NACCHO
National Aboriginal Community Controlled Health Organisation

Network Position on the National Disability Insurance Scheme from the Aboriginal Community-Controlled Health Sector, comprising:

National Aboriginal Community Controlled Health Organisation (NACCHO) and the Affiliates:

Aboriginal Health and Medical Research Council (AH&MRC)

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Queensland Aboriginal and Islander Health Council (QAIHC)

Aboriginal Health Council of South Australia (AHCSA)

Aboriginal Health Council of Western Australia (AHCWA)

Tasmanian Aboriginal Corporation (TAC)

Aboriginal Medical Services Alliance Northern Territory (AMSANT)

Winnunga Nimmityjah Health and Community Services (ACT).

Executive Summary

The Aboriginal community controlled health sector provides primary health care services to almost half of all Aboriginal people. This paper draws on experience from across our Sector and finds the following.

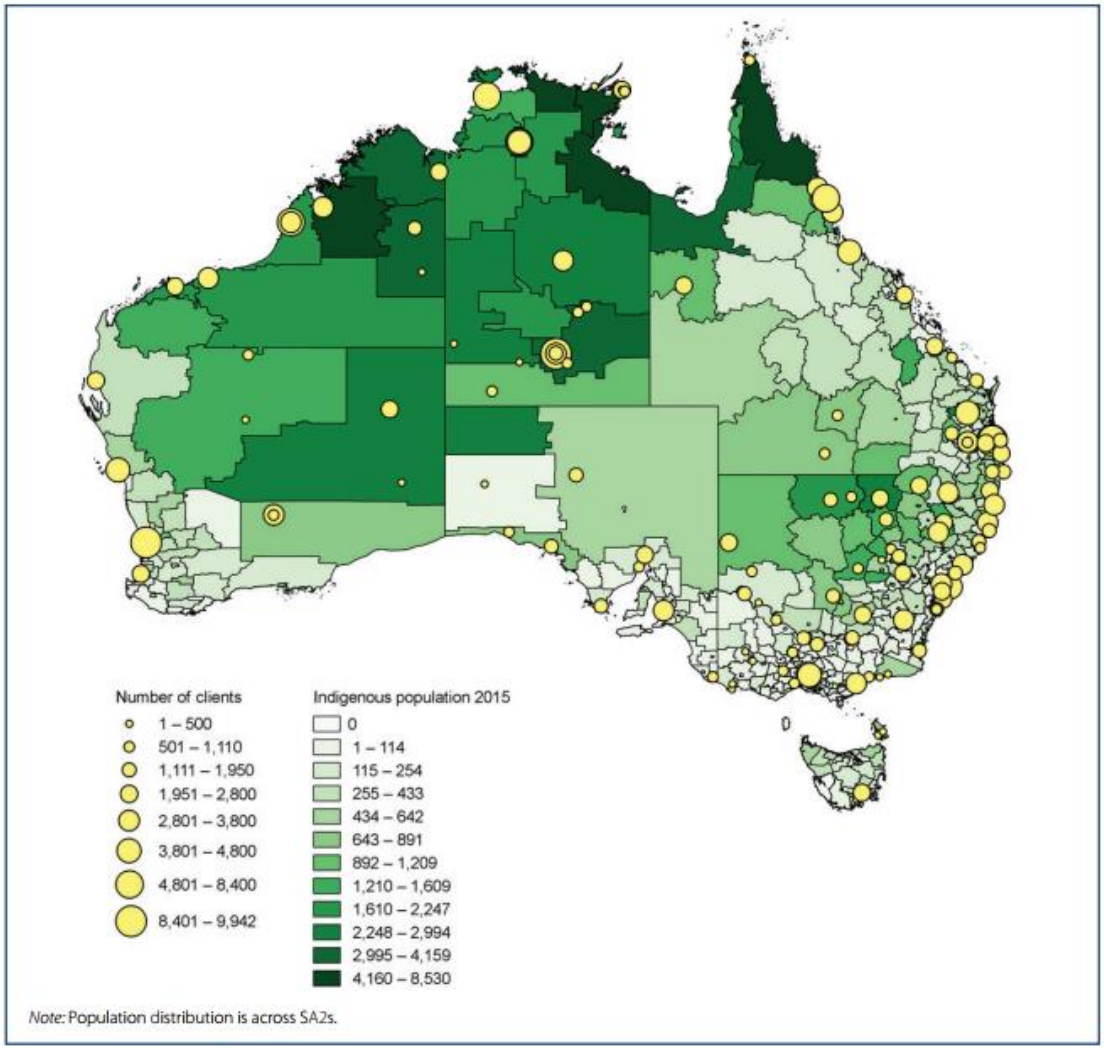
- There are problems for many Aboriginal people accessing NDIS services:
    - Some people struggle because they do not fit the assumed NDIS client model, given that they do not have access to online services, transport or someone who can advocate on their behalf;
    - Some find the system does not always provide for needs specific to Aboriginal culture (such as sorry business and interpreter services) and is not always welcoming to and respectful of Aboriginal people, and:
    - Some Aboriginal people, such as those living in remote areas and many regional areas find there are no disability services available at all, let alone the choice of an Aboriginal organisation.
- Our members, the Aboriginal Community Controlled Health Services (ACCHSs) are experienced at providing extra assistance to Aboriginal people as needed. They fill out forms on behalf of some clients, help them with housing and justice issues, and provide outreach services and transport. Our members are also well-established and reliable, with some operating for as long as 40 years, and many are accustomed to dealing with multiple different and complex funding arrangements (one Member Service in Western Australia reported they were managing applications and reporting requirements for over 100 State, Commonwealth and private funding agreements).
- Many of our ACCHSs are attracted to providing NDIS services to assist the most vulnerable Aboriginal people in their communities and to help reduce the cost-shifting they are currently experiencing (when NDIS services are not working for Aboriginal customers, they often seek (unfunded) help from their local ACCHS).
- However, there are barriers to our ACCHSs becoming service providers including:
    - Given the extra costs associated with providing some Aboriginal people with the extra support that they need to interact with the existing NDIS system, the pricing for funded services is too low. It is so low that ACCHSs are choosing not to be providers so that they do not endanger the viability of their existing health services.
    - There are also problems with the market (the number of participants) being too small to support the competitive provision of services to Aboriginal clients. The problem of 'thin markets' was identified by the Productivity Commission some time ago, but this problem has yet to be addressed by the NDIA.
    - There is insufficient workforce. If our ACCHSs want workers, they find that they need to train their own. Again, this is at cost to the ACCHS.
    - We also anticipate that many ACCHSs would struggle with the upfront investment needed to start providing NDIS service delivery.
- The NACCHO network is very supportive of the NDIS. We understand it is a complex and highly valued national reform that if implemented well, it will substantially improve the wellbeing of people with disability and Australians more generally. We are keen to collaborate with the Commonwealth Government to develop better solutions for Aboriginal people which may include increased NDIS service delivery by our members.

