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Response to the Independent Pricing Review – understanding 'complexity' in early intervention

The Independent Pricing Review (IPR) incorrectly compares the NDIA with road trauma and workplace accident rehabilitation schemes. For the reasons stated below, those interventions are largely irrelevant to individuals qualifying for the NDIS and in failing to understand the difference, the IPR fails to adequately understand the notion of 'complexity' in delivering disability and early intervention services.

Road trauma and workplace accident rehabilitation is generally designed to return an injured person to normal/typical function. Whilst some road trauma and workplace accidents result in lifelong disability, what constitutes a 'low complexity' injury or illness could be as routine as a single broken bone or minor surgical intervention. (By way of comparison, the Australian Institute of Health and Welfare defines a 'serious' injury in road vehicle traffic accidents as one that requires hospitalization – of which more than one in three are only ***same day*** hospitalisations). Conversely, NDIS participation is predicated on an individual experiencing what is expected to be a lifelong condition/disability that limits day to day living. All but very few NDIS cases would be characterized as complex in these other schemes.

Other schemes are most commonly face to face, and the receiver far more likely to be able to communicate their understanding (or lack of) regarding the therapist's instructions and when required, can seek clarification of a therapist's directions and instructions. Persons with a disability, especially young children, often have challenges communicating. This requires the therapist to be reactive to a patient's every action and response to their instruction. In addition to monitoring the patient's progress and adoption of the therapist's directions, there is also a requirement to instruct primary carers and others (such as child care workers and school teachers) of the relevance and correct application of exercises and techniques for sitting, standing, walking, etc. Again, the most straightforward of NDIS treatment scenarios can rarely be defined as anything but complex in the other schemes.

In addition to the mis-characterisation of what constitutes complexity, the IPR fails to adequately identify or acknowledge the range of non-compensable obligations professional and committed therapists have in treating NDIS clients.

In 2001, the World Health Organisation endorsed the International Classification of Functioning, disability and health (ICF). It is a model used to describe function and a provide framework to develop intervention for a person with a disability. It is taught in universities throughout Australia and results in improved inclusion and participation in the community and workforce, outcomes the NDIS is striving for.

The ICF sets goals by asking the question "what is the participant wanting to be able to do?". An intervention plan is created by:

1. researching the activity the participant wants to be able to do and understand its components
2. assessing the participant's ability to perform that activity and identify the barriers preventing them from being successful with this activity
3. assessing the environment where this activity takes place

https://www.aihw.gov.au/getmedia/04d1e9c5-6bea-4dca-bc12-07a61525aedd/12267.pdf.aspx?inline=true, page 17

4. researching appropriate modifications and/or adaptive equipment that will enable the participant to be successful with this activity
5. building the capacity of key people within the environment that this activity occurs. This can include the family, daycare, school or community groups
6. organising equipment trials
7. teaching the activity in the environment that it would occur.

Funded by NDIS Not funded by NDIS

The ICF framework is the therapy intervention model currently utilised by therapists registered as NDIS providers. A small component of this intervention model is face-to-face and highlighted in yellow. It is only the yellow highlighted components of intervention that are currently funded in the NDIS price guide. (Most of the above were funded in the past under transdisciplinary practice for 0 – 6-year-old age groups in trial phase).

The discord between the funding model in place in the NDIS (and moving to the funding model proposed in the Independent Pricing Review), and the service delivery model required (and recognised internationally as best practice for people with a lifelong disability), is a key cause of the significant financial strain experienced by providers.

The IPR makes a very big assumption about how the NDIS will deliver advances in the provision of early intervention and disability therapy (page 7):

> *"For example, as evidence develops as to which interventions are most effective in reducing costs associated with complexity, it should be possible to reduce the number of complex participants and provider costs and prices".*

There is a very broad assessment and inherent to the statement is an assumption there has been inadequate academic research into treatment methods and no professional effort to share our experiences. There is no evidence presented to support his view and most importantly, it makes no assessment on the timing and level of funding that would be required to collect and analyze this evidence nor how and when these learnings will be implemented.

There are other financial elements of the IPR that warrant comment. In determining new rates (the three Levels detailed at page 30), the IPR compares the current NDIA rate with the government schemes mentioned above. The definitions of these levels themselves are worth considering. Level 1 is described as '*treatment of a single physical condition.*' As stated above, a broken bone (or a muscle tear) would constitute a single physical condition, Level 2 is described '*multiple (2-3) entirely separate injuries or conditions where treatment applied to one condition does not affect the symptoms of the other injury.*' Level 3 proposes a specific payment for '*complex pathology and clinical presentation (including complicated injuries involving multiple joints and tissues, spinal cord injuries, head injuries, major trauma.*' **It is difficult to foresee circumstances where an individual who requires support due to a Level 1 or 2 condition would ever even be accepted as an NDIS participant.**

Acceptance of the IPR's recommendations on therapy and early intervention threatens the objectives of the NDIS. The IPR displays an inadequate understanding of the complexity of service delivery to NDIS participants, a failure to recognise (and acknowledge in the pricing structure) the

range of activities that therapists undertake supporting NDIS participants and presents unrealistic comparative 'benchmarks' with other Schemes. It is recommended that the IPR recommendations regarding therapy services be set aside pending more research and sector consultation.

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