurance Scheme*: <http://www.treasury.gov.au/Policy-Topics/PeopleAndSociety/National-Injury-Insurance-Scheme>

⁶ COAG Disability Reform Council Communiqué, 21 March 2014: <http://mitchfield.dss.gov.au/media-releases/76>

⁷ Funding for existing services in these categories is being transferred to the NDIS under bilateral agreements with the states and territories.

- diagnosis, assessment and treatment of health conditions;
- medications and pharmaceuticals;
- sub-acute care;
- post-acute care; and
- dental care and all dental treatments.

Health care funding arrangements (by individual, families, governments and private health insurers) remain unchanged.

Rehabilitation

Initial rehabilitation following an injury, accident or other medical event remains the responsibility of the health system.

The NDIS is responsible for assisting scheme participants once initial rehabilitation is complete. The NDIS can cover:

- home modifications, aids and equipment
- personal care and domestic assistance
- ongoing allied health and other therapies to enable the participant to maintain their level of functioning.

Early intervention

The NDIS can cover early intervention treatments for participants which increase their functional capacity. This includes supports such as a speech therapy and occupational therapy.

However, “if the support is provided after a recent medical or surgical event, with the aim of improving the person’s functional status, this support is the responsibility of the health system. This includes rehabilitation or post-acute care”.

Mental health

There is some concern within the mental health sector about the implications of the scheme in its current form for mental health consumers, carers and service providers, which are discussed later in this paper.

The rules specify that the NDIS will be responsible for “supports that are not clinical in nature and that focus on a person’s functional ability, including supports that enable a person with a mental illness or psychiatric condition to undertake activities of daily living and participate in the community and social and economic life.”

The rules also specify the range of mental health services that the NDIS will not cover:

- “(a) supports related to mental health that are clinical in nature, including acute, ambulatory and continuing care, rehabilitation/recovery; or
- (b) early intervention supports related to mental health that are clinical in nature, including supports that are clinical in nature and that are for child and adolescent developmental needs; or
- (c) any residential care where the primary purpose is for inpatient treatment or clinical rehabilitation, or where the services model primarily employs clinical staff; or
- (d) supports relating to a co-morbidity with a psychiatric condition where the co-morbidity is clearly the responsibility of another service system (for example, treatment for a drug or alcohol issue).”⁸

Implications of the NDIS for the health sector

The full details of the NDIS are not yet resolved. At the Council of Australian Governments (COAG) meeting of May 2014, all governments reaffirmed their commitment to implementing the NDIS (albeit that Western Australia has committed to only a two year trial). COAG noted recent reports from the NDIS Board that costs in the trials are coming down. The NDIA board has commissioned a report on full scheme transition, which will advise governments in June on how best to proceed with the rollout. COAG agreed to list the NDIS as a standing agenda item for all COAG meetings.⁹

With the caveat that the NDIS may change as it is further developed, the remainder of this section identifies implications for health care providers and other stakeholders, required changes for better integration across the sectors and other health policy and systems issues.

Eligibility and access

Health care providers will need to understand the eligibility criteria for the scheme and how to refer to it. This includes an awareness of the staged nature of the scheme’s roll-out and specific eligibility criteria that will apply in some regions.

The NDIS will inevitably result in some anomalies. For example, a consumer with non-traumatic brain damage will be eligible for the NDIS while those with traumatic brain damage will largely not be eligible. Those with traumatic brain damage will instead be eligible for the NIIS. There is a need for public education on this issue as there is a general community perception that the NDIS will be for anyone with a disability from any cause.

⁸ National Disability Insurance Scheme (Supports for Participants) Rules 2013. Page 15. Accessed 28 February 2014.

⁹ COAG Disability Reform Council Communiqué. Accessed 9 May 2014:

<http://mitchfield.dss.gov.au/media-releases/76>

Likewise, eligibility to the NDIS is limited to those aged under 65 years at the time of making application. In consequence, the range of services available to someone who is 64 is likely to be very different to the range available to someone who is 66 years old. This is illustrated in the case study, documented by the Royal Society for the Blind, found in Box 1 on the following page.¹⁰

Box 1: case study

Christine's story

Life as Christine Davis knew it changed in the blink of an eye in 2010 when she suffered a retinal bleed in not one, but both of her eyes. She was only 69 years of age and with her sight diminishing immediately, Christine's life and future was suddenly turned upside down...

As Christine is over the age of 65, she will be placed into the overstretched aged-care system and will no longer be eligible for funding under the National Disability Insurance Scheme. In fact, Christine will have to make a co-payment to access services within the aged-care system.

A key equity risk also exists for people who have a disability but whose level of impairment is not sufficient for them to be eligible for Tier 3 of the NDIS. Depending on the investment in Tier 2, there is a risk that this group will be forgotten as funding and policy attention focuses on Tier 3 participants.

While there might be a perception that clinicians will have a significant role to play in addressing equity issues, the way in which the NDIS was framed does not envision this, and there is no formal mechanism to allow for this.

