EXERCISE & SPORTS SCIENCE AUSTRALIA

Current Scheme Implementation and Forecasting for the NDIS

Joint Standing Committee on the National Disability Insurance Scheme

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EXERCISE & SPORTS SCIENCE AUSTRALIA (ESSA) SUBMISSION

RE: CURRENT SCHEME IMPLEMENTATION AND FORECASTING FOR THE NDIS

Joint Standing Committee on the National Disability Insurance Scheme

Thank you for the opportunity to provide feedback in relation to the *Current Scheme Implementation and Forecasting for the NDIS* Inquiry.

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports science professionals in Australia, representing more than 10,000 members comprising university qualified Accredited Exercise Physiologists, Accredited Sports Scientists, Accredited High-Performance Managers and Accredited Exercise Scientists.

Accredited Exercise Physiologists (AEPs) currently work within the National Disability Insurance Scheme (NDIS), by providing exercise physiology supports, while Accredited Exercise Scientists (AESs) provide supports as therapy assistants alongside allied health professionals, or as personal trainers, social engagement facilitators and support workers.

This submission responds to the terms of reference of the inquiry, particularly with regard to:

- the reasons for variations in plan funding between participants with similar needs
- how capacity building supports can assist with long-term scheme sustainability
- the future of the flexible planning and personalised budgets proposed by the National Disability Insurance Agency (NDIA).

Many of the issues experienced by participants can be resolved by addressing operational issues of the NDIA, such as planner training on the value and scope of allied health therapy supports and holding the NDIA accountable for poor operation by regulating Agency staff and NDIS data transparency.

ESSA welcomes the opportunity to provide further detail or appear before the Joint Standing Committee on the NDIS (the Committee) if invited. Please contact ESSA Policy & Advocacy Advisor, Carla Vasoli at policy@essa.org.au for further information or questions arising from this submission.

Yours sincerely

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1.0 ABOUT ACCREDITED EXERCISE PHYSIOLOGISTS AND ACCREDITED EXERCISE SCIENTISTS

Accredited Exercise Physiologists (AEPs) are four-year university degree qualified allied health professionals who design and deliver prescribed exercise for people with or at risk of chronic disease, injury or disability. Exercise physiology services are recognised by Australian compensable schemes including Medicare, the National Disability Insurance Scheme (NDIS), Department of Veteran Affairs (DVA), workers' compensation schemes and most private health insurers. AEPs are dual qualified with a foundational undergraduate degree in exercise science followed by a fourth year, Masters or Honours, in exercise physiology.

Australia's exercise physiology profession comprises approximately 7,000 AEPs. Most of the profession work in private practice and are underutilised in the public health sector.

Accredited Exercise Scientists (AESs) are three-year university degree qualified professionals who deliver exercise programs to Australia's well populations to prevent chronic disease, injury and disability, and improve health, fitness and performance. AESs empower, motivate and coach clients to adopt long-term behavioural changes. They work in numerous sectors spanning allied health as Allied Health Assistants (AHAs); the NDIS as support workers; personal trainers in the fitness industry and for private health insurers; coaches in sporting organisations; and as program coordinators in education and corporate health.

Australia's exercise science profession comprises approximately 1,000 AESs. Most of the profession work in private allied health clinics, run their own business or work in the corporate sector.

2.0 SUMMARY OF RECOMMENDATIONS

Recommendation 1: That the Committee advise the Minister for the NDIS and that participants should not be referred to mainstream or tier 2 supports, such as Medicare CDM items, until they have been successfully exited from the scheme, in line with recommendations by their qualified and experienced allied health providers.

Recommendation 2: That the Committee advocate to the Australian Government that it fast track additional Medicare Benefits Schedule allied health sessions.

Recommendation 3: That the Committee advocate to the Australian Government that the NDIA provide adequate budgets for NDIS clients to allow them the appropriate access to qualified allied health professionals, including Accredited Exercise Physiologists.

Recommendation 4: That the Committee requests that the Minister for the NDIS to

- mandate:
  - a minimum level of knowledge of each NDIS therapeutic support and allied health profession for internal NDIA decision-making staff, including planners
  - ongoing planner training to ensure planners' knowledge of therapeutic supports and allied health professions is regularly updated, in accordance with new and emerging evidence and
  - the employment of planners who have qualifications and/or experience in health or human services and
- provide sufficient resourcing to support planners to develop a strong understanding of the complex needs associated with participants' disabilities and their required care.