1. Introduction

The Aboriginal community controlled health sector

There are 143 Aboriginal Community Controlled Health Services (ACCHSs) who are members of NACCHO. Our members provide services through over 300 clinics. We offer three million episodes of care each year to about 350,000 people, servicing over 47% of the Aboriginal population. About 1 million episodes of care are delivered in remote areas. We employ 6,000 staff, the majority of whom are Aboriginal. In fact, we are the largest single employer of Aboriginal workers in the country.

Number of Indigenous clients for ACCHS and Indigenous population distribution, 2011



Source: Australian Institute of Health and Welfare 2016. Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171. Canberra: AIHW. p72

Aboriginal people are more likely to have a disability but are less likely to access disability services

Aboriginal people are more than twice as likely to experience a disability than non-Indigenous Australians (9% with a severe condition compared to 4% for non-Indigenous).[1] Around 60,000 Aboriginal people in Australia have significant disability that could make them eligible for NDIS support, representing 12.5% of potential NDIS participants (while Aboriginal people only represent 3% of the total Australian population).[2] We note that currently 5% of NDIS participants are Aboriginal or Torres Strait Islander[3], which some consider to be 'about right' but we suspect this is far too low.

The percentage of NDIS participants who are Aboriginal is indicative of the numbers of Aboriginal people with plans, but is not necessarily indicative of the extent to which Aboriginal people are receiving assistance under those plans (see box in Section 2 on Indications of under-supply of NDIS services for Aboriginal people).

We welcome the introduction of the NDIS, but are concerned that consistent with previous experience, Aboriginal people may not benefit from the NDIS to the same extent as non-indigenous people.