However clinicians do have a role in providing supporting documentation for people applying to become NDIS participants,^{11,12} and the NDIA has an internal process to review decisions when applicants and participants disagree with them. Should applicants and participants disagree with the NDIA's internal review, the Australian Administrative Appeals Tribunal then plays a role in reviewing decisions made by the NDIA under the National Disability Insurance Scheme Act 2013 (NDIS Act), including decisions about who is eligible to access the scheme, supports provided under the scheme, and the registration of providers of supports.¹³

¹⁰ The Royal Society for the Blind. *No one left behind*. February 2014.

[http://www.rsb.org.au/site/DefaultSite/filesystem/documents/Publications/No%20One%20Left%20Behind%20-%20February%202014%20\(web\).pdf](http://www.rsb.org.au/site/DefaultSite/filesystem/documents/Publications/No%20One%20Left%20Behind%20-%20February%202014%20(web).pdf)

¹¹ Allied Health Professions Australia, submission to the Joint Standing Committee on the National Disability Insurance Scheme, 8 May 2014, p 4:

http://www.aph.gov.au/~media/Committees/Senate/committee/ndis_ctte/Correspondence/AHPA%208%20May%202014.pdf

¹² Joint Standing Committee on the National Disability Insurance Scheme, 7 May 2014 public hearing, Brooklyn Park, South Australia:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/04be1adf-7782-4cb4-bdbb-a91a97b30c26/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_07_2448.pdf;fileType=application%2Fpdf#search=%22Ndis%20Eligible%22

¹³ Administrative Appeals Tribunal of Australia, 'Information for National Disability Insurance Scheme applicants':

Health service providers will be asked to provide supporting documentation for applicants and participants, and members of the health sector have raised concerns related to increased workload related to preparing supporting documentation and the inefficient and non-standardised manner in which this information is currently collected.^{11,14,15}

The Australian Administrative Appeals Tribunal has developed extensive information on how NDIS applicants and participants are able to seek a review of their decisions handed down by the NDIA.¹⁶ This suggests that they anticipate the need for an appeal process.

People aged 65 and older

Once in the scheme, a person who turns 65 years is to be given the option of remaining in the scheme or transferring to the aged care system. The advice of treating health professionals may be helpful in these cases.

Coordination between the health sector and NDIS

NDIS participants will continue to require clinical treatment and rehabilitation from the health sector while at the same time receiving a range of non-health services via the NDIS. Coordination between the two sectors will thus remain a key issue.

Some members of the disability sector have raised some concerns about the co-ordination of health and disability services. When testifying before the Joint Standing Committee on the National Disability Insurance Scheme, Disability SA stated that it currently runs a number of cross-sector programs, jointly funded by SA Health, to support people with multiple diagnoses who require cross-sector support services. These programs are meant to stop people from falling between service provision gaps, ensure that services are delivered, and that the disability and health sectors decide who is responsible for funding after services are provided. Disability SA and SA Health do not believe the NDIA will accept these cross-sector programs under the NDIS and are deliberating whether or not they should hold back some of their current funding in order to ensure they continue.¹⁷

<http://www.aat.gov.au/ApplyingForAReview/NDIS.htm>

¹⁴ Australian Medical Association, *Submission to the Senate Community Affairs Legislation Committee inquiry into the National Disability Insurance Scheme Bill 2012*, 25 January 2013, p 7.

¹⁵ Royal Australian College of General Practitioners, *Inquiry into the National Disability Insurance Scheme Bill 2012*, submission, 25 January 2013, pp 2-3.

¹⁶ Administrative Appeals Tribunal of Australia, 'Information for National Disability Insurance Scheme applicants': <http://www.aat.gov.au/ApplyingForAReview/NDIS.htm>

¹⁷ Joint Standing Committee on the National Disability Insurance Scheme, 8 May 2014 public hearing, Brooklyn Park, South Australia:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/3e4c1ae6-06d6-4846-8224-d503cb4e984d/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_08_2454.pdf;fileType=application%2Fpdf#search=%22Ndis%20Health%20system%22

Conversely, the Joint Standing Committee also heard that the Government of Tasmania had previously removed itself from the disability sector over a six year period; disability services are now run by the not-for-profit sector. The committee was informed the transition had been considered successful with minimal issues of poor coordination across the two sectors.¹⁸

At present, there is no formal communication processes in place to resolve any issues in the health sector arising from the roll out of the NDIS. The Commonwealth Department of Health, for example, has raised a number of questions about the relationship between its programs and the NDIS; these are questions where the Department, itself, does not have clarity at the moment. While the Department is trying to get some clarity on these issues, they have yet to be resolved.¹⁹

Workforce

There are no major changes required to the way health care services are structured and delivered to patients as a result of the NDIS. Once referred to the NDIS, the NDIS is responsible for determining eligibility, for assessing needs and for working with the participant to plan and organise the services they will receive.