Recommendation 5: That the Committee requests the NDIA engage ESSA to implement the Exercise is Medicine© program for NDIS planners to augment workforce knowledge and health literacy to better support NDIS participants.

Recommendation 6: That the Committee requests the Minister for the NDIS develop a legislative instrument to support NDIA staff accountability relating to plan funding decision making consistency, and which will be administered by the NDIS Quality and Safety Commission.

Recommendation 7a: That the Committee advise the NDIA to increase price limits for therapy supports delivered in MMM regions 3 by 20%, 4-5 by 40% and 6 by an additional 10%, in line with the Workforce Incentive Program.

Recommendation 7b: That the Committee advice the NDIA that planners need to ensure participants residing in MMM regions 3-6 have their plan budgets for therapy supports increased in line with the price limit increases for their region.

Recommendation 8: That the Committee acknowledge the potential for cost savings in core supports and tax income by adequately funding capacity building supports, such as investing in exercise physiology therapy, as a means of future funding support and/or financial sustainability of the NDIS.

Recommendation 9: That the Committee advocate to the Minister of the NDIS to implement an online platform with publicly available data on participant plan budget allocation, expenditure on allied health therapies and participant outcomes.

Recommendation 10: That the Committee instruct the NDIA to publicly report on internal review data, including:

- the number of internal review applications
- the number of internal review applications that resulted in a change of the original decision
- information on those applications that did not result in a change of the original decision, and the reasons why the decision was confirmed.

Recommendation 11: That the Committee advocate to the Minister of the NDIS to amend the current policy for personalised budgets and plan flexibility to better consider participant goals, and to engage in meaningful consultation with the sector (including participants, providers and peak bodies) to ensure the policy fully meets the needs of participants.

3.0 MEDICARE CHRONIC DISEASE MANAGEMENT PLANS

The impact of boundaries of NDIS and non-NDIS service provision on the demand for NDIS funding, including:

i. the availability of support outside the NDIS for people with disability (e.g. community-based or 'Tier 2' supports)

ESSA members have reported that NDIS planners often require participants to exhaust allied health services under a Medicare Chronic Disease Management (CDM) Plan, before they will offer funding to therapy supports in their NDIS plan.

Given that CDM plans and the NDIS aim to achieve very different outcomes, it is inappropriate for planners to force participants to use Medicare allied health services before granting access to NDIS allied health supports. The purpose of allied health services offered under CDM plans is to help people manage their chronic conditions [1], which may avoid the need for more complex care in the future. In contrast, the goal of NDIS funded allied health supports is to improve or maintain a participant's functional capacity and to increase their independence to be able to live an ordinary life [2]. This means that allied health professionals will take a different approach to treating clients under each scheme, therefore allied health services offered in CDM plans should not be considered an alternative to NDIS allied health therapy.

Further, CDM plans offer insufficient support for people with a disability. Under a Medicare CDM plan, patients have access to a maximum of five allied health services per calendar year [3]. Five allied health sessions per calendar year is far less than standard clinical practice suggests is necessary to effectively manage chronic health conditions [4], making current Medicare arrangements insufficient to meet the needs of patients with a chronic disease, particularly when considering that the five sessions are shared among all allied health services.

Recommendation 1: That the Committee advise the Minister for the NDIS and that participants should not be referred to mainstream or tier 2 supports, such as Medicare CDM items, until they have been successfully exited from the scheme, in line with recommendations by their qualified and experienced allied health providers.

Recommendation 2: That the Committee advocate to the Australian Government that it fast track additional Medicare Benefits Schedule allied health sessions.

4.0 INEQUITIES IN NDIS PLAN BUDGETS

The reasons for variations in plan funding between NDIS participants with similar needs, including:

i. the drivers of inequity between NDIS participants living in different parts of Australia,

ii. whether inconsistent decision-making by the NDIA is leading to inequitable variations in plan funding, and

iii. measures that could address any inequitable variation in plan funding;

4.1 NDIS PLANNERS

Variations is plan funding between participants seems to be dependent on the planner that each participant sees at their plan review. Some planners provide sufficient funding in participant plans for necessary allied health supports, while other planners seek lower-cost alternatives that do not offer safe and effective therapy options.

ESSA members from various locations across the country, have reported that many NDIS planners are allocating plan funds to specific support hours and delegating therapy supports to support workers in an attempt to reduce costs, despite not having the knowledge or qualifications to make clinical decisions. These cost cutting measures have resulted in overly prescriptive plans that do not align with allied health professional recommendations or participant preferences.