2. The appropriateness of NDIS arrangements for Aboriginal participants

Based on our experience providing health services, we suspect that Aboriginal people are less likely to use disability services than non-indigenous people owing to:

- lack of available disability services, especially in remote areas
- lack of available disability services that are culturally competent
- lack of accessible disability services (owing to barriers faced by some Aboriginal people including the need to use interpreters, lack of access and skills to use on-line information, needing to travel long distances, not having transport, unstable housing and many other potential issues).

State Governments are withdrawing supports faster than the NDIS can replace them

People who were previously receiving disability support services under State Government schemes are sometimes finding it difficult to obtain replacement services under the NDIS. An example of the impact of this problem is shown in Case Study 1 below.

[1] Aboriginal and Torres Strait Islander Health Performance Framework 2017 report, section 1.14 Disability.
[2] Australian Bureau of Statistics, National Aboriginal and Torres Strait Islander Social Survey, 2014-15.
[3] National Disability Insurance Scheme (2017) COAG Disability Reform Council Quarterly Report, 30 September 2017 pp24

Client case study

1: Unable to replace a broken wheelchair

(as retold by a former Local Area Coordinator in NSW)

Participant needing a new wheelchair as her old chair was being held together by gaffer tape. After over 60 emails to and from the Participant and NDIS and after 4 months, NDIS still couldn't tell me how or who I could talk to, to get the quote approved for the chair. This started in December 2016 and to date I still do not believe the wheelchair has been approved by the NDIS.

NDIS participant planning process is inappropriate for many Aboriginal people

There are significant issues with the NDIS planning process, where participants work with an NDIS planner (who may be either a Local Area Coordinator or an NDIA representative) to develop their care plan based on their 'reasonable and necessary needs'. NDIS planning conversations are brief and in the past, have sometimes been conducted over the phone and participants were not given adequate time or resources to prepare for their conversations. We understand that some of the issues around the planning process have already been addressed by the NDIA, with the possible exception of the need to provide more pre-planning support by LACs.

It has been reported by our Member Services across the country that NDIA planners are not always sufficiently culturally aware to assist participants appropriately, to understand their goals or to offer them the supports that they need or are entitled to. One example given is that the NDIS is supposed to fund participants' ability to participate in social and cultural life. Without a proper understanding of Aboriginal culture, planners do not offer or allow for Aboriginal people to choose supports to participate in family, spiritual and traditional cultural practices that are of significant benefit to them.

Client case study 2:

Loss of contact with man with mental illness

(as retold by a former Local Area Co-Ordinator in NSW)

A middle aged Aboriginal man, with mental illness and brain injury – allocated a <$10,000 plan. All relevant and current information and supports were collected and recorded by the LAC at the preplanning meeting but the Planner at the NDIS office created the plan and took little or none of the information into account. The inconsistencies with plans that come out of the planner's office is impalpable and the outcomes depend on the individual planner and their subjective views. There was no transport allowance which would help him to access the community. He received no funding to cover his current supports which now have been cut. These supports were helping him to function within the community. The NDIS plan was put in place and because of lack of funding in the plan for his current supports, they were reduced and to date his behaviour in the community has been worrying and he is currently missing and tomorrow, a mental health worker, a support worker and myself and police will be looking for him as he is now missing. If NDIS had funded the plan correctly and put a Support Coordination in place, this man would be participating well within the community. How is he able to put in a review for more supports or find the supports he requires?

There is a lack of culturally appropriate resources to assist participants and providers. Other services routinely provide interpreters for Aboriginal people but there appears to be no allowance for this under the NDIS. NDIS resources are often in technical language, can require a high degree of computer literacy (and a good internet connection, not always available in remote areas). There are few informational or planning resources specifically tailored to Aboriginal people and their needs.

Lack of case coordination for NDIS participants

Another concern is a lack of organisations who are willing to take on case coordination roles. Where case coordination is funded under an NDIS plan, there is often inadequate allocation of hours in a plan to reflect the amount of support required.

Client case study 3:

Elderly mother unable to get support to manage $200k plan for her daughter (as retold by a former Local Area Coordinator in NSW)

Kylie is a middle-aged participant diagnosed with a severe intellectual disability. Kylie's elderly carer, her mother, is hearing impaired. Kylie received a plan of just under $200K and her mother was overwhelmed with the funding, but the plan did not include support coordination. I worked with the Mother and a local provider to put care in place for Kylie and I also helped with advice to put in for a review for Support Coordination and home modifications that were required for Kylie's safety. The review was carried out by the NDIS after 3 months and the result was that the exactly the same plan was put back in place, without support coordination or home modifications. The mother of Kylie was at breaking point.