While a person's treating clinician may be consulted in the process, treating clinicians are not responsible for assessing NDIS eligibility or for service planning. However, a number of peak-bodies representing health professionals and service providers have raised concerns related to the non-streamlined, non-standardised and inconsistent nature in which their clinical judgements are sought, resulting in an increased workload.^{20,21,22}

Another second order workforce implication with the NDIS is what Walter Leutz described as a classic law of service integration: 'Your integration is my fragmentation'.²³ While services within the disability sector could become more integrated as a result of the NDIS, there is a risk that the

¹⁸ Joint Standing Committee on the National Disability Insurance Scheme, 6 May 2014 public hearing, Newcastle, New South Wales:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/c435617c-9a7a-4c8a-8508-ec31c43d86c6/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_06_2442.pdf;fileType=application%2Fpdf#search=%22Ndis%20Health%20care%22

¹⁹ Senate Community Affairs Legislation Committee, Budget Estimates 2014–15, 2 June 2014, Canberra, pp 109-10:

http://parlinfo.aph.gov.au/parlInfo/download/committees/estimate/09c0e6e8-1dd3-46ea-9659-7946563384b4/toc_pdf/Community%20Affairs%20Legislation%20Committee_2014_06_02_2541.pdf;fileType=application%2Fpdf#search=%22committees/estimate/09c0e6e8-1dd3-46ea-9659-7946563384b4/0002%22

²⁰ Allied Health Professions Australia, submission to the Joint Standing Committee on the National Disability Insurance Scheme, 8 May 2014, p 4:

http://www.aph.gov.au/~/media/Committees/Senate/committee/ndis_ctte/Correspondence/AHPA%208%20May%202014.pdf

²¹ Australian Medical Association, *Submission to the Senate Community Affairs Legislation Committee inquiry into the National Disability Insurance Scheme Bill 2012*, 25 January 2013, p 7.

²² Royal Australian College of General Practitioners, *Inquiry into the National Disability Insurance Scheme Bill 2012*, submission, 25 January 2013, pp 2-3.

²³ Leutz WN Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. *Milbank Q.* 1999; 77(1):77-110, iv-v.

NDIS may result in further fragmentation between health and disability services. This may result in some additional time to ensure coordinated care for NDIS patients when using health services. The health and disability sectors need to work together to ensure care provided across the two sectors is well coordinated. This has been flagged by South Australia as an issue needing further consideration.²⁴

Permanent impairment and people with episodic or fluctuating illnesses

Eligibility for the NDIS is based on a person having a 'permanent impairment', as outlined in the NDIS Act. As such, there is a risk the scheme will work against people with episodic or fluctuating illness, and the scheme may also work against a focus on recovery for some participants.

The full implications for people with episodic or fluctuating illnesses (including mental and chronic illness) are yet to be understood. A person is only eligible for the scheme if he or she has a permanent impairment that impacts on their capacity to socially and economically participate. However, the NDIS Act recognises that an impairment may be permanent notwithstanding 'that the severity of its impact on the functional capacity of the person may fluctuate or there are prospects that the severity of the impact of the impairment on the person's functional capacity, including their psychosocial functioning, may improve.'

An issue that arises is the inherent tension between the NDIS and best practice health care. The NDIS focuses on providing disability support for long-term conditions and is prevented from paying for health care. Best practice health care focuses on recovery and on fostering maximum independence for people with disabilities and chronic conditions.

Consider a young, low-level quadriplegic who meets the disability requirements under Tier 3 of the NDIS. Later in life, this individual begins to develop chronic respiratory illness as a result of being a quadriplegic. The NDIS may push to have the health system intervene to manage the respiratory condition (particularly if it is episodic) while the health system may recommend long-term support to manage it. In this instance, the development of chronic respiratory illness is a health condition stemming from the disability, and this raises issues around who is responsible for funding care and which treatment option should be pursued.

Another example for consideration is an older quadriplegic who develops pressure sores from the long-term effects of sitting in a wheel chair. Should the pressure sores be considered a consequence of being a quadriplegic, making it the NDIS' responsibility to fund additional equipment or care? Or should the pressure sores be considered a health condition requiring only short-term treatment in the health system?

²⁴ Joint Standing Committee on the National Disability Insurance Scheme, 7 May 2014 public hearing, Brooklyn Park, South Australia:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/04be1adf-7782-4cb4-bdbb-a91a97b30c26/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_07_2448.pdf;fileType=application%2Fpdf#search=%22Ndis%20Eligible%22

It will be important to monitor the scheme as it develops to ensure it does not create perverse incentives that work against the recovery approach that underpins the health system, and that actions are patient-centred and not based on cost shifting between the NDIS and health.

The mental health sector is equally concerned with issues relating to episodic illness.

Mental health

While it is too early to know how the definition of permanent impairment will be interpreted once the scheme is fully operational, it is clear that the scheme will be available only to the small proportion of mental health consumers who are assessed as having a permanent impairment and placed in Tier 3. The exact number is not known, but the Productivity Commission estimated that out of the approximately 489,000 people with serious mental illness in Australia only 12 per cent of adults, approximately 60,000 people, will be eligible for Tier 3's individualised package of support.²⁵ However, the Mental Health Council of Australia notes that many more than 60,000 will have significant disability, warranting long-term support.²⁶

One implication of this is that some consumers will have access to a range of support services via the NDIS while others will not. For those that do, the NDIS potentially represents an important funding stream for services provided by the public, private and NGO sectors.