4.1.1 INAPPROPRIATE DELEGATION TO SUPPORT WORKERS

ESSA has expressed concerns to the National Disability Insurance Agency (NDIA) that participant outcomes are being diminished by cost cutting at both the NDIS planning and review stages. ESSA has observed a growing trend in NDIA planners cutting, or significantly reducing, participant funding for exercise physiology and requesting that AEPs train unqualified support workers in the delivery of clinical exercise physiology interventions.

ESSA advocates for an active Australian population and understands the importance of support workers and carers in encouraging physical activity. However, ESSA has repeatedly expressed to the NDIA that there is a significant distinction between:

1. understanding the benefits of physical activity and encouraging incidental exercise day-to-day, and
2. the assessment, prescription and delivery of clinical physical activity interventions, and the monitoring and evaluation of those prescribed interventions for targeted outcomes.

These concerns are underpinned by the physical and health risks to NDIS participants where unqualified workers are expected to deliver prescribed, clinical exercise treatments. It is inappropriate and dangerous to expect carers or support workers, who do not have the expertise, experience, qualifications, knowledge, or skill of AEPs, to conduct ongoing risk stratification, monitor symptomology, and adjust the prescription of exercise based upon complex interactions of diagnosis, exercise tolerances and changing medication regimes.

In other circumstances where AEPs have complied with NDIS demands and provided training to support workers, the following has been observed:

- Some participants receive supports from more than one allied health professional, which increases the amount of therapy support expected to be delivered by support workers (refer to Case Study A).
- Participants do not always receive the same support worker day to day or week to week, making it difficult to train a consistent team of support workers to deliver therapy support (refer to Case Study A).
- Support workers who are trained by AEPs often do not follow through on actively supporting participants to engage in prescribed activities and lack the behavioural counselling skills of AEPs to motivate clients to complete exercise sessions.
- Group home staff have been known to sign off on records confirming that home exercise services have been provided, but these records often conflict with the advice of participants.

Case Study A

A 17-year-old female had been receiving a range of therapies, including exercise physiology, occupational therapy, physiotherapy, and speech pathology. As part of the review process, funding was reduced across all therapies and the therapists were asked to train the participant's support workers in the delivery of therapy supports. The AEP noted that the participant received support from over 20 different care workers a week, and concerns had been raised about the risks associated with training such a large number of care workers in such a diverse range of therapy supports.

Further, participants that are forced to receive allied health therapy from support workers are less likely to receive therapeutic benefit from treatment, limiting their ability to experience optimal functional capacity.

Cost cutting measures by some NDIS planners is resulting in insufficient allied health intervention delivered by an appropriately trained and qualified professional, as well as variations in plan funding between NDIS participants with similar needs.

Recommendation 3: That the Committee advocate to the Australian Government that the NDIA provide adequate budgets for NDIS clients to allow them the appropriate access to qualified allied health professionals, including Accredited Exercise Physiologists.

4.1.2 ACCOUNTABILITY AND LACK OF UNDERSTANDING OF ALLIED HEALTH

ESSA strongly supports the legislation and regulations that ensure NDIS provider compliance and accountability for high quality and safe NDIS supports by the NDIS Quality and Safety Commission. ESSA understands that this is due to the recognised risk to participant wellbeing, should poor quality supports be provided. Unfortunately, this accountability is limited to providers and should be extended to those NDIA employees whose delegated authority has significant impact on a participant's life, such as NDIS planners.

NDIS planners who chose to reduce participant plan funding or limit funds to services against allied health professionals' evidence-based recommendations and participant choice see no repercussions for the harm and stress they cause to the participant. This is despite the National Disability Insurance Scheme Act 2013 Object (1)(e), which states that the Act aims to "enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports."

ESSA has observed that NDIS planners do not understand the role or value of allied health. They have insufficient knowledge and lack qualifications and experience to determine the allied health needs of a participant. They also lack understanding of the scopes of practice and value of various allied health professions and often look to identify lower value alternatives which can be to the detriment of the participant's functional capacity outcomes. NDIS planners also do not receive ongoing training or professional development, despite new evidence and research emerging in relation to the impact of therapeutic supports on functional outcomes for people living with disability.