I was unable to advocate for these ladies nor did she think she had any one that could help them. During my visit, I discussed with the Mum about asking her adult son to help who lived interstate. I called her son and discussed the situation and he was more than willing to help. In about January 2017 he put a second review in for his sister for support coordination and home modifications however nothing had happened by June 2017.

The mum told me she received phone calls from various people within the NDIS and received different stories and was never given a number to call back. After months of not hearing about the review the son called the NDIS and he found that he encountered all the issues that many have faced and identified in dealings with the NDIS. The son has now given up and reportedly said to his mother "*this total NDIS thing is Impossible, I give up*".

The day before I left my LAC role, I received a call from Kylie's mother. She cried and told me about her son's frustrations and in all the years of living with Kylie's disability she has never felt depressed but now NDIS is '*sending me over the edge'* and she is finding everything impossible and overwhelming. That day I gave her information to call the Ombudsman and our Local member to get some help.

As a result, many Affiliates and Members Services have reported cost shifting to ACCHSs. NDIS participants who have difficulty in the planning process or who cannot access services, often seek help from their local ACCHSs. They trust their local ACCHS to ensure quality, cultural safety and advocacy for Aboriginal people and families that is not adequately provided/funded under the NDIS. ACCHSs are taking on this role at cost to themselves.

Even when Aboriginal people have plans under the NDIS, many are still not receiving the supports to which they are entitled, due to a lack of available providers. There are two aspects to this: a lack of Aboriginal specific or otherwise culturally appropriate disability providers in general, and a lack of any providers at all in parts of regional and remote Australia where Aboriginal people are over-represented and disproportionately suffer from a lack of services.

Thin markets for disability service providers for Aboriginal people

In its recent enquiry into NDIS costs, the Productivity Commission reported on the existence of 'thin markets', where the market-based model of the NDIS does not work because there is insufficient supply of participants or disability service organisations to provide a genuine market.

While the Productivity Commission particularly found regional and remote Australia is likely to have thin markets, it also noted that there may be thin markets for Aboriginal specific providers all over Australia, even in urban areas. As an example, one of our members reports that in the ACT, only around 10% (20-40 of 250-300) of eligible Aboriginal people within ACT were accessing NDIS supports under their plans in 2016, in part due to the lack of any Aboriginal specific or culturally safe providers in Canberra.

There are few, if any incentives within the NDIS for service providers to actively work to build community capacity or show that they are able respond to the unique cultural, social and health needs of Aboriginal people. Competitive market models may in fact discourage this. Smaller ACCHSs and other Aboriginal organisations, and particularly those operating in remote areas with thin and fragmented markets, will be unfairly disadvantaged when compared with the economies of scale of larger mainstream providers, including those who operate for profit.

Indications of under-supply of NDIS disability services for Aboriginal people
(from National Disability Insurance Scheme (2017) COAG Disability Reform Council Quarterly Report, 30 September 2017)

The following table shows that as more plans are being rolled out across Australia, that less of the committed funds are being spent. This may indicate that there is insufficient supply of services to enable participants to spend their funds.

Table 2.2 Payments by financial year, compared to committed supports ($m)

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19 and beyond	Total
Total Committed	132.8	496.8	933.6	3,177.7	4,466.4	286.8	9,494.1
Total Paid	85.3	370.1	700.3	2,061.7	717.4	-	3,934.8
% utilised to date	64%	74%	75%	65%	-	-	64%[28]

As shown below, this is particularly evident in the Northern Territory, for which spending of committed funds was only 38% last year.

Table J.27 Payments by financial year, compared to committed supports ($m) – NT

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19 and beyond	Total
Total Committed	-	1.9	5.5	19.7	75.7	6.5	109.3
Total Paid	-	1.6	4.0	7.5	3.7	-	16.8
% utilised to date	-	81%	73%	38%	-	-	38%[99]

Most participants in the Northern Territory are Aboriginal (77% as shown in the next table) and so it appears that under-supply of services is particularly affecting Aboriginal clients. This could be established more accurately if the NDIA quarterly report tables could be provided separately for Aboriginal and Torres Strait and non-indigenous populations.