Individuals with serious mental health illness but who are designated Tier 2 and are not eligible for individualised support will need to rely on existing systems of referral and support. However, as noted below, many of these existing programs have uncertain futures as they are absorbed into the NDIS through the current funding arrangements.

There are a range of other unresolved issues in relation to mental health at this point. This includes how the NDIS will interface with mental health services and with the mental health legal system, how potential overlaps with existing intensive support services will be resolved and systems for substitute decision-making when a person is unwell.

The mental health sector is working to address these uncertainties. The following fictional case studies developed by the National Mental Health Consumer and Carer Forum²⁷ illustrates the complexity of illness and complexity in determining whether or not an individual with a mental health illness is eligible for a personal support plan under the NDIS. Clinical advice will be important in determining in whether the NDIA accepts an individual for a personal support plan.

²⁵ Productivity Commission, *Disability Care and Support* page 755.

http://www.pc.gov.au/__data/assets/pdf_file/0014/111290/19-disability-support-chapter16.pdf

²⁶ Mental Health Council of Australia, *Mental Health and the National Disability Insurance Scheme: Position Paper* pp 1-2: http://mhca.org.au/sites/default/files/docs/mhca_position_paper_-_ndis.pdf

²⁷ Mental Health Council of Australia, *Am I eligible for a package of support? NDIS Fact Sheet 2*, January 2014: http://mhca.org.au/sites/default/files/docs/mhca_ndis_fact_sheet_2_draft_march_2014.pdf

Box 2: case study

Caleb's story

Caleb is 38 years old and experiences delusions and hallucinations due to psychosis. This has led to the breakdown of his marriage, the loss of his job and an inability to work. Caleb requires occasional access to acute clinical care, in addition to his ongoing treatment, and has been hospitalised many times for his condition.

Caleb lives alone and has trouble caring for his own health. He has no contact with his wife or child. He has no significant social connections. He needs regular support from a family relative to manage tasks like attending appointments and paying bills and would probably benefit from the right support with managing his household and personal care. Caleb has been on income support for more than 10 years and while he has found some work during this time, he has not been able to keep a job for more than a few months because of the difficulties he has with social interaction and memory.

Is Caleb eligible for a personal support plan under the NDIS?

Almost certainly yes.

Box 3: case study

Anne's story

Anne is a 45-year-old Aboriginal woman with a history of complex trauma since childhood for which she began to receive therapy during her 30s. Anne was taken into formal care at birth and spent her childhood in institutional care and a series of foster homes. She studied nursing in her late teens and, although she struggled with alcohol use, she maintained her career, married and had two children.

Ten years ago one of her children became seriously ill and it was about this time that Anne started to experience severe anxiety and depression. During this time she was also traumatised by a bushfire in her local area. Following these events Anne was unable to work, became housebound and her dependence on alcohol increased. After losing her accommodation and becoming homeless Anne was hospitalised for major depressive disorder for six months. She is now on a disability pension and lives in a Department of Housing flat where she is unable to leave her house for extended periods and relies on the support of neighbours for shopping and other errands.

Is Anne eligible for a personal support plan under the NDIS?

Not clear. The significance of Anne's impairments would suggest that she meets the disability requirements. However Anne's use of alcohol makes it difficult for assessors to determine what her support needs are. Anne may only meet the disability requirements once she has received support for her alcohol use.

Box 4: case study

Nik's story

Nik is 27 years old and has been experiencing clinical depression with varying intensity for almost ten years. Nik has been taking prescribed medication on and off since first seeing his GP and from time to time he sees a counsellor when he finds engaging in social activities more difficult.

While his depression and the effects of his medication lead him to occasionally sleep for long periods or, at other times not sleep much at all, Nik is employed at a café 30 hours per week. Apart from occasional absenteeism when his depression or medication symptoms are at their worst, Nik has maintained employment at the same café for over two years. He would like to study or find another job but he fears his condition would prevent him from doing either successfully.

Nik is in contact with his family and has a modest network of friends with whom he engages in social activities. However he does not feel well enough to engage with them as often as he would like to and finds it difficult to plan for any events in advance in case he will not be well enough.

Is Nik eligible for a personal support plan under the NDIS?

Almost certainly not. While Nik can show that he has a permanent impairment, it is not sufficiently significant for Nik to meet the disability requirements.

For many people with mental illness, their disability is cyclical, and they require both clinical and non-clinical services. In order to provide the best patient-centred care, the NDIA and the Department of Health and the Department of Social Services should jointly work out, in more detail, the implications of the scheme design arrangements for the mental health sector, and coordinate actions to be taken to overcome any barriers people face in accessing the care they need.

Service provision boundary issues

The boundary between health and disability services as defined in the NDIS guidelines is somewhat arbitrary, leaving plenty of room for conflict, cost-shifting and misunderstanding. As one simple example, therapy for maintenance purposes is eligible for NDIS funding, while therapy for the purposes of functional improvement is not.