Currently, AEPs must spend time educating individual NDIS planners on the role of an AEP and benefits of exercise physiology to support their NDIS participants to access exercise physiology funding in their plans, even though they provide reports outlining the participant's progress toward their goals, along with clinically justified therapy recommendations. Despite providing this education to planners, participants continue to see therapy funding cuts for valuable supports.

Refusal to allocate funds to therapeutic supports is consistently occurring in the sector, despite participants and allied health professionals providing all the evidence requested by the NDIA to support the need for recommended allied health supports. Evidence provided has included peer reviewed research, case studies and allied health progress reports demonstrating therapeutic benefit for individual NDIS participants. Insufficient funds for recommended therapeutic supports have resulted in the functional decline and negative impacts on the health of many participants that are treated by AEPs, as seen in Case Study B.

Case Study B
A 9-year-old male with Autism Spectrum Disorder (ASD) presented with communication shut-down, emotional regulation issues, lack of motivation and below average fine and gross motor skills. Goals included developing communication and social skills so he can build and maintain friendships and relationships with others, and to recognise and understand emotions, learn strategies to self-regulate his emotions. During the 12-month plan period, as a result of weekly AEP interventions, the client had improved confidence; increased engagement and communication with little to no signs of communication shut down; increased exercise tolerance; increased time engaging within a community environment; improved gross motor skills; and required little to no parental support and supervision during therapy compared to last plan period. The participant's AEP recommended in the client's progress report that he continue to receive exercise physiology to further improve functional capacity, health and wellbeing outcomes and recommended that a future goal be to increase his exercise tolerance from 45 minutes to 1 hour per week.

At plan review, all AEP funding was removed and only funding for occupational therapy and psychology was provided, despite the family's preference for him to continue seeing his AEP. The planner indicated that funding for AEP was removed, as the child would now be able to get the physical activity he needed from school. After a few months of engaging with the new plan, the child's parents contacted his AEP to provide feedback that he was disengaging from school due to reduced confidence to participate in social and sporting activities, as he did not have the coordination or social skills to participate. The participant was not responding to new allied health therapies, resulting in them being ineffective.

Case Study B highlights that the planner was not aware of the value that exercise physiology provides over general physical activity, or the impacts that AEP interventions provide relating to the development of fine and

gross motor skills, coordination and increased confidence for social engagement in people with ASD. As indicated in Case Study B, if the participant's fine and gross motor skills, coordination, and confidence are not addressed, the participant will not engage in physical activity within a community environment.

ESSA members have previously reported claims from planners that AEP supports are only relevant for people with a physical disability. However, research evidence highlights that exercise therapy is beneficial for many cognitive and psychosocial disabilities as well. For example, various forms of exercise therapy have been proven to provide behavioural, emotional and social benefits for people with ASD [5-9].

Exercise is also shown to improve the lives of people with psychosocial disability by improving both their mental and physical states [10]. AEPs are qualified to understand and treat the symptoms and presentations of mental illness to prescribe the appropriate level and type of physical activity at each presentation, as people with severe psychosocial disability are not recommended the same level of physical activity as the general population [11].

The lack of planners' understanding about the role or value of allied health is currently one of the most significant issues that AEPs report in relation to their ability to successfully provide services for NDIS participants and has been highlighted by many other allied health peak bodies. The NDIA needs to ensure these planners are appropriately trained and educated on each allied health scope of practice, so that funding allocations will ensure the best possible outcomes for NDIS participants.

As demonstrated above, funding decisions made against participant preferences and allied health recommendations have detrimental consequences on NDIS participants' functional capacity and health outcomes.

This happens because there is no enforced requirement for planners to undergo training, including ongoing training, on the value that allied health therapy has for people with disability, longer-term scheme sustainability and equity in plan funds between participants with similar needs. Nor are there repercussions for poor decision making by NDIS planners, which results in negative outcomes for participants.

Recommendation 4: That the Committee requests that the Minister for the NDIS to

- **mandate:**
  - **a minimum level of knowledge of each NDIS therapeutic support and allied health profession for internal NDIA decision-making staff, including planners**
  - **ongoing planner training to ensure planners' knowledge of therapeutic supports and allied health professions is regularly updated, in accordance with new and emerging evidence and**
  - **the employment of planners who have qualifications and/or experience in health or human services and**
- **provide sufficient resourcing to support planners to develop a strong understanding of the complex needs associated with participants' disabilities and their required care.**

ESSA has offered the NDIA the opportunity to inform planners by providing education and resources on the evidence-based benefits of exercise treatments for NDIS participants as well as the role and value of exercise physiology services on numerous occasions, through tailoring the content of Exercise is Medicine© (EIM©) Australia, to suit the needs of NDIS planners.