Table J.11 Participant profile per quarter by Aboriginal and Torres Strait Islander status – NT

	Prior Quarters		2017-18 Q1		Total	
Participant profile	**N**	**%**	**N**	**%**	**N**	**%**
Aboriginal and Torres Strait Islander	296	79.1%	116	73.0%	**412**	**77.3%**
Not Aboriginal and Torres Strait Islander	76	20.3%	31	19.5%	**107**	**20.1%**
Not Stated	2	0.5%	12	7.5%	**14**	**2.6%**
Total	**374**	**100%**	**159**	**100%**	**533**	**100%**

3. Benefits associated with ACCHSs becoming providers of NDIS services

Many of the problems discussed in the previous sections could be addressed if Aboriginal Community Controlled Health Services became providers of NDIS services such as:

- Undertaking Local Area Coordinator roles (i.e. developing client plans)
- Providing support coordination (i.e. linking up clients with plans to service providers)
- Becoming a NDIS registered service provider (i.e. providing disability and allied health services consistent with a client's plan)
- Receiving block grant funding for community engagement and participant access support (including identification and engagement, as well as practical support through eligibility and assessment, pre-planning and planning processes)

As far as we can tell:

- Up to 40 ACCHS are providing allied health services to clients paid for by NDIS packages (this is effectively a new source of fee-for-service funding for service delivery already undertaken by ACCHSs). We are unsure how many are registered providers.
- Only a few ACCHSs provide the remaining possible services (e.g. LAC services, support co-ordination services or the extensive range of disability services that do not require an allied health professional).

Provision of more disability services by ACCHSs would have the following advantages:

- Our Member Services already have a relationship with many Aboriginal people who are or will become NDIS clients.
- We specialise in providing services that are accessible.
    - For those people who need it, we undertake home and community visits, we use available opportunities to treat people (e.g. we treat all attending family members as needed when they visit the clinic), we provide transport and make specialist appointments on behalf of our clients. We also provide wrap around care relating to other services such as housing and justice.
- Our Member Services are culturally safe for Aboriginal people.
- Our Member Services are reliable. Some of our members have been in operation for over 40 years. Our services have been maintained in rural and remote areas in which other services often fail.
- We are accustomed to dealing with funding complexity, with some of our larger ACCHSs juggling requirements from over 100 funding agreements.

4. Barriers to ACCHSs providing NDIS services

However, our ACCHSs are choosing not to become registered providers of NDIS services owing to issues relating to:

i) pricing of services below cost to the provider
ii) lack of available disability workers
iii) need for upfront investment

Pricing of services below cost to the provider

Only a few ACCHSs are becoming registered NDIS providers, as it is not financially viable for most of them to do so and they are not willing to put at risk their organisational viability and/or existing service delivery.

- One of the major problems identified is that NDIS funding support is priced at a level that in practice only pays for costs at the point of care as it is based on assumptions about wages, organisational overheads, supervision and billable time that are completely unrealistic and inadequate. In addition, it does not cover holistic care and participant support.
- Training and recruitment costs for staff are also problematic for organisations, as training is not funded under the NDIS.
- Transport for participants, disability workers and other sundry costs are not sufficiently considered or provided for, especially for regional and remote participants and workers who must travel long distances to access or deliver services.
- In general, the remote 25% loading provided by the NDIA is simply inadequate and does not reflect the true costs of providing services in these locations. Our members and other organisations on the ground suggest that 80-100% loading might be more appropriate, given experience in the cost differentials for very remote services.

Provider case study 1:

Costings for NDIS services compared to NDIS pricing
Calculated by Winnunga Nimmityjah Aboriginal Health Service, October 2016

In 2016, Winnunga secured funding under an NDIS Business Investment Package which was used to do a cost-benefit analysis for providing NDIS services.

Given their understanding of their clients' needs, Winnunga calculated the likely costs of providing the services required under NDIS for one year and compared this against the revenue they were likely to receive from the NDIA (see Table). To become an effective provider of NDIS services to their Aboriginal clients, they calculated that they would need to obtain supplementary funding of over $270k per annum. Most of this was needed to fund provision of assistance to clients with forms (eligibility, access forms, identification processes and processing of claims = $235k) which is currently unfunded by NDIS and to supplement funding for remaining activities. Winnunga is open to providing the full report on request.