The NDIS is for people who have life-long disabilities and two thirds of those in the scheme at present have an intellectual/learning disability. The health system remains responsible for meeting their health care needs and the NDIS is responsible for disability support. There is no intention that consumers will move back and forth between the health system and the NDIS. But in practice the distinction is not always clear. Problems may also arise when there are differences of opinion about what constitutes therapy aimed at improving function, and what constitutes maintenance. This is particularly relevant for young children with developmental delays as it can be difficult to judge the point at which treatment is no longer improving function.

While this is likely to be a relevant issue for only a small proportion of participants, a mechanism needs to be established whereby the boundary is negotiated rather than determined solely by the NDIA. There are a number of services that might span across the boundaries of both health and disability services – for example, splinting, enteral nutrition, continence assessments and basic foot care. Policymakers will need to determine whether they are funded through the health system or the NDIS. Resolution of boundary disputes will likely occur through a mix of policy and case-by-case basis.

The risk of inequity

While the NDIS should be strongly supported by the health sector, there is a significant risk of inequity between those in Tier 3 and those people with disabilities who are deemed to be ineligible for Tier 3. This is a critical issue.

Based on estimates by the Productivity Commission, about \$7 billion of the funding for the NDIS will come from current funding allocated for existing services.²⁸ These offsets will inevitably include services currently provided to individuals who will not be eligible for Tier 3. It is unclear what might be funded under Tier 2 of the NDIS and how Tier 2 services will interface with the

²⁸ Productivity Commission, *Disability Care and Support* page 779. Accessed 21 February 2014.

health system. There is no decision yet on when Tier 2 will start. This is an issue that requires urgent policy consultation between the two sectors.

Timely access

Timeliness of access to NDIS services has not been addressed to date. From the health system perspective, the NDIS will need to have a fast track system for referrals from hospitals. If this does not occur rapidly, there is a risk that people with disabilities will be discharged before services are put into place, or that extended length of hospital stays will occur. This runs the risk of further stretching an already overstretched health system and leading to additional costs. There are also funding implications for public hospitals in the context of Activity-based Funding should hospitals miss their emergency access and elective surgery targets as a result of bed block throughout the hospital system.

Stakeholder awareness and education

The scheme is not well understood in the general community. Nor is it well understood by those working in the health system. The widespread community perception is that the NDIS is a new funding scheme for people who have suffered traumatic injuries (particularly those in wheelchairs). This is not the case and needs to be resolved to minimise confusion.

Health care providers are frequently the first point of contact for people with disabilities and their families. As such, it is important that information about the NDIS is widely available throughout the health system. In addition, education about the NDIS needs to be progressively incorporated into undergraduate, postgraduate and continuing education programs.

Healthcare providers have an important role in explaining the scheme to both patients and their families, in ensuring that appropriate referrals are made and that family expectations are realistic. Equally, healthcare providers have a key role in explaining the role of the NDIS, in making referrals as appropriate and in facilitating access to alternate services that a patient may benefit from. Additionally, there is a perception that an applicant or participant's current therapeutic treatment regime will be paid for by their NDIS plan funding, which also is not the case in most instances. Health departments will need to work with the NDIA and key stakeholders to develop targeted information campaigns raising awareness and informing stakeholders of their roles and responsibilities.

Other policy issues

Existing disability support services

All government funded disability services for eligible participants will be progressively transferred for funding purposes to the NDIS. By the time that the NDIS is fully established, disability services delivered by some state and territory governments (including, for example, group homes and other supported accommodation) will be fully transferred to the non-government and/or private

sectors. NSW, for example, has announced its decision to transfer all of its disability services to the non-government sector by June 2018 and implementation has already commenced.²⁹

Funding for existing services for Tier 3 participants will move from current block funding arrangements (typically an annual grant to cover the running costs of the service) to a payment for each participant who chooses to use that particular service. This realignment of service provision will inevitably result in changes in existing referral patterns and in the mix of services provided by some agencies.

From some participant's perspective, this arrangement has caused concern and frustration. The following case study is taken from testimony at a Joint Standing Committee on the National Disability Insurance Scheme public hearing (identifying details have been changed to protect identities).³⁰

Box 5: case study

Mary's story

Mary's middle child, aged two, has multiple disabilities and is a participant in the NDIS.

In gathering clinical documentation to support her child's NDIS application, Mary was advised by hospital staff that once her child became a participant in the NDIS that her child would lose access to all allied health services through the Women's and Children's Hospital in her state, which her child had been accessing frequently and for free. These services included physiotherapy, occupational therapy, speech pathology, and orientation and mobility instruction.

When Mary raised this concern with her child's NDIS planner, the planner stated Mary had to prioritise her child's funding package and that therapy is not beneficial to her child's condition. The planner's statement countered a number of clinical reports Mary had received from a number of medical specialists, which all recommended a number of therapeutic treatments to improve her child's situation.