EIM® is a bespoke education program facilitated by local AEPs and can be delivered in face-to-face workshops and online. EIM sessions are currently designed to increase literacy of primary healthcare providers on the role that physical activity plays in health, wellbeing, inclusion, self-efficacy and the prevention and treatment of chronic disease. However, ESSA is yet to receive a response from the NDIA relating to its desire to utilise these resources.

Recommendation 5: That the Committee requests the NDIA engage ESSA to implement the Exercise is Medicine© program for NDIS planners to augment workforce knowledge and health literacy to better support NDIS participants.

ESSA advocates for the development of a legislative instrument such as a Code, Standard or Rule to align the NDIA's operations with the required accountability under the *National Disability Insurance Scheme Act 2013*. This instrument would support NDIA employees and provide clear requirements for accountability in NDIS participant decision making.

Recommendation 6: That the Committee requests the Minister for the NDIS develop a legislative instrument to support NDIA staff accountability relating to plan funding decision making consistency, and which will be administered by the NDIS Quality and Safety Commission.

4.2 RURAL AND REMOTE INEQUITIES

For NDIS plan budgets to be considered equitable, it would be expected that participant plan budgets should be higher for those who reside in rural and remote locations, due to the increased cost of service provision in these locations. However, the NDIA has failed to recognise that cost of goods and services are higher in Modified Monash Model (MMM) regions 3-5 then in MMM regions 1-2 [12] and has only allowed providers to claim additional funding for supports offered in MMM regions 6 and 7.

The NDIA uses a modification the MMM to categorise metropolitan, regional, remote and very remote areas. The NDIA use the table below to identify which MMM region a location is, with the exception of specifically listed towns, as indicated in the *NDIS Pricing Arrangements and Price Limits 2021-22* as *Isolated Towns Modification* [13].

Table 1: MMM region definitions as per the *NDIS Pricing Arrangements and Price Limits 2021-22*

Description	NDIA Zone	MMM	Inclusion
Metropolitan	MMM 1	1	All areas categorised as Major Cities of Australia in the Australian Bureau of Statistics Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) framework (see the ABS website).
Regional Centres	MMM 2-3	2	Areas categorised as Inner Regional Australia or Outer Regional Australia in the ASGS-RA that are in, or within 20km road distance, of a town with population >50,000.
		3	Areas categorised as Inner Regional Australia or Outer Regional Australia in the ASGS-RA that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
Regional Areas	MMM 4-5	4	Areas categorised as Inner Regional Australia or Outer Regional Australia in the ASGS-RA that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
		5	All other areas categorised as Inner Regional Australia or Outer Regional Australia in the ASGS-RA, except areas on islands that have a population of less than 1,000 and are not classified as MM2, MM3 or MM4.
Remote	MMM 6	6	All areas categorised as Remote Australia in the ASGS-RA, except areas on a populated island that is separated from the mainland and is more than 5km offshore; and Areas categorised as Inner Regional Australia or Outer Regional Australia in the ASGS-RA that are islands that have a population of less than 1,000 and are not otherwise classified.
Very Remote	MMM 7	7	All other areas - that being areas classified as Very Remote Australia in the ASGS-RA, and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

The *NDIS Pricing Arrangements and Price Limits 2021-22* states that price limits are 40% higher for supports delivered to a participant in an MMM 6 region and 50% higher for supports delivered to a participant in an MMM 7 region [13]. However, price limits are the same for participants who receive supports in MMM regions 1-5, despite the wide variability in the cost-of-service provision across these regions.

ESSA notes that the number of registered and employed health professionals decreases from 543,515 professionals in the MMM 1 and 2 regions, to just 98,590 professionals in MMM 3-7 regions combined [14] (Note: this data does not include self-regulating health professions). In order to attract health professionals into regional areas, governments have offered financial incentives to health professionals that practice in MMM regions 3—5, in addition to MMM regions 6 and 7.

One example of this is the Workforce Incentive Program, delivered by the Australian Government. The program offers quarterly financial incentives to practices that meet eligibility criteria, including those that offer allied health services, with loadings to these incentives of 20% for practices in MMM 3 regions, 30% for MMM 4-5 regions and 50% for MMM 6-7 regions [15].