Cluster of service	**What NDIS pays**	**Estimated cost to Winnunga**	**Gap per annum**
Services with gap > $10k pa			
Assistance with: eligibility and access form; identification process; and, processing claims	Not funded	$235,225	-$235,225
Specialist support coordination	$42,137	$18,945	$23,192
Assistance to access community, social and recreational activities	$18,982	$37,852	-$18,870
House and/or yard maintenance	$8,746	$22,995	-$14,249
Exercise physiology	$29,715	$16,640	$13,075
Assistance with decision making, daily planning, budgeting	$8,900	$18,926	-$10,026
Services with gap < $10k pa	$134,768	$163,488	-$28,720
Total	$243,248	$514,071	-$270,823

Lack of available disability workers (and cost-shifting to the Sector)

There is a lack of Aboriginal people trained to provide disability and other allied health services. If clinics want workers, they find that they need to develop their own and this is costly.

Provider Case Study 2:

Provision of training in partnership with the local TAFE

Katungul Aboriginal Corporation on the Far South Coast are currently providing NDIS services.

Owing to lack of trained staff in their area, they have partnered with the local TAFE to develop appropriate training. This is a good outcome, but it was only achieved owing to good relationships at the local level and at some cost to Katungul.

Provider Case Study 3:

Provision of training to school students in NT

The Aboriginal Medical Services Alliance in the NT (AMSANT) has used grants from a variety of sources to fund the NT Aboriginal Allied Health Academy, which is aimed at school students in Darwin. The Academy seems to be going well and is helping AMSANT to better understand the training needs and drivers of its allied health workforce, but there is insufficient funding for the Academy to be fully developed or evaluated. If pilot funding could be provided, then this might be a useful model for use by other States.

Need for upfront investment

NDIS payments do not appear to cover the costs of the business transformation needed to become a disability provider, such as dedicated staffing, IT and accreditation.

5. Suggested solutions

1. As recommended by the Productivity Commission (2017) in their report, *National Disability Insurance Scheme (NDIS) Costs*, the National Disability Insurance Agency should address thin markets with a focus on thin markets for disability services suited to the needs of Aboriginal people by:
    a. Considering a range of approaches, including block-funding

        A possible funding model could be a case-based model, akin to the model being trialled under the 'Health Care Homes' program. Under this model ACCHSs would receive direct funding based on the number of participants they enrol for care and the assessed needs of those participants, along with an amount of block funding to cover organisational transformation and overheads.
    b. As a matter of urgency, publicly releasing its Provider of Last Resort (POLR) policy and Market Intervention Framework discussed in the NDIS Market Approach: Statement of Opportunity and Intent
    c. Collecting and making publicly available disaggregated data, feedback and reports on thin markets, including when POLR arrangements are used.

2. Devote significant investment into training to grow the Aboriginal disability and allied health workforce.
    a. We note that the Government has recently announced the appointment of a consortium led by Ernst and Young to implement its $33 million measure announced in the 2017-18 Budget, *Boosting the Local Care Workforce Program*. Minister Jane Prentice's media release (20 December 2017) notes that the consortium includes the First Peoples' Disability Network. We are keen to know more about the governance of this scheme, what services will be available and whether these will be sufficient.

3. That the NDIA develop and implement specific processes/standards and training regarding interactions and engagement with Aboriginal and Torres Strait Islander people that respect their cultural practices and ways of doing business, both for planning staff and local area coordinators. Again, NACCHO and the sector could assist.

4. That the NDIA develop improved pre-planning and reference tools and resources suitable for Aboriginal participants and providers. NACCHO and the sector would be able to assist with the development of these materials (but need to be funded for the capacity to do so).

5. That the NDIA fund dedicated project officer positions within the sector to assist clients to access the NDIS and advocate for them during interactions with planning officers. These positions must be dedicated within the ACCHO sector to support community engagement and funded on an ongoing basis to have real long-term benefits. Furthermore, positions within the Affiliates are required.

6. Introduce Aboriginal Cultural Support as a funded support category under the NDIS and/or introduction of weighting of packages for Aboriginal people. This will help ensure the cultural needs of Aboriginal people with disability can be taken into account when planning for access to an 'ordinary life'. It will also improve the incentives and financial viability of organisations that are Aboriginal specific, or who invest in becoming culturally safe providers.

7. We need revised standard to become providers as these are complex and administratively onerous.

8. Undertake an independent review of the impacts of NDIS on Aboriginal and Torres Strait Islander people and how to build an effective system to meet the needs of Aboriginal people.

9. That DSS consider providing funding to the NACCHO network to help fund the development of policy advice specific to each State on Aboriginal NDIS services.