As an NDIS participant, the NDIS funding does not cover the full range of therapeutic treatments recommended by medical specialists for Mary's child, and previously accessed free of charge. Her child no longer accesses the same amount of treatments she had accessed prior to being an NDIS participant, and Mary now pays for a portion out-of-pocket.

²⁹ Joint Standing Committee on the National Disability Insurance Scheme, 6 May 2014 public hearing, Newcastle, New South Wales:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/c435617c-9a7a-4c8a-8508-ec31c43d86c6/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_06_2442.pdf;fileType=application%2Fpdf#search=%22Ndis%20Health%20care%22

³⁰ Joint Standing Committee on the National Disability Insurance Scheme, 7 May 2014 public hearing, Brooklyn Park, South Australia:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/04be1adf-7782-4cb4-bdbb-a91a97b30c26/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_07_2448.pdf;fileType=application%2Fpdf#search=%22Ndis%20Eligible%22

The realignment of service provision is also expected to result in the closure of some services, or it will require the state and territory governments to step in with additional funding for services the NDIS will not fund but they deem vital.³¹ Additionally, some services that currently provide both disability and health services may no longer be viable should the disability portion be removed.

The mental health sector is particularly concerned that not all mental health consumers will be able to access the support services they need in the future.³² While a guarantee of ongoing care is in place (through Commonwealth, state and territory agreements) for current clients, no matter which tier they are placed in, no such guarantee exists for future clients, including clients of mental health programs that have a high rate of turnover from year to year.³³

The Joint Standing Committee on the National Disability Insurance Scheme received testimony that some NDIS participants living in rural communities have been refused on-going care by some non-government service providers with no other provider able to take them on.²⁹

NDIS funding and service mix

Funding for the NDIS includes both growth funding and funding offset against existing programs. This offset funding includes some programs that have historically been funded and managed by health departments such as aids and appliances schemes, early intervention programs for children with disabilities, and some Home and Community Care services. As with other disability services, this change can be expected to result in changes in existing referral patterns and in the mix of available services.

There is a risk for people who have a disability but who do not qualify for Tier 3 of the NDIS in this process. Funding offsets against existing programs will inevitably include funds for existing services for this group. This strengthens the need for investment in Tier 2 and further increases the risk of inequity between those in Tier 3 and those who just miss out.

³¹ Joint Standing Committee on the National Disability Insurance Scheme, 8 May 2014 public hearing, Brooklyn Park, South Australia:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/3e4c1ae6-06d6-4846-8224-d503cb4e984d/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_05_08_2454.pdf;fileType=application%2Fpdf#search=%22Ndis%20Health%20system%22

³² Joint Standing Committee on the National Disability Insurance Scheme, 15 April 2014 public hearing, Geelong, Victoria, p 5:

http://parlinfo.aph.gov.au/parlInfo/download/committees/commjnt/26c33ede-95fb-4231-bb55-11552455269/toc_pdf/Joint%20Standing%20Committee%20on%20the%20National%20Disability%20Insurance%20Scheme_2014_04_15_2394.pdf;fileType=application%2Fpdf#search=%22committees/commjnt/26c33ede-95fb-4231-bb55-11552455269/0000%22

³³ Mental Health Council of Australia, *Mental Health and the National Disability Insurance Scheme: Position Paper*, p 3: http://mhca.org.au/sites/default/files/docs/mhca_position_paper_-_ndis.pdf

The cost of the NDIS

The baseline estimates of the cost of the NDIS were highly uncertain with future costs being predicted using best estimates of the number of people who will participate, how long each person will be in the scheme and the range of services they will need.

The experience of the first few months is that the scheme is more expensive per participant than had been anticipated. However, it is not yet clear whether this represents an initial underestimate of costs. It may be that scheme participants enrolled in the early phase have higher needs than what will prove to be the long-term average.

Health departments are not expected to realise savings as a result of the NDIS, and some state and territory governments may incur additional costs should they choose to fund current services the NDIA does not take on.

Inconsistency with the 2011 National Health Reform Agreement

The 2011 National Health Reform Agreement attempted to rationalise the role of the Commonwealth, states, and territories with the Commonwealth taking on primary responsibilities for aged care and the states and territories taking responsibility for younger people with disabilities. It is unclear whether the NDIS and the NDIA (established as a national statutory authority) do not conflict and are in line with the statutory requirements of the National Health Reform Agreement.

Opportunities for system learning

The NDIS is still in its early days and the details of the scheme are still evolving. An independent evaluation has been commissioned³⁴ and it will be important that the findings are used to inform the final design of the scheme. This evaluation may also have lessons that are relevant to the health system.

At the system level, the NDIS presents opportunities to learn more about individualised service planning and funding and better ways to measure need and outcomes. In the context of the parallel fee for service and Activity-based Funding models that largely apply in the health system, this is an opportunity too good to be missed.

³⁴ <http://www.ndisevaluation.net.au/>. Accessed 14 March 2014.