ESSA suggests that by not offering higher price limits to therapy supports delivered in MMM regions 3-5, compared with MMM regions 1-2, allied health professionals are not incentivised to travel to MMM regions 3-5 to offer valuable therapy supports. This results in participants in MMM regions 3-5 with choice and access issues, i.e. limited choice and control unless they are willing and able to travel for hours to a region that offers the therapy supports they need.

ESSA suggests that the NDIA should raise therapy price limits in MMM regions 3-6 to match that of the Workforce Incentive Program, and concurrently raise the therapy supports budgets in participants' plans who live in these regions by an equivalent amount.

Recommendation 7a: That the Committee advise the NDIA to increase price limits for therapy supports delivered in MMM regions 3 by 20%, 4-5 by 40% and 6 by an additional 10%, in line with the Workforce Incentive Program.

Recommendation 7b: That the Committee advice the NDIA that planners need to ensure participants residing in MMM regions 3-6 have their plan budgets for therapy supports increased in line with the price limit increases for their region.

5.0 INADEQUATE FUNDING ALLOCATION FOR CAPACITY BUILDING SUPPORTS

How the NDIS is funded, including:

- ***i. the current and future funding sources for the NDIS,***
- ***ii. the division of funding between the Commonwealth, States and Territories, and***
- ***iii. the need for a pool of reserve funding;***

The NDIA has failed to recognise the potential return on investment in appropriately funding capacity building supports, including allied health therapy. As discussed above, NDIS planners often cut allied health therapy funding in participant plans as a cost saving measure. However, by adequately funding capacity building supports, such as exercise physiology, the NDIA may save costs on core supports, as well as increase participants ability to gain employment and pay income tax.

5.1 CORE SUPPORTS

Promoting independence is considered a core capability of allied health professionals that work with people with disabilities [16], including AEPs delivering therapeutic supports under the NDIS. By increasing participants' independence, their reliance on core supports, such as disability support workers to carry out everyday tasks on behalf of the participant, decreases. This has been experienced by many people with disabilities that received support by an AEP, as indicated in the case studies below.

Case study C

Nineteen-year-old female began seeing an AEP when she was 16. By the age of 16 her mobility and strength had deteriorated significantly as a result of having low tone Cerebral Palsy, and her weight had increased dramatically. When she first met her AEP, she needed assistance from two other people to stand from her wheelchair, she couldn't lift her own arms, and faced the prospect of developing chronic health conditions at a young age. She attended two exercise physiology sessions per week, starting at 30-minute sessions and progressing to 60-minute sessions. Through completing a variety of strength training exercises, she can now walk with minimal assistance, lift her arms above her head to be able to dress and shower herself, can throw a ball to her dog, and can stand from her wheelchair with no assistance, resulting in the participant's reduced need for a funded support worker to assist her with these tasks.

Case study D

Nine months after experiencing an ischaemic spinal cord injury, resulting in partial paralysis of the muscles in her legs, 40-year-old female presented to her AEP to improve her walking and ability to participate in daily activities with her family. Her ability to walk independently, to work, and to complete everything she had previously done as a mum of two teenagers was severely impacted by her injury. At the time of her initial appointment, she was using a 4-wheel frame indoors, a wheelchair outside, and needed assistance with daily family chores. For 6 months, she attended one 45-minute exercise physiology session per week focusing on strength training, improving muscle activation, and gait retraining and completed a daily home Pilates and walking program written by her AEP. She has now returned to part time work, can complete most daily activities to maintain her home with her children, has returned to driving, and can walk for 20 minutes with a walking stick. With these improvements she can now get back to enjoying time with her family and being a mum, without the daily assistance of a disability support worker.

Case study E

Forty-two-year-old with spastic quadriplegia cerebral palsy presented to an AEP with a goal to improve lower limb strength and quality of standing transfers. The participant's mobility had reduced significantly due to physical inactivity over the previous 18 months. In consultation with the referring physiotherapist and an occupational therapist, the AEP devised an intervention plan incorporating twice weekly sessions over 12 weeks with an aim to increase lower limb strength, standing endurance and increase confidence in completing standing transfers. Based on advice provided by the physiotherapist and occupational therapist, if improved leg strength and confidence in completing standing transfers was not achieved through exercise physiology, then the OT would explore potential assistive technology solutions, including hoisting systems and home modifications, and would need to introduce significant in-home care from support workers as a result.