Recommendations for action

1. Establish formal Department of Health, Department of Social Service and National Disability Insurance Agency tripartite working group with the following roles and responsibilities

- **Education and information**
 - Develop and roll-out targeted education campaigns directed at the general community, the disability community and health and disability services to educate these key audiences on the eligibility requirement and other key implications of the NDIS and the National Injury Insurance Scheme (NIIS), which are currently not well understood.
- **Workforce implications**
 - Actively monitor and develop policy responses to health and disability sector workforce recruitment and retention issues and signs of fragmentation between health and disability services.
- **Patient inequity**
 - Actively monitor and develop appropriate policy responses to issues of inequity that might arise between NDIS participants in Tier 3 and those people with disabilities who are deemed to be ineligible for Tier 3.
- **Permanent and fluctuating impairment**
 - Actively monitor and develop appropriate policy responses to any perverse incentives that might arise, which work against the recovery approach that underpins the health system.
- **Mental health**
 - Develop a better picture of the implications of the scheme design arrangements for the mental health sector and coordinate actions to be taken to overcome barriers, which could include the development of guidelines for clinicians to use when assisting their clients navigate between primary health care, the NDIS and other implicated sectors.
- **Service delivery boundary disputes between health and disability sectors**
 - Establish a mechanism to resolve boundary disputes through negotiation rather than determined solely by the NDIA.

- **Timely access**
 - Establish a fast track system for hospital referrals to/from the NDIS in order to avoid people with disabilities experiencing fragmented care or extended length of hospital stay.
- **Inconsistency with the 2011 National Health Reform Agreement**
 - Determine if NDIS and the NDIA are in line with the statutory requirements of the National Health Reform Agreement.

2. National roll-out

While it is the responsibility of the Department of Social Services and the NDIA to work toward a nationally consistent approach as the scheme moves to full roll-out, the Department of Health should monitor roll-out to ensure health services are not negatively impacted.

3. Opportunities for system learnings

Review the NDIS evaluation in order to inform the health system with applicable lessons. At the system level, the NDIS presents opportunities to learn more about individualised service planning and funding, and better ways to measure need and outcomes.

Attachment 1: NDIS roll-out by state and territory

From 1 July 2013, the NDIS began in Tasmania for young people aged 15-24, in South Australia for children aged 0-14, and in the Barwon area of Victoria and the Hunter area in NSW for people up to age 65.

The NDIS will commence on 1 July 2014 across the ACT, the Barkly region of Northern Territory and in the Perth Hills area of Western Australia.

New South Wales

From 1 July 2013, the first stage of the scheme commenced for existing clients of specialist disability services living in the local government area (LGA) of Newcastle. People living in the Lake Macquarie LGA will enter the scheme from 2014, and people living in the Maitland LGA will be able to access it from mid-2015.

From July 2016, the NDIS will progressively roll out in New South Wales and by July 2018, all eligible residents will be covered.

Victoria

The first stage of the scheme in the Barwon area commenced for residents living in the local government areas (LGAs) of City of Greater Geelong, the Colac-Otway Shire, the Borough of Queenscliffe and the Surf Coast Shire in July 2013. By July 2016, all Barwon area residents with significant and permanent disability will be able to access the scheme.

The NDIS will progressively roll out across Victoria from July 2016 with full coverage by July 2019.

South Australia

Children with disability in South Australia started to move into the NDIS from 1 July 2013. Children currently in disability support programs aged from birth to two years are the first group to access the scheme, with children up to five years entering the scheme before July 2014. From July 2014, the age limit will be extended to 13 years and in the third year of launch all children up to 14 years will be able to enter the scheme.

From July 2016, the NDIS will progressively roll out in South Australia and by July 2018, all eligible residents will be covered.

Tasmania

People with permanent and significant disability in Tasmania aged 15–24 years as at 1 July 2013 are able to access the scheme during the first stage of the NDIS. Between 2013 and 2016, young people with significant and permanent disability will be able to access the scheme when they turn 15 years old. From July 2016, the NDIS will progressively roll out in Tasmania and by July 2019, all eligible residents will be covered.

Australian Capital Territory

The NDIS will launch in the ACT on 1 July 2014. The NDIS will have full coverage across the ACT by July 2016.

Northern Territory

The launch of the NDIS will commence in the Barkly region from July 2014. From July 2016, the NDIS will progressively roll out in the Northern Territory and all eligible residents will be covered by July 2019.

Queensland

From July 2016, the NDIS will progressively roll out in Queensland and, by July 2019, all eligible Queensland residents will be covered.

Western Australia

Western Australia has signed on at this stage to a two-year trial of the NDIS. This is different to the other states and territories. The NDIS trial in WA is also unique as it involves the implementation of two different models in different locations over a two year period and an independent evaluation of these two models. The Commonwealth NDIS model will be trialled from July 2014 in the Perth Hills area for residents living in the local government areas (LGAs) of Swan, Kalamunda and Mundaring. The Western Australian My Way model will be trialled from July 2014 for people in the Lower South West area and from July 2015 for people in the Cockburn-Kwinana area.

Attachment 2: other NDIS inclusions and exclusions

Early childhood

Inclusions:

- early interventions, allied health or other therapies, such as speech therapy or physiotherapy.
- individualised supports to enable a child to attend an early learning service. This is only in situations where a child has very significant and complex care needs that are beyond a reasonable expectation for early learning services to provide. For example, a child requiring ventilation which must be supervised by a trained carer or nurse.