After the 24 sessions with an AEP and the introduction of an appropriate home exercise program to compliment these sessions, the participant drastically improved lower limb strength, standing endurance and self-reported confidence in completing standing transfers. The impact of this intervention averted the need for assistive technology supports, and the need to engage support workers to assist with the activities of daily living that the participant was now able to conduct independently.

Case study F

Fifty-one-year-old with autism spectrum disorder (ASD) level 2 and intellectual disability, living in supported accommodation, presented with difficulty standing and carrying out self-care activities. The participant's house manager and support workers put in a referral to improve standing endurance during standing transfers, as there was recently a need to allocate two support workers to support the participant in self-care activities, such as dressing.

Exercise physiology was only allocated 10 hours in the NDIS plan to complete an appropriate assessment of current functional status and implement an intervention plan that would lead to improved standing endurance. In consultation with the house manager the AEP facilitated a blended model of service delivery which included 4 home visits, telehealth sessions which involved check in with support workers and developing capability with the house staff to facilitate the implementation of a home exercise program. Three months after the initial consultation the participant had increased standing endurance from 30 seconds at a time to over 90 seconds. As a result, the participant was able to independently carry out some activities of daily living. The house manager no longer needed to allocate two support staff to these activities daily, reducing rostering pressures on the house.

Further, many peer reviewed articles recognise that allied health intervention can increase independence and reduce reliance on supports for activities of daily living (ADLs). Some examples of these include:

- A study recognising that early intervention to address the symptoms negatively impacting independent living skills in people with Fragile X Syndrome is needed to improve functional outcomes [17].

- A study outlining that there is strong evidence supporting the ability for exercise therapy to restore balance and gait in people who have suffered a stroke [18].
- A study finding that allied health utilisation is associated with less assistance in ADLs and lower falls risk in people who have suffered a stroke [19].
- A systematic review that found strong evidence supporting that multidisciplinary allied health intervention improves ADLs in Parkinson's Disease [20].

5.2 EMPLOYMENT OF PARTICIPANTS

When allied health supports are adequately funded, participants are better supported to gain and maintain employment. One example of this is outlined in Case study D, above, where the participant was able to return to part time work as a result of AEP intervention.

Case study G also outlines an example of how access to exercise physiology has enabled a participant to maintain employment.

Case study G

22-year-old male with Rubinstein Taybi syndrome commenced work stacking shelves at a supermarket and needed assistance with improving his fine and gross motor skills to maintain his ability to complete tasks involved with his role. He also presented with significant intellectual disability.

The participant began seeing an AEP twice a week for a one-hour session. Treatment focused on strength and conditioning to maintain the participant's ability to lift heavy objects safely. These sessions have enabled the participant to maintain employment and prevent gross motor function related injury at work.

By increasing employment of people with a disability, the Australian Government may see an increase in income tax revenue and a decrease in spending on welfare via the Disability Support Pension (DSP). A 2011 Deloitte report states that "closing the gap between labour market participation rates and unemployment rates for people with and without disabilities by one-third would result in a cumulative $43 billion increase in Australia's GDP over the next decade" [21].

The Australian Institute of Health and Welfare reported that 668,000 people of working age (or 4.1% of this population) were receiving the DSP in 2019 [22]. The 2011 Deloitte report confirms that a significant number of these people want to work, but feel they are unable to access the support they need to gain and maintain employment [21]. As explained above, exercise physiology is a good example of a capacity building support that can help people with a disability move into work.

Recommendation 8: That the Committee acknowledge the potential for cost savings in core supports and tax income by adequately funding capacity building supports, such as investing in exercise physiology therapy, as a means of future funding support and/or financial sustainability of the NDIS.

6.0 DATA TRANSPARENCY AND ACCESSIBILITY

The measures intended to ensure the financial sustainability of the NDIS (e.g. governance, oversight and administrative measures), including:

- ***i. the role of state and territory governments, and the Disability Reform Ministers Meetings,***
- ***ii. the arrangements for providing actuarial and prudential advice about the scheme, and***
- ***iii. the way data, modelling, and forecasting is presented in public documents about the NDIS, (e.g. NDIS Quarterly Reports and Reports by the Scheme Actuary), and***
- ***iv. measures to ensure transparency of data and information about the NDIS;***

6.1 OUTCOMES AND EXPENDITURE DATA

ESSA notes that the NDIA often report on broad expenditure of the scheme and participant plan budgets. It would be useful to be able to obtain more detailed data. Specifically, ESSA is interested in how much funding is being

allocated to exercise physiology by NDIS planners, as well as how much participants are spending on exercise physiology.