Exclusions:

The early childhood system has responsibility for the education and care needs of children, including children with disability or developmental delay including:

- 'inclusion supports' that enable an early learning service to meet a child's needs through increased staff to child ratios and enabling staff to attend disability-specific training
- adapting their educational program to the needs of children with disability
- making reasonable adjustments to buildings, such as ramps, and fixed or non-transportable equipment such as hoists
- transporting children while they are in an early learning service such as for an excursion.

Individual and family responsibilities for funding early learning and education activities (such as childcare fees, general educational resources and excursion fees) remain unchanged.

School education

Inclusions:

- assistance with self-care at school related to the participant's disability such as assistance with eating or mobility
- specialist transport required because of the student's disability
- equipment that is transportable such as a wheelchair, personal communication device or a hearing aid
- specialised or intensive support to transition between schools, or from school to post-school options.

Exclusions:

The education system has responsibility for assisting students with their educational attainment, including through teaching and educational resources. This includes:

- employing teachers, learning assistants, facilitating access to educational resources
- learning-specific aids and equipment such as computers and text books
- making reasonable adjustments to the school curriculum to enable access by students with disability
- reasonable adjustments to school buildings, such as installing ramps, and fixed or non-transportable equipment such as hoists
- transporting students for school activities such as excursions
- day-to-day supervision of students while undertaking school activities including addressing behavioural issues while participating in school

Family support

Inclusions:

- family support and counselling due to a family member's disability
- building the skills and capacity of other family members to manage the impact of a participant's disability on family life
- supports that increase the participant's independence, as well as supports that enable the participant to enjoy social and community activities independent of their informal carers
- supports aimed at increasing the sustainability of family caring arrangement, including personal care and domestic assistance related to the person's disability
- where a child's caring or living arrangement changes due to a child protection order, the Scheme can continue to fund the child's disability related supports such as aids and equipment, therapies, transport or community access.

Exclusions:

The community services system continues to have responsibility for broad, population wide programs and statutory services including:

- family support and counselling, parenting skills programs and family relationships services
- all aspects of the statutory child protection system, including assessing and responding to suspected child abuse and neglect

- arranging out of home care for children subject to child protection orders, including making these arrangements sustainable for children with disability
- guardianship arrangements for people under the age of 18 years.

Higher and vocational education

Inclusions:

The NDIS will fund supports that enable participants to engage in higher education or vocational courses which are related to the participant's disability including:

- personal care on campus related to the participant's disability such as assistance with eating or self-care
- assistance with transport to and from campus required because of the participant's disability
- aids and equipment that is transportable such as a wheelchair, personal communication device or a hearing aid
- specialised or intensive support to transition into higher education and VET, or transition once the participant finishes studying.

Exclusions:

The education system has responsibility for assisting students with their educational attainment, including through teaching and educational resources including:

- employing teachers, learning assistants, facilitating access to educational resources
- learning-specific aids and equipment such as computers and text books
- making reasonable adjustments to the educational curriculum to enable access by people with disability
- reasonable adjustments to campus buildings, such as ramps, and fixed or non-transportable equipment such as hoists
- transporting students with disability on the same basis as other students for educational activities such as excursions or field trips.

Individual and family contributions to funding education-related supports such as course fees and purchasing education materials remain unchanged.

Housing and independent living

Inclusions:

- supports that build people’s capacity to live independently in the community, such as living skills training, money and household management, social and communication skills and behavioural management
- home modifications to the participant’s own home or a private rental property
- support with personal care, such as assistance with showering or dressing
- domestic assistance around the home where the participant is unable to undertake these tasks due to their disability, such as assistance with cleaning and laundry.

The Scheme may also contribute to the cost of accommodation in situations where the participant has a need for specialised housing due to their disability. The Scheme will only assist with this cost where it is higher than the standard rental cost that the participant would otherwise incur.

Exclusions:

Most participants will continue to access housing in the private market – rental or home ownership – or through social housing including:

- social and community housing
- homelessness and emergency accommodation services
- Commonwealth Rent Assistance
- National Rental Affordability Scheme (NRAS)

Employment

Inclusions:

- assisting participants who are not eligible for Disability Employment Services (DES) or Job Services Australia (JSA) to build their skills and capacity to participate in employment, as well as assistance to find and maintain employment.
- personal care or assistance with transport where the participant requires these supports regardless of the activity they are undertaking
- assistive technology devices such as wheelchairs, personal communication devices or a hearing aid

- supported employment, such as Australian Disability Enterprises, for participants who require on-going support to maintain their employment

Exclusions:

Employers are responsible for:

- making reasonable adjustments to enable people with disability to access their workplace
- employment specific aids and equipment such as computers and modified desks
- reasonable adjustments to buildings, such as installing ramps
- transportation for work activities, such as attending a meeting.

Employment services are responsible for assisting participants to build skills to participate in work and to assist them to maintain employment.