It would also be useful for the NDIA to publish data on the outcomes of participants against plan budget expenditure. This would evidence the value and effectiveness of various supports. For example, the sector would be able to understand the impact of funding capacity building supports, such as allied health therapies.

If data was available on the allocation and expenditure of each NDIS support alongside participant outcomes, ESSA believes that this would enhance accountability and help drive better performance.

Recommendation 9: That the Committee advocate to the Minister of the NDIS to implement an online platform with publicly available data on participant plan budget allocation, expenditure on allied health therapies and participant outcomes.

6.2 INTERNAL REVIEW DATA

As described above, ESSA has seen many cases of NDIS planners making decisions against participant preferences and allied health professional recommendations, as well as creating overly prescriptive plans. For this reason, many participants are unsatisfied with their plans, and wish to lodge an appeal to have planner decisions altered. It is a requirement for participants to undergo an internal NDIA review of their appeal before they are able to apply to the Administrative Appeals Tribunal (AAT).

While the AAT report how many NDIS appeals they receive and clear, the NDIA do not report how many internal reviews that are applied for by participants, nor do they report on the outcomes of these internal reviews. It would be useful to have this information, as it would provide insight into the operation of the Agency and to see how many participants go on to apply to the AAT for an external review. Further, the ability to compare the number of changed decisions as a result of internal review with change decisions as a result of AAT review would offer accountability to the internal review process and outcomes and may result in reduced AAT applications.

Recommendation 10: That the Committee instruct the NDIA to publicly report on internal review data, including:

- **the number of internal review applications**
- **the number of internal review applications that resulted in a change of the original decision**
- **information on those applications that did not result in a change of the original decision, and the reasons why the decision was confirmed.**

7.0 PERSONALISED BUDGETS AND PLAN FLEXIBILITY

The ongoing measures to reform the scheme including:

i. the new early childhood approach, including whether or how early intervention and other supports intended to improve a participant's functional capacity could reduce their need for NDIS funding, and

ii. planning policy for personalised budgets and plan flexibility; and

ESSA members frequently report that NDIA planners prescribe how participant budgets are to be spent, down to the hour of support. The family described in Case Study B expressed that they could not use their child's plan for anything other than the plan dictated by the planner, in fear of having funds cut in the following year. Additionally, if planners continue to dictate how each hour of support is to be spent in a plan budget, participants are not empowered or enabled to explore multiple therapies to determine which will best suit their needs. For this reason, ESSA is supportive of the plan to introduce flexible plans. However, ESSA cautions that profiling participants, as stated in the NDIA's Personalised Budgets Technical Information Paper [23], will not offer personalised budgets that allow participants to achieve their individual goals.

ESSA recognises that participants with the same functional capacity and environmental impacts will have very different goals, resulting in different levels of funding required. For example, consider three participants with a visual impairment. One has the goal to join the workforce, another has the goal to learn to use a guide dog and a third wishes to improve physical capacity to ambulate safely following a fall that occurred due to their impaired vision. All three participants may have the same functional capacity, but require different supports, all with different costings.

The proposal by the NDIA indicates that draft budgets will be determined by the NDIA delegate prior to the participant's first planning meeting, where they discuss the participant's individual goals, and that draft budgets will only be adjusted if a participant has extensive and/or complex support needs or if additional high-cost supports relating to accommodation, assistive technology or home modifications. This approach does not allow for varying funding requirements based on participant goals.

ESSA suggests that consideration of participants' goals in determining the appropriate level of funding directly reflects the object prescribed in section 3(1)(e) of the National Disability Insurance Scheme Act 2013 (the Act), which states that an object of the Act is to "enable people to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports." Further, section 6 of the Act provides that the NDIA may provide financial support to participants in relation to meet obligations under the Act, i.e. pursuit of goals, as prescribed in section 3(1)(e).

Goals are an important component of what makes each participant individual. For the NDIA to allocate a truly personalised budget, goals must be considered when allocating draft personalised budgets and finalising personalised budgets.

Recommendation 11: That the Committee advocate to the Minister of the NDIS to amend the current policy for personalised budgets and plan flexibility to better consider participant goals, and to engage in meaningful consultation with the sector (including participants, providers and peak bodies) to ensure the policy fully meets the needs of participants.